# ALBANY COUNTY COALITION ON HOMELESSNESS: CONTINUUM OF CARE WRITTEN STANDARDS

## Preamble

The Continuum of Care (CoC) is responsible for establishing and consistently following written standards for administering assistance. Written standards provide a reference for coordinating and implementing a system to meet the needs of the population and subpopulations experiencing homelessness within the geographic area of the Albany County Coalition on Homelessness (ACCH). Both the Emergency Solutions Grant (ESG) and the Homeless Emergency Assistance and Rapid Transition to Housing Act (HEARTH) Continuum of Care Project Interim Rules and Regulations state that CoCs, "in consultation with recipients of ESG project funds within the geographic area, are intended to coordinate service delivery...and assist CoCs and their recipients in evaluating the eligibility of individuals and families consistently and administering assistance fairly and methodically" § 578.7(a)(9).[1]

All programs that receive ESG or CoC funding are required to abide by the ACCH written standards. The CoC strongly encourages projects that do not receive either of these sources of funds to accept and utilize these written standards. The goals of the ACCH written standards are to:

- Establish community-wide expectations and performance standards
- Provide the basis for monitoring CoC and ESG funded projects
- Clarify local priorities, which will ensure a transparent system
- Document the system for prioritizing assistance per project type
- Outline a strategy for the use of limited resources.

The ACCH written standards have been established to ensure that persons experiencing homelessness, who enter projects throughout the CoC, will be given unvarying information and support to access and maintain permanent housing and enable the CoC to end homelessness.

For each project type, the standards outline:

1. Purpose of the project type
2. Eligibility criteria
3. Prioritization
4. Minimum standards of assistance
5. Client access, and
6. Performance standards.

As a baseline, the ACCH has adopted current minimum standards set by HUD for all CoC funded projects and has worked collaboratively with CoC and ESG recipients/subrecipients to adopt the City of

[1] 24 CFR § 576.400(e)(1) If the recipient is a metropolitan city, urban county, or territory, the recipient must have written standards for providing Emergency Solutions Grant (ESG) assistance and must consistently apply those standards for all program participants. The recipient must describe these standards in its consolidated plan; (2) if the recipient is a state: the recipient must establish and consistently apply, or require that its sub recipients establish and consistently apply, written standards for providing ESG assistance.

Albany ESG standards as noted in the most recent Consolidated Plan. Requirements set by HUD for CoC and ESG projects include:

- Projects must have written policies and procedures and consistently apply them to all participants
- Projects that serve households with children must comply with the following:
    - A staff person must be designated as the educational liaison that will ensure children are enrolled in school, connected to appropriate services in the community, including early childhood project such as Head Start, Part C of the Individuals with Disabilities Education Act, and the McKinney Vento education services
    - The age and gender of a child under age 18 must not be used as a basis for denying any family's admission to a project that provides shelter for families with children
- Programs receiving ESG and CoC funding must participate in HMIS (Homeless Management Information System), however all homeless programs are strongly encouraged to participate in HMIS and meet the minimum HMIS data quality standards.
- Programs must coordinate and collaborate with other service providers within the geographic area (such as housing, social services, employment, education and youth programs, etc).
- Programs are required to participate in the Coordinated Entry System and use the prioritization criteria established in this document.
- Programs must keep documentation of homelessness on file
- Programs must keep documentation of amount, source and use of resources for each match contribution
- Programs must keep documentation of use of HMIS
- Programs must keep documentation for all eligible costs charged to the grant
- Eligibility requirements as defined by CoC and ESG funding are the standard for receiving assistance. Additional project requirements for eligibility are not the standard and cannot be grounds for rejection. Project participants can only be rejected because the eligibility criteria as defined by CoC and ESG funding and noted in the written standards is not met.
- Projects must have a formal procedure for terminating assistance to a participant that abides all project funding, state and federal regulations.
- All HUD funded projects must ensure equal access in housing to all eligible individuals and families regardless of sexual orientation, gender identity, or marital status. Equal access must be granted to individuals in accordance with the individual's gender identity, and in a manner that affords equal access to the individual's family.

The *Continuum of Care Written Standards* are implemented in coordination with *the Coordinated Entry Policies and Procedures,* the *Albany County 10 Year Plan to End Homelessness* and *A Strategic Plan to Prevent, Reduce and Combat Homelessness in Albany County*. Specifically, the following written standards for administering assistance within the Albany CoC geographic area serve as a reference to:

- Assist with the coordination of service delivery across the geographic area and are the foundation of the Coordinated Entry system
- Assist in assessing individuals and families consistently to determine project eligibility
- Set prioritization standards for administering assistance that are in line with strategies outlined by the CoC's vision and guiding principles for local targets that are complimentary to those within HUD's *Opening Doors*
- Assist in administering projects fairly and methodically to meet funding regulations
- Establish common core performance measures for all CoC and ESG component types

- Provide the basis for monitoring CoC and ESG funded projects
- Establish how standards will be reviewed regularly and evaluated for effectiveness

## Ongoing Review & Evaluation

As a document that represents the CoC, its available housing and services, populations, as well as local goals and values, these standards serve as a resource for providing assistance across the continuum in order to end homelessness.

The standards are to be reviewed annually in order to ensure the system of providing assistance is transparent, ensure local priorities are clear to all recipients, and as a CoC that limited resources are being used strategically. To guarantee the written standards are implemented comprehensively, project performance, HMIS data, Coordinated Entry tracking, as well as project participant and stakeholder input will all be considered when evaluating the written standards for effectiveness. As noted in the ACCH Bylaws, ongoing review and evaluation will be completed at least annually.

## Prioritization Standards

These written standards establish the community-wide expectation of how resources are to be targeted within the community. This is separate from meeting eligibility requirements, and specific to prioritizing assistance according to population and household types. Project participants must always meet eligibility criteria while all individuals and household types can be prioritized for a type of assistance. As prescribed in the *Coordinated Entry Policies & Procedures*, CoCs are instructed to prioritize assistance based on vulnerability and severity of service needs to ensure that people who need assistance the most can receive it in a timely manner. All CoC program-funded PSH accept referrals only through a single prioritized list that is created through the CoC's Coordinated Entry process, which is also informed by the CoC's street outreach. Populations and households prioritized for assistance include:

- Those prioritized in CoC funded PSH beds **Dedicated** to Persons Experiencing CH **or** PSH **Prioritized** for Occupancy by CH Persons are, in order of prioritization:
    - First Priority- Chronically Homeless Individuals and Families with the Longest History of Homelessness and with the Most Severe Service Needs are.
    - Second Priority- Chronically Homeless Individuals and Families with the Longest History of Homelessness are prioritized in CoC funded PSH beds **Dedicated** to Persons Experiencing CH and PSH **Prioritized** for Occupancy by CH Persons.
    - Third Priority- Chronically Homeless Individuals and Families with the most severe service needs are prioritized in CoC funded PSH beds **Dedicated** to Persons Experiencing CH and PSH **Prioritized** for Occupancy by CH Persons.
    - Fourth Priority- All other Chronically Homeless Individuals and Families
    - Fifth Priority- Non-chronically homeless households, as long as the recipient of CoC Program-funded PSH documents how it was determined that there were no chronically homeless households identified for assistance within the CoC's geographic area at the point at which a vacancy becomes available.
- Those prioritized in PSH beds that are NOT Dedicated or Prioritized for Persons Experiencing Chronic Homeless, in order of prioritization:
    - First Priority–Homeless Individuals and Families with a Disability with Long Periods of Episodic Homelessness, fewer than four occasions where they have been living or residing in a place not meant for human habitation, a safe haven, or in an emergency

shelter but where the cumulative time homeless is at least 12 months, **and** Severe Service Need.

- Second Priority - Homeless Individuals and Families with a Disability with Severe Service Needs. No minimum length of time required.
- Third Priority - Homeless Individuals and Families with a Disability Coming from Places Not Meant for Human Habitation, Safe Haven, or Emergency Shelter Without Severe Service Needs. No minimum length of time required.
- Fourth Priority–Homeless Individuals and Families with a Disability Coming from Transitional Housing where prior to residing in the TH had lived in a place not meant for human habitation, in an emergency shelter, or safe haven. This priority also includes individuals and families residing in TH who were fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking and prior to residing in that TH project even if they did not live in a place not meant for human habitation, an emergency shelter, or a safe haven prior to entry in the TH.
- Fifth Priority- All others that meet a lower priority of order, as long as the recipient of CoC Program-funded PSH documents how the determination was made that there were no eligible individuals or families within the CoC's geographic that met a higher priority.

**Housing First**

Housing First is a proven approach, applicable across all elements of systems for ending homelessness, in which people experiencing homelessness are connected to permanent housing swiftly and with few to no treatment preconditions, behavioral contingencies, or other barriers. Programs ensure that no potential clients are screened out or terminated based on any criteria outlined below.

- Access to programs is not contingent on sobriety, minimum income requirements, lack of a criminal record, completion of treatment, participation in services, or other unnecessary condition.
- Programs or projects do everything possible not to reject an individual or family on the basis of poor credit or financial history, poor or lack of rental history, minor criminal convictions, or behaviors that are interpreted as indicating a lack of "housing readiness."
- People with disabilities are offered clear opportunities to request reasonable accommodations within applications and screening processes and during tenancy, and building and apartment units includes special physical features that accommodate disabilities.
- Programs or projects that cannot serve someone work through the Coordinated Entry Process to ensure that those individuals or families have access to housing and services elsewhere.
- Housing and service goals and plans are highly tenant – driven.
- Supportive services emphasize engagement and problem- solving over therapeutic goals.
- Participation in services or compliance with service plans are not conditions of tenancy, but are reviewed with tenants and regularly offered as a resource to tenants.
- Services are informed by a harm-reduction philosophy that recognizes that drug and alcohol use and addiction are part of some tenants' lives. Tenants are engaged in non-judgmental communication regarding drug and alcohol use are offered education regarding how to avoid risky behaviors and engage in safer practices.
- Substance use in and of itself, without other lease violations, is not considered a reason for eviction.

- Tenants in supportive housing are given reasonable flexibility in paying their share of rent on time and offered special payment arrangements for rent arrears and/or assistance with financial management, including representative payee arrangements.
- Every effort is made to provide a tenant the opportunity to transfer from one housing situation, program, or project to another if a tenancy is in jeopardy. Whenever possible, eviction back into homelessness is avoided.

## Project Requirements Specific to City of Albany ESG-funded Projects

Projects funded with ESG funds will be expected to adhere to the following to be considered in good project standing and align with the standards:

- Project will be familiar with and adhere to all project requirements of ESG as stated in Title 24 of the Code of Federal Regulations, Part 576
- Project will work with City of Albany staff in developing and implementing the Albany County Continuum of Care Plan
- Collaborate with other homeless providers in the operation of the project
- Participate in trainings and coordination meetings
- Cooperate with related research and evaluation activities
- Prioritize referrals from homeless service providers with the City's Continuum of Care System as it relates to the Coordinated Entry System
- Meet high standards of professionalism in implementing the project
- Conform to all fiscal accountability standards required by the City of Albany and by the federal governments (24CFR, Part 84)

***Objectives and Outcomes Specific to ESG Funded Projects***

- Suitable living environment
- Affordable housing and affordability of services
- Creating economic opportunities
- Availability and accessibility of services and housing
- Sustainability of the above stated objectives

***Strategic Planning Objectives Specific to CoC Funded Projects***

- Increase the number of beds dedicated and prioritized to serve chronically homeless individuals
- Increase housing stability
- Increase project participant income
- Increase the number of participants obtaining mainstream benefits
- Increase the number of individuals and families served by Rapid Rehousing

## Written Standards by Project Type

The project types directly providing homeless housing and services included within the written standards and their location within the document are listed below.

## ACCESSING ASSISTANCE

The Albany County Coalition on Homelessness' *Coordinated Entry Policies and Procedures* is to be referenced per assistance type as it relates to *accessing assistance*. The *Policies and Procedures* outline the standardized access, assessment, and referral process for housing and other services across agencies in a community. This process is not intended to determine acceptance into a program; it is meant to prioritize community services based on need. Coordinated Entry assesses the person's housing needs, preferences, and vulnerability. During assessment, the person's needs and level of vulnerability may be documented for purposes of determining prioritization. Prioritization helps the CoC manage its inventory of community housing resources and services, ensuring that those persons with the greatest need and vulnerability receive the supports they need to resolve their housing crisis. Following prioritization, persons are referred to available CoC housing resources and services in accordance with the CoC's prioritization guidelines.

This Coordinated Entry process is intended to assure household eligibility for waiting list acceptance with programs having the ability and responsibility to ensure that household needs are best served by their program. The goal of Coordinated Entry is to link all Emergency Solutions Grant, CoC funded, and non-CoC funded programs in order to best assess households to effectively and efficiently refer households to services.

***HUD Required Fundamentals***

- Full coverage - The Coordinated Entry Process must cover the CoC's entire geographic area with access points that are accessible and well advertised to the people living there.
- Outreach - Any street outreach efforts must be linked to the Coordinated Entry Process.
- Emergency Services – The Coordinated Entry Process must allow people experiencing a housing crisis to access emergency services with as few barriers as possible.
- Standardized Access and Assessment – The Coordinated Entry Process must use the same assessment process at all access points.
- Marketing and Non-Discriminatory Access – CoC's and recipients of HUD Coc and ESG Programs are required to affirmatively market their housing and supportive services projects to eligible persons who are least likely to apply in the absence of special outreach.
- Safety Planning – The CoC's access must ensure the safety of persons who are fleeing, or attempting to flee, domestic violence (as well as dating violence, sexual assault, trafficking, or stalking).
- Privacy – The Coordinated Entry Process must ensure adequate privacy protections are extended to and enforced for all participants from the first point of access, through assessment and prioritization, and after participants have been offered permanent housing and even exited CoC projects.

The *Coordinated Entry Policies and Procedures* can be found on the Albany County Coalition on Homelessness website caresny.org/continuum-of-care/albany-county-coalition-on-homelessness/coordinated-entry-albany-county/.

## HOMELESSNESS PREVENTION

Homeless Prevention activities are available to persons who are at risk of becoming homeless. Homeless prevention assistance can be used to prevent an eligible individual or family from becoming homeless or to help to regain stability in their current housing or other permanent housing. Eligible activities include housing relocation and stabilization services as well as short and medium-term rental assistance. Please note, for further information regarding the administration of Homelessness Prevention, refer to the *Substantial Amendment to the City of Albany's* most recent *Annual Action Plan* which can be found on the City of Albany's website, albanyny.org.

***Eligibility Criteria (ESG)***

- Participants must meet the HUD definition of homelessness or at risk of becoming homeless.
- Participants must have combined income **below** 30% Area Median Income (AMI).
- Participant must be a City of Albany resident.
- Participant lacks identifiable financial resources and/or support networks.

***Minimum Standard of Assistance (ESG)***

- Up to $450 in arrear payments
- A set stipend of $200 for up to three months
- Up to $300 for utility payments (arrears, deposit, or first month's rent)
- Rental assistance is provided for a maximum of 3 months (not including arrear payments)
- Assistance will not be adjusted over time

***System Performance Standard: Expected Outcomes***

- Reduce the Number of Homeless Households Seeking Emergency Shelter
    - At least a 20% increase in diversions for homeless households within the City of Albany
    - At least 80% of households served will maintain permanent housing for 90 days after discharge.

## OUTREACH

Street Outreach serves unsheltered homeless individuals and families, connecting them with emergency shelter, housing, or critical services, and providing them with urgent, non-facility-based care. Services are provided to eligible participants residing in a place not meant for human habitation. Essential services of street outreach include: engagement, case management, emergency health and mental health services, and transportation, and services for special population. Please note, for further information regarding the administration of Outreach, refer to the *Substantial Amendment to the City of Albany's* most recent *Annual Action Plan.*

***Eligibility Criteria***

- Participants must meet the HUD definition of unsheltered homelessness.

***Minimum Standard of Assistance***

- Please note, due to the varying nature of Outreach projects that may function within the CoC, the official minimum standards of assistance are tailored to align with the specific purpose of the particular project.

***System Performance Standards: Expected Outcomes***

- Expand Homeless Outreach Services
    - At least 10% more households will be provided services than the previous year.

## EMERGENCY SHELTERS

Essential services of emergency shelter includes: case management, child care, education services, employment assistance and job training, outpatient health services, legal services, life skills training, mental health services, substance abuse treatment services, transportation, and services for special populations.

***Eligibility Criteria***

- Participants must meet the HUD definition of homelessness

***Minimum Standard of Assistance***

- Provision of shelter, food, and personal care items.
- Assistance in transitioning to permanent housing

***System Performance Standards: Expected Outcomes***

- Reduce Rates of Homelessness
    - At least 30% of households will exit to permanent housing destinations.
    - Average length of stay is less than 20 days

## RAPID RE-HOUSING PROJECTS (RRH)

Rapid Re-Housing is available to help those who are literally homeless be quickly and permanently housed. Rapid Re-Housing Projects (RRH) provide housing relocation and stabilization services and short or medium term rental assistance as needed to help a homeless individual or family move as quickly as possible to permanent housing and achieve stability in that housing. Please note, Rapid Rehousing funds are available through both CoC and ESG. For further information regarding the administration of Rapid Rehousing through ESG, refer to the *Substantial Amendment to the City of Albany's* most recent *Annual Action Plan.*

***Eligibility Criteria (ESG)***

- Participants must meet the HUD definition of homelessness.
- Participants must have combined income below 30% Area Median Income (AMI).
- Participant must be a City of Albany resident.
- Participant lacks identifiable financial resources and/or support networks.

***Minimum Standards of Assistance (ESG)***

- A set rental stipend of $200 for three months with the possibility of a one-time three month extension with written approval from Albany Community Development
- Up to $300 for utility payments (arrears, deposit, or first month's rent)
- Rental assistance is provided for a maximum of 3 months (not including arrear payments)
- Assistance will not be adjusted over time

- Follow-up will occur at minimum monthly while participants are receiving assistance
- Follow-up will occur at six months after discharge

***Eligibility Criteria (CoC)***

- Participants must meet the HUD definition of homelessness.
- Participants lack identifiable financial resources and/or support networks

***Minimum Standards of Assistance (CoC)***

- A rental subsidy based on income for six months with the possibility to extend assistance
- The rental subsidy amount will account for participants paying no more than 30% of their adjusted income or 10% of their gross income towards rent
- Assistance may be extended
- Supportive services designed to meet the needs of the project participants must be made available to the project participants throughout the duration of RRH assistance
- Follow-up will occur at minimum monthly while participants are receiving assistance
- Follow-up will occur at six months after discharge

***System Performance Standards: Expected Outcomes***

- Reduce the Number the Length of Homelessness for Homeless Households
    - At least 80% of households served will be placed in permanent housing within 60 days.
    - At least 80% of households served will maintain permanent housing for 90 days after discharge.

***Performance Standards: Strategic Planning Objectives***

- 80% or more of all participants remain stable in RRH or exit to other permanent housing destinations
- 54% or more of adult participants will increase income from sources other than employment
- 20% or more of adult participants will increase income from employment

## TRANSITIONAL HOUSING PROGAMS

Transitional Housing (TH) is designed to provide homeless individuals and families with interim stability and support to successfully move to and maintain permanent housing.

***Eligibility Criteria***

- Participants must meet the HUD definition of homelessness

***Minimum Standards of Assistance***

- Maximum length of stay cannot exceed 24 months
- Assistance in transitioning to permanent housing must be provided
- Support services must be provided throughout the duration of stay in transitional housing
- Project participants in transitional housing must enter into a lease agreement for a term of at least one month. The lease must be automatically renewable upon expiration, except on prior notice by either party, up to a maximum term of 24 months

***Performance Standards: Strategic Planning Objectives***

- 80% or more of all participants will exit to permanent housing destinations
- 54% or more of adult participants will increase income from sources other than employment
- 20% or more of adult participants will increase income from employment

## PERMANENT SUPPORTIVE HOUSING

Permanent Supportive Housing (PSH) for persons with disabilities is permanent housing with indefinite leasing or rental assistance paired with supportive services to assist homeless persons with a disability or families with an adult or child member with a disability achieve housing stability.

***Eligibility Criteria***

- Participants must meet the HUD definition of homelessness
- PSH can only provide assistance to individuals with disabilities and families in which at least one adult or child has a disability.

***Minimum Standards of Assistance***

- There can be no predetermined length of stay for a PSH project
- Supportive services designed to meet the needs of the project participants must be made available to the project participants throughout the duration of stay in PSH
- Project participants in PSH must enter into a lease (or sublease) agreement for an initial term of at least one year that is renewable and is terminable only for cause. Leases (or subleases) must be renewable for a minimum term of one month.

***Performance Standards: Strategic Planning Objectives***

- 80% or more of all participants will remain stable in PSH or exit to other permanent housing destinations
- 54% or more of adult participants will increase income from sources other than employment
- 20% or more of adult participants will increase income from employment

## SUPPORTIVE SERVICES PROJECTS

The supportive services only (SSO) project component allows for the provision of services to homeless individuals and families not residing in housing operated by the recipient of SSO funding. SSO projects provide services to persons experiencing homelessness that are not tied to specific housing units. Supportive services can include conducting outreach to sheltered and unsheltered homeless persons and families, link clients with housing or other necessary services, and provide ongoing support.

***Eligibility Criteria***

- Participants must meet the HUD definition of homelessness

***Minimum Standards of Assistance***

- Please note, due to the varying nature of SSO projects that may function within the CoC, the official minimum standards of assistance are tailored to align with the specific purpose of the particular project.

***Performance Standards: Strategic Planning Objectives***

- Please note, due to the varying nature of SSO projects that may function within the CoC, the official performance standards are tailored to align with the specific purpose of the particular project.

## HOMELESS MANAGEMENT INFORMATION SYSTEM

Under the HEARTH Act, HMIS participation is a statutory requirement for all CoC and ESG funded projects. Victims service providers cannot participate in HMIS, these providers must use a comparable database that produces unduplicated and aggregate reports in its place. The ACCH is responsible for designating the HMIS lead who is responsible for the operation and administration of the HMIS.

***Minimum Standards***

- Produce an unduplicated count of persons experiencing homelessness for the CoC
- Describe the extent and nature of homelessness within the CoC
- Identify patterns of service use
- Measure program effectiveness

***Performance Standards: Expected Outcomes***

- Increase and Maintain Data Quality within HMIS
- No more than 5% error rate for all required fields.

## MOVE ON STRATEGY FOR RECOGNITION OF TENANT INDEPENDENCE

Albany County Coalition to End Homelessness (ACCH, the Albany County Care Continuum of Care) has created a Move On Strategy to transition households in Supportive Housing (including Permanent Supportive Housing (PSH) and Rapid Rehousing (RRH)) who no longer need intensive services to affordable housing. This strategy is broken into Phase I and Phase II, and sets out the actions ACCH will take to ensure the community has suitable long-term, affordable housing options for tenants ready to move on, and that tenants have the skills and are empowered to make this decision. The fundamental goal of the Move On Strategy is to promote the highest levels of independence and choice for tenants, as well as to create flow in supportive housing units to ensure these units are available for currently homeless families and individuals with disabilities who need housing combined with services. Promoting economic mobility and self-sufficiency, the Move On Strategy is first and foremost about celebrating growth, recovery and tenant success, and ensures all services are provided using strengths-based language and a recovery-focused model. Below details the CoC's process for identifying tenants who are eligible to move on; documentation needed to request ideal candidates for the strategy; and providing guidance for tenants on safety and security while prioritizing resources where they are most needed. The plan is based on a model Move On strategy discussed by the U.S. Department of Housing and Urban Development (HUD) and the Corporation for Supportive Housing. The ACCH Systems, Operations and future

Resource Development Committees will be responsible for providing regular trainings, resources, relationship building, and outcome tracking to support implementation of and monitor the Moving On Strategy.

**Recruiting Affordable Housing Providers**

The Move On Strategy targets existing tenants in supportive housing who are stable and require only minimal supportive services. These tenants are, with client choice, assisted to transition to a mainstream rent subsidy (typically the Housing Choice Voucher program) or an affordable housing unit, which frees up their subsidy for someone who is chronically homeless and needs the intensive services and long-term subsidies offered in supportive housing. The mainstream rent subsidy may include programs like Public Housing Authorities (PHAs), multifamily assisted housing owners, Low Income Tax Credit (LIHTC) developments, and local low-income housing programs. Phase I of the Move On Strategy has been implemented with Albany Housing Authority (AHA), who has a preference for individuals and families moving on from RRH units. Phase II of the Move On Strategy will include recruiting other local affordable housing providers to participate in the program, by setting preferences for tenants moving on from supportive housing.

**Identifying Households for Moving On**

Housing providers identify households in supportive housing that may be ready to move on through ongoing case management with tenants. Specifically, program staff meet with tenants on an ongoing basis to establish tenant goals and set a plan towards meeting those goals, utilizing strengths-based language and a recovery-focused model. Program staff implement a client-choice model by ensuring tenants know there is a voluntary option to move on. Program staff ensure tenants interested in moving on (1) have demonstrated the ability to live stably and maintain housing, (2) will meet PHA (or other affordable housing providers) screening criteria, and (3) understand the decision to move on from supportive housing is voluntary. During Phase II of this strategy, a standardized assessment for moving on will be developed and implemented.

Program staff work with tenants to create a formal and comprehensive transition plan that identifies tenant strengths, living skills and the supports necessary to help them meet transition goals. Pre-transition plans are individualized to meet the specific needs of each household. Some common resources or supports tenants often need and are connected to include: employment supports, benefits counseling, activities of daily living skills, community living skills, and connection to community-based services. As households volunteer, housing providers make referrals to the PHA (or other affordable housing providers).

**Eligibility Considerations for Tenants**

Individuals are identified by housing provider program staff who work directly with clients in the housing programs. Clients should meet four basic criteria in order to be recommended to move on: 1) a good rental history of on-time payments, 2) evidence of “good neighbor” behavior without any complaints or property management conflicts, 3) supported progress of quantitative areas and 4) low service needs.

Housing providers identify households in supportive housing who may be candidates for moving on by analyzing observations (interviews/survey's, demonstrated ability to live stably and maintain housing or any other mitigating circumstances) combined with quantitative key areas for assessing tenant capacity, motivation, confidence and emotional readiness. These key quantitative areas include:

- Emotional independence (interest and confidence in moving on),
- Financial Capacity (employment, income, savings, budgeting skills),
- Housing history (housing tenure, rent arrears, past evictions, neighbor/landlord relationships)
- Intensity of service use (need for on-site services),
- Health/behavioral health (substance use, mental health, medication management, treatment engagement, mobility),
- Connection to mainstream resources (rental supports if needed),
- Connection to family or other natural supports,
- Community living skills (self-managing behavior, limit setting relating to drugs, etc.),
- Activities of daily living skills (ability to get meals, keep apartment clean, follow lease), and
- Housing goals (location, size, affordability, live with family/friends).

**Transition Services**

Housing Providers are required to provide: assistance with locating and securing a housing unit; case management to support transition including but not limited to assistance building linkages to community supports and services, such as mental and physical health services, substance use treatment, stores for groceries and other necessities, recreational activities and public transportation options; and support with landlord negotiations. Services offered may also include: providing funds to cover moving services, utility deposits/arrears and furniture/household items; and assistance with family reunification.

**Aftercare Supports**

ACCH recommends housing providers offer voluntary aftercare services to individuals who have moved on for at least six months after their move-out, and track types of supports provided and outcomes of those supports. It is recommended housing providers provide a minimum of two check-ins per month that can be in-person, by phone or by email.

**Creating a Culture of Moving On**

ACCH believes a programmatic reward/incentive structure for Moving On can assist in further promoting a culture of independence and self-sufficiency. The CoC will develop a variety of strategies to publicize and build interest in Moving On opportunities, including providing trainings on and working with providers to: post fliers in highly visible locations; host community meetings on Moving On; conducting one-on-one outreach to tenants; and encourage Moving On peers to talk about their experiences and engage tenants.

**Moving on Timing and Availability**

ACCH understands a Move On request may not be able to be satisfied immediately due to a variety of variables. However, the housing program will act as quickly as possible with community partners to move a tenant into appropriate affordable housing.

**Ongoing CoC Assessment of Move On Strategy**

Once annually the CoC will assess the success of this Move On Strategy, reviewing number/percentage of persons who have moved on and rate of retention in affordable housing destinations. The CoC will also discuss strengths/weaknesses related to the strategy's recommendations for recruiting affordable housing providers, identifying households for moving on, eligibility considerations for tenants, transition services, aftercare supports, and creating a culture of moving on.

## MOVE ON STRATEGY FOR RECOGNITION OF TENANT INDEPENDENCE

Albany County Coalition to End Homelessness (ACCH, the Albany County Care Continuum of Care) has created a Move On Strategy to transition households in Supportive Housing (including Permanent Supportive Housing (PSH) and Rapid Rehousing (RRH)) who no longer need intensive services to affordable housing. This strategy is broken into Phase I and Phase II, and sets out the actions ACCH will take to ensure the community has suitable long-term, affordable housing options for tenants ready to move on, and that tenants have the skills and are empowered to make this decision. The fundamental goal of the Move On Strategy is to promote the highest levels of independence and choice for tenants, as well as to create flow in supportive housing units to ensure these units are available for currently homeless families and individuals with disabilities who need housing combined with services. Promoting economic mobility and self-sufficiency, the Move On Strategy is first and foremost about celebrating growth, recovery and tenant success, and ensures all services are provided using strengths-based language and a recovery-focused model. Below details the CoC's process for identifying tenants who are eligible to move on; documentation needed to request ideal candidates for the strategy; and providing guidance for tenants on safety and security while prioritizing resources where they are most needed. The plan is based on a model Move On strategy discussed by the U.S. Department of Housing and Urban Development (HUD) and the Corporation for Supportive Housing. The ACCH Systems, Operations and future Resource Development Committees will be responsible for providing regular trainings, resources, relationship building, and outcome tracking to support implementation of and monitor the Moving On Strategy.

**Recruiting Affordable Housing Providers**

The Move On Strategy targets existing tenants in supportive housing who are stable and require only minimal supportive services. These tenants are, with client choice, assisted to transition to a mainstream rent subsidy (typically the Housing Choice Voucher program) or an affordable housing unit, which frees up their subsidy for someone who is chronically homeless and needs the intensive services and long-term subsidies offered in supportive housing. The mainstream rent subsidy may include programs like Public Housing Authorities (PHAs),

multifamily assisted housing owners, Low Income Tax Credit (LIHTC) developments, and local low-income housing programs. Phase I of the Move On Strategy has been implemented with Albany Housing Authority (AHA), who has a preference for individuals and families moving on from RRH units. Phase II of the Move On Strategy will include recruiting other local affordable housing providers to participate in the program, by setting preferences for tenants moving on from supportive housing.

**Identifying Households for Moving On**

Housing providers identify households in supportive housing that may be ready to move on through ongoing case management with tenants. Specifically, program staff meet with tenants on an ongoing basis to establish tenant goals and set a plan towards meeting those goals, utilizing strengths-based language and a recovery-focused model. Program staff implement a client-choice model by ensuring tenants know there is a voluntary option to move on. Program staff ensure tenants interested in moving on (1) have demonstrated the ability to live stably and maintain housing, (2) will meet PHA (or other affordable housing providers) screening criteria, and (3) understand the decision to move on from supportive housing is voluntary. During Phase II of this strategy, a standardized assessment for moving on will be developed and implemented.

Program staff work with tenants to create a formal and comprehensive transition plan that identifies tenant strengths, living skills and the supports necessary to help them meet transition goals. Pre-transition plans are individualized to meet the specific needs of each household. Some common resources or supports tenants often need and are connected to include: employment supports, benefits counseling, activities of daily living skills, community living skills, and connection to community-based services. As households volunteer, housing providers make referrals to the PHA (or other affordable housing providers).

**Eligibility Considerations for Tenants**

Individuals are identified by housing provider program staff who work directly with clients in the housing programs. Clients should meet four basic criteria in order to be recommended to move on: 1) a good rental history of on-time payments, 2) evidence of “good neighbor” behavior without any complaints or property management conflicts, 3) supported progress of quantitative areas and 4) low service needs.

Housing providers identify households in supportive housing who may be candidates for moving on by analyzing observations (interviews/survey’s, demonstrated ability to live stably and maintain housing or any other mitigating circumstances) combined with quantitative key areas for assessing tenant capacity, motivation, confidence and emotional readiness. These key quantitative areas include:

- Emotional independence (interest and confidence in moving on),
- Financial Capacity (employment, income, savings, budgeting skills),
- Housing history (housing tenure, rent arrears, past evictions, neighbor/landlord relationships)
- Intensity of service use (need for on-site services),
- Health/behavioral health (substance use, mental health, medication management, treatment engagement, mobility),

- Connection to mainstream resources (rental supports if needed),
- Connection to family or other natural supports,
- Community living skills (self-managing behavior, limit setting relating to drugs, etc.),
- Activities of daily living skills (ability to get meals, keep apartment clean, follow lease), and
- Housing goals (location, size, affordability, live with family/friends).

**Transition Services**

Housing Providers are required to provide: assistance with locating and securing a housing unit; case management to support transition including but not limited to assistance building linkages to community supports and services, such as mental and physical health services, substance use treatment, stores for groceries and other necessities, recreational activities and public transportation options; and support with landlord negotiations. Services offered may also include: providing funds to cover moving services, utility deposits/arrears and furniture/household items; and assistance with family reunification.

**Aftercare Supports**

ACCH recommends housing providers offer voluntary aftercare services to individuals who have moved on for at least six months after their move-out, and track types of supports provided and outcomes of those supports. It is recommended housing providers provide a minimum of two check-ins per month that can be in-person, by phone or by email.

**Creating a Culture of Moving On**

ACCH believes a programmatic reward/incentive structure for Moving On can assist in further promoting a culture of independence and self-sufficiency. The CoC will develop a variety of strategies to publicize and build interest in Moving On opportunities, including providing trainings on and working with providers to: post fliers in highly visible locations; host community meetings on Moving On; conducting one-on-one outreach to tenants; and encourage Moving On peers to talk about their experiences and engage tenants.

**Moving on Timing and Availability**

ACCH understands a Move On request may not be able to be satisfied immediately due to a variety of variables. However, the housing program will act as quickly as possible with community partners to move a tenant into appropriate affordable housing.

**Ongoing CoC Assessment of Move On Strategy**

Once annually the CoC will assess the success of this Move On Strategy, reviewing number/percentage of persons who have moved on and rate of retention in affordable housing destinations. The CoC will also discuss strengths/weaknesses related to the strategy's recommendations for recruiting affordable housing providers, identifying households for moving on, eligibility considerations for tenants, transition services, aftercare supports, and creating a culture of moving on.

# EMERGENCY TRANSFER PLAN FOR VICTIMS OF DOMESTIC VIOLENCE, DATING VIOLENCE, SEXUAL ASSAULT OR STALKING

**Emergency Transfers**

The Albany County Coalition on Homelessness Care Continuum of Care is concerned about the safety of the tenants of the housing programs within its geographic area that are funded by Continuum of Care (CoC) Grant funds and such concern extends to tenants who are victims of domestic violence, dating violence, sexual assault, or stalking. In accordance with the Violence Against Women Act (VAWA), CoC - funded programs providing permanent housing or transitional housing, except safe havens, must allow tenants who are victims of domestic violence, dating violence, sexual assault, or stalking to request an emergency transfer from the tenant's current unit to another unit.

The ability of a housing program to honor such a request for tenants currently receiving rental assistance, however, may depend upon a preliminary determination that the tenant is or has been a victim of domestic violence, dating violence, sexual assault, or stalking, and on whether the housing provider has another dwelling unit that is available and is safe to offer the tenant for temporary or more permanent occupancy.

This plan identifies tenants who are eligible for an emergency transfer; the documentation needed to request an emergency transfer; confidentiality protections; and how an emergency transfer may occur. In addition, it provides guidance for tenants on safety and security. The plan is based on a model emergency transfer plan published by the U.S. Department of Housing and Urban Development (HUD), the federal agency which ensures that ACCH and the CoC funded providers within its geographic area in compliance with VAWA.

**Eligibility for Emergency Transfers**

A tenant who is a victim of domestic violence, dating violence, sexual assault, or stalking, as provided in HUD's regulations at 24 CFR part 5, subpart L, is eligible for an emergency transfer, if: The tenant reasonably believes that there is a threat of imminent harm from further violence if the tenant remains within the same unit; or The tenant is a victim of a sexual assault, and the sexual assault occurred on the premises within the 90-day period preceding a request for an emergency transfer. A tenant requesting an emergency transfer must expressly request the transfer in accordance with the procedures described in this plan.

To request an emergency transfer, a tenant must notify the housing program's administrator or manager and submit a written request for a transfer to that individual. The tenant's written request for an emergency transfer should include either:

1. A statement expressing why the tenant reasonably believes that there is a threat of imminent harm from further violence if the tenant remains in the same dwelling unit assisted under the housing provider's program; or

2. A statement that the tenant was a sexual assault victim and that the sexual assault occurred on the premises during the 90-day period preceding the tenant's request for an emergency transfer.

The housing program may request additional documentation from a tenant in accordance with the documentation policies of HUD's regulations at 24 CFR part 5, subpart L.

**Confidentiality**

The housing program will keep confidential any information that the tenant submits in requesting an emergency transfer, unless the tenant gives the housing program written permission to release the information or disclosure of the information is required by law or in the course of an eviction or termination proceeding. This includes keeping confidential the new location of the dwelling unit of the tenant, if one is provided, from the person or persons that committed the act or acts of domestic violence, dating violence, sexual assault, or stalking against the tenant.

**Emergency Transfer Timing and Availability**

The housing program cannot guarantee that a transfer request will be approved or how long it will take to process a transfer request. However, the housing program will act as quickly as possible to move a tenant who is a victim of domestic violence, dating violence, sexual assault, or stalking to another unit, subject to the availability and safety of a unit. If the housing program does not expect to have another unit available within a reasonable period of time, it will contact other housing programs in the area to determine whether they have an available unit. If a unit is available, the tenant must agree to abide by the terms and conditions that govern occupancy in the unit to which the tenant is being transferred.

**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. The tenant is encouraged to contact the National Domestic Violence Hotline at 1-800-799-7233, or a local domestic violence shelter, for assistance in creating a safety plan. For persons with hearing impairments, that hotline can be accessed by calling 1-800-787-3224 (TTY).

**Attachment 1: Local organizations offering assistance to victims of domestic violence.**

**ATTACHMENT 1**

# LOCAL ORGANIZATIONS OFFERING SERVICES TO VICTIMS OF DOMESTIC VIOLENCE

## **Equinox** - Dynamic human services agency with deep roots in the Capital Region community.

**24-hour Domestic Violence Hotline (518) 432-7865**

All calls are confidential. We provide information, crisis intervention, counseling, referral, and/or shelter. **The hotline is available to victims, friends, family, and other concerned individuals. Collect calls accepted**.

**People**

Equinox Domestic Violence Services are available to all victims and their dependent children, regardless of gender, age, ethnicity, or sexual orientation.

**Programs**

Equinox is Albany County's primary provider of services for victims of domestic violence. **All Domestic Violence services are confidential and free of charge**.

**Purpose**

To provide safety for victims of Domestic Violence, including the elderly, and offer the support, assistance and tools they need to escape abusive situations and take control of their lives.

## Albany County Support for Domestic Violence Victims

**24-Hour Sexual Assault Hotline: (518) 447-7716**

**The Albany County Crime Victim and Sexual Violence Center offers information and confidential counseling to victims** of domestic violence and their children and to their families and friends. Short-term, goal-oriented treatment is available to child and adult crime victims recovering from the trauma.