SACRAMENTO STEPS FORWARD

Ending Homelessness. Starting Fresh.

Combined CES and CES Evaluation Committee Meeting

February 6, 2020 | 1:00 PM – 3:00 PM
1331 Garden Highway, Suite 100, Sacramento, CA 95833 | NIC Main

Attendance:

Member	Area of Representation
John Foley	Sacramento Self Help Housing
Steve Watters	First Step Communities
Shelly Hubertus	Waking the Village
Josh Arnold	Volunteers of America
Peter Muse	Veterans Resource Center
Tina Glover	SACOG
Ragan Kontes	Salvation Army
Robynne Rose-Hayner	Wind Youth Services
Monica Rocha-Wyatt	Behavioral Health Services
Julie Field	Sacramento County DHA
Howard Lawrence	ACT
Peter Bell	Wind Youth Services

Staff	Title
Michele Watts	SSF Chief of Programs
Keri Arnold	SSF Referral Specialist
Joe Concannon	SSF CES Program Manager
Christine Wetzel	SSF Referral Lead

I. **Welcome & Introductions:** John Foley, Chair			
A. Update on CESH Work report from Systems Committee	- Joe Concannon, SSF	2:05 PM	Information
John Foley and Joe Concannon described the content of the first Systems Committee meeting. They presented the concept of the two committees meeting together at points during the			

System Mapping and CE Redesign phases of the Homebase contract to prevent duplicate efforts and to ensure providers familiar with Coordinated Entry (CE) are included those phases of the project. Joe described Homebase timeline and potential timing of Homebase recommendations coming to the Committee.

B. Review of Discussion with Santa Clara County CoC and Feedback on Re-Design	Presenter: John Foley, Chair	2:15 PM (10 minutes)	Information

John asked for observations on the discussion with Santa Clara CoC on their CE program. He shared that it was interesting how Santa Clara required all programs receiving County funding to participate in CE. The CoC also didn't use case conferencing for the general population and instead relied on county-wide coordinated outreach to get clients ready for housing.

Joe suggested that having the County as the administrator of the CoC programs made it easier for all County departments and providers to buy into CE. He said that it was also good to hear about Santa Clara County's formal diversion program. He explained that a similar program was asked for in the community meetings the solicited ideas for the HHAP funding.

Peter B. brought up the "smart shelter" model (identifying clients who are most vulnerable via Coordinated Entry, move that client into a shelter, get the person doc ready with the intention of moving client to stable, Permanent Supportive Housing (PSH)). Committee members discussed the "smart shelter" model, e.g. what implementation would look like, how turnover rate at shelter would be advantageous to all, etc.

C. Refresher – HUD Requirements for Prioritization and Overview of the Current Processes	- Joe Concannon, CES Program Manager, SSF	2:10 PM (15 minutes)	Discussion

Joe presented the slides below to refresh the Committee's understanding of how the Coordinated Entry Referral process (VI-SPDAT, Community Queue, Types of Programs (via HUD), Documentation requirements for each program, Referral Process into PSH &RRH, CoC Hotlist Alerts, Case Conferencing for Coordinated Entry) is operating at SSF. There were no questions.

D. How Case Conferencing is Working in the TAY and Veteran Subpopulation Working Collaboratives.	- Presenter(s): Shelly Hubertus, Waking the Village, Peter Muse, Veterans Resource Center.	2:40 PM (30 min)	Discussion

TAY Case Conferencing:

There is broad Inter-agency participation with a client-centered approach (front-line staff also present). The collaborative uses the by-name list to identify the next TAY who are being prioritized for PSH (staff can also make recommendations of youth who are not on the by-name list but who is in need). Twenty to twenty-five clients are discussed at each meeting. Collaborative members develop solutions to overcome the challenges each client faces for entering the available programs.

Veteran Case Conferencing:

Veterans Collaborative operates similarly to the TAY Collaborative. Provider case conferencing was initially specific to just Veteran opportunities/housing inventories, but has since expanded to include Coordinated Entry opportunities, as well. It grew from the Homeless Veteran Challenge, Built for Zero and is supported nationally by Community Solutions. The Collaborative has set a goal of housing all, chronic, senior, veterans before moving down the list to non-seniors.

E. Open Discussion – How Can We Design Case Conferencing for the General Population?	Meeting Attendees	3:15 PM	Discussion

Based on the discussion with the TAY and Veteran Collaboratives meeting attendees offered the following observations and suggestions.

- SSF should explore the possibility of trying to re-engage providers for the general population and get feedback more detailed feedback on how case-conferencing might work.
- Look into dividing by-name list (e.g. top 100 most vulnerable) into subcategories based on commonalities, e.g. families with minors grouped together, etc. Set up meetings working with providers who work with those populations.

- Regular & consistent meetings, at consistent locations, is important to keep the community on track.
- Make sure the participants acknowledge their accomplishments t garner more interest/buy-in from others.
- It is important for case conferencing include more than just housing, much in the same way the TAY case conferencing is currently structured with supportive health services at the table.
- Engaging and coordinating the Outreach and Shelter providers would help to have one voice at the table on locating clients and keeping them sheltered as they are waiting for enrollments into identified housing opportunities. The case conferencing group would need access to refer into shelter beds for this to work. Steve W. mentioned that there is discussion about a meeting to coordinate shelter providers in the River District but there has been nothing scheduled yet. Joe C. mentioned that there is a working group designing new Outreach standards with TAC, a technical assistance provider for HUD.
- There is also a need for better training across the provider community on how to efficiently get clients document ready for housing opportunities.

Next Steps:

- Investigate whether shelter providers will meet and investigate whether it is possible to allot beds to people who are next on the by-name.
- Invite the Outreach Standards working group to the next CE Committee Meeting.
- Hold a Doc Readiness workshop for providers.
- Increase the transparency of the CE Referral system.
- Investigate what data is available for clients in the By-Name-List to group them into similar populations that would benefit from similar services. (Families with children, singles needing AOD, ect..)
- Bring back information why those on By-Name-List couldn't be housed.

F. Meeting Adjourned	Next Meeting – March 5, 2020 – 2:30 pm (Time changed to follow TAY Community Case Conferencing Meeting)

Coordinated Entry Overview (Prioritization and Referrals)

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Coordinated Entry

A HUD Mandate & Best Practice

- Provisions in the CoC Program interim rule at 24 CFR 578.7(a)(8) require that CoCs establish a Centralized or Coordinated Assessment System
- Coordinated entry processes help communities 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
- Coordinated entry processes also provide information about service needs and gaps to help communities plan their assistance and identify needed resources

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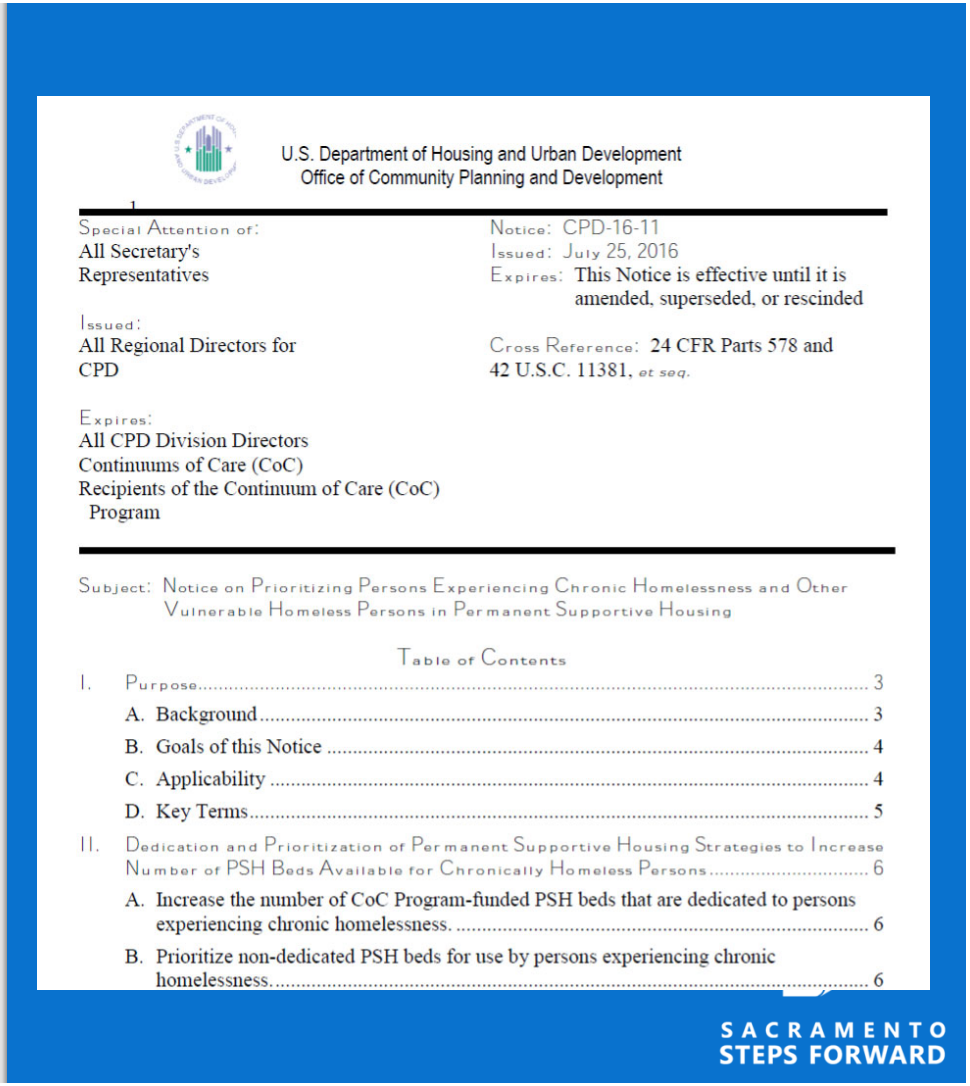
Prioritization

A HUD Mandate & Best Practice



U.S. Department of Housing and Urban Development
Office of Community Planning and Development

Special Attention of:
All Secretary's Representatives

Issued:
All Regional Directors for CPD

Expires:
All CPD Division Directors
Continuums of Care (CoC)
Recipients of the Continuum of Care (CoC) Program

Notice: CPD-16-11
Issued: July 25, 2016
Expires: This Notice is effective until it is amended, superseded, or rescinded

Cross Reference: 24 CFR Parts 578 and 42 U.S.C. 11381, *et seq.*

Subject: Notice on Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing

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Prioritization

A CoC Process

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Ending Homelessness. Starting Fresh.

TO: CoC Advisory Board Coordinated Entry System (CES) Committee

FROM: Sacramento Steps Forward (SSF) CES Department

DATE: October 20, 2017

SUBJECT: Sacramento CoC Plan for Rapid Rehousing Prioritization Policy Decisions

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In recent meetings, as part of the HUD CES Compliance Self-Assessment Checklist's Prioritization section, potential changes to how the CES prioritizes households for referral to Rapid Rehousing (RRH) have been discussed. Specifically, CES staff have led a discussion of HUD's guidance to prioritize all HUD-funded resources to serve households with the most severe service needs, including RRH, and what impact this prioritization would have locally. While the original intent of staff was to guide the committee and other stakeholders through the adoption of a new RRH prioritization policy that targets households with the most severe service needs and/or people who are chronically homeless, after listening to community input and consulting with our HUD-funded CES implementation Technical Assistance (TA) provider, we are now recommending disconnecting the prioritization policy-setting from the January 2018 CES compliance deadline and launching a more in-depth approach to making this decision that includes a longer planning timeline.

Current Prioritization & CES Compliance

Prioritization for RRH (and Transitional Housing) currently follow the RRH housing type recommendation embedded within the VI-SPDAT, specifically referral of households in the mid-range of need to RRH (and TH), with any deviation from referral of households in this range accompanied by input on unique participant strengths or needs provided by service partners familiar with the people being referred. For the January 23, 2018 compliance deadline, the current RRH (and TH) prioritization will be presented along with the CoC's plans for further review and potential action.

Continuing the Prioritization Discussion

Based on SSF's reading of HUD's guidance on this issue, reinforced by our CES TA provider, the Sacramento CoC still needs a plan to move toward prioritizing at least a portion of our RRH for households with severe service needs. This discussion will take place in the coming months, with the goal of finalizing a plan for phasing in prioritization of needier households by mid-2018.

The intent of this process is to develop a RRH prioritization policy that balances local needs and resources with HUD's expectations. Planning inputs and priorities will include a clear understanding of HUD's policy direction, national and local best practices, what local data tells us, and a commitment to ensuring responsiveness to client and program needs. To ensure the policy developed reflects the realities of how our RRH projects operate and what their needs are, CES staff will consult the Rapid Rehousing Collaborative of all RRH providers in the Sacramento CoC on an ongoing basis. The RRH Collaborative will continue to play a role during the implementation phase, serving as a "learning community" as we monitor impacts and make adjustments along the way. CES staff will serve as the formal link between the Collaborative and the CES Committee and will be responsible for ensuring both groups receive the information they need to make recommendations and decisions (HUD guidance, local data, research, etc.).

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Coordinated Entry Implementation in Sacramento

PLANNING
2012 - 2014

Focus Strategies Feasibility Study

CoC Board Approval of Model for Access (multiple points of entry: 211, Access Points, Outreach)

Selection of VI-SPDAT

LAUNCH
2015

Outreach and other access points begin conducting VI-SPDAT

Referrals into new programs begin

PILOT IMPLEMENTATION
2016

20+ agencies conducting VI-SPDATs

Referral into existing programs begins in 2016

Three more projects join in 2018

CE RE-DESIGN
2019

Using one-time CESH funds SSF Contracts with Homebase to develop a System Map, Gaps Analysis and Recommendations to Re-Design CE System.

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2015 Choosing the VI-SPDAT

- Most frequently used triage tool in North America & Australia
- Already built into HMIS platforms
- No clinical skills needed to conduct
- Simple training from the Lead Agency

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VI-SPDAT:
Vulnerability Index – Service Prioritization Decision Assistance Tool

A pre-screening, or triage, tool designed to be used by all providers within a community to quickly assess the health and social needs of homeless persons and match them with the most appropriate support and housing interventions that are available.

The VI-SPDAT allows homeless service providers to similarly assess and prioritize the universe of people who are homeless in their community and identify whom to treat first based on the acuity of their needs.

The VI-SPDAT was not intended to provide a comprehensive assessment of each person's needs.

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The 4 Domains of the VI-SPDAT

History of Housing

- History of Housing and Homelessness

Risks

- Risk of Harm to Self or Others
- Involvment in High-Risk and/or Exploitive Situations
- Interactions with Emergency Services
- Legal Issues

Socialization & Daily Functions

- Self-Care & Daily Living Skills
- Personal Administration & Money Management
- Meaningful Daily Activities
- Social Relations & Networks

Wellness

- Mental Health and Wellness & Cognitive Functioning
- Physical Health & Wellness
- Medication
- Substance Use
- Experience of Abuse and/or Trauma

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When should VI-SPDAT be conducted?

- After trust and rapport has been built
- After determining the household is Category 1 or Category 4 Homeless

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Category 1 Homeless: Literally Homeless

Individual or family lacks a fixed, regular, and adequate night time residence

Category 4 Homeless: Fleeing / Attempting to Flee Domestic Violence

Any individual or family who:

i) is fleeing, or is attempting to flee, domestic violence
ii) has no other residence; AND
iii) lacks the resources or support networks to obtain other permanent housing

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What to expect when conducting the VI-SDAT.

- This is a Self-Report tool.
- All questions result in a “Yes”, “No”, “Refused”, or one-word answers.
- Each question must be asked. Persons can elect to “skip” or refuse to answer a question.

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The Various VI-SPDAT Tools

- Single VI-SPDAT: Any adult over the age of 25.
- Transition Age Youth (TAY) VI-SPDAT: Young adults between the ages of 18 to 24.
- Family VI-SPDAT: Any household with minor children.

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When should a replacement VI-SPDAT be conducted?

- Change to the household unit.
- A qualifying life event has happened.
- New episode of homelessness has begun.
- Original VI-SPDAT was not conducted in household's primary language.
- Original VI-SPDAT was conducted greater than 1 year ago.

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How are the VI-SPDAT and the Community Queue connected?

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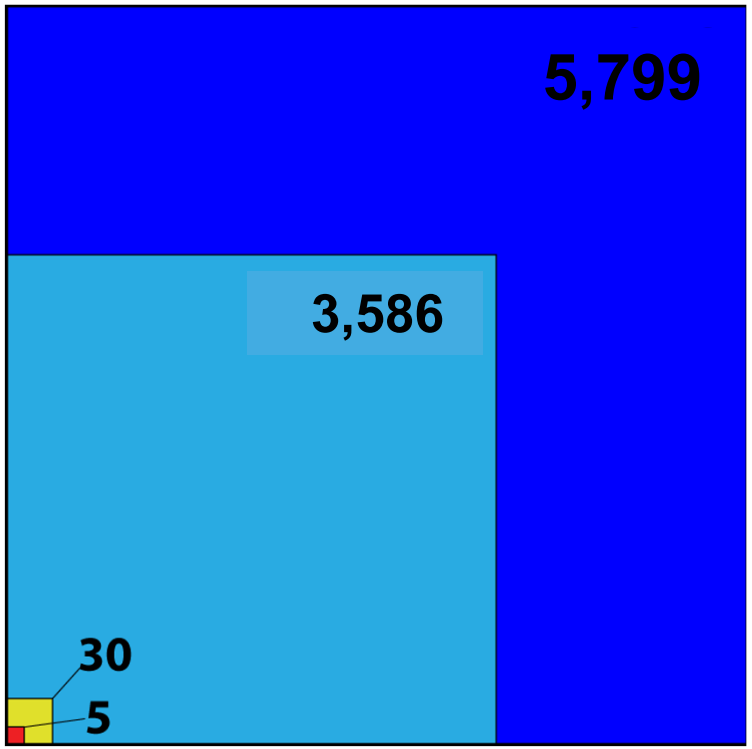
Coordinated Entry Groupings



By-Name-List (5,799 People – 02/04/20)

Is literally homeless
Service or contact entered in HMIS within 90 days

Community Queue (3,586 People)

Eligible for By-Name-List
Has VI-SPDAT

Priority Queue for PSH (30 People)

Prioritized from the CQ for vulnerability and length of homelessness. Priority Queue size is ˜ 2x the anticipated openings for the month.

PSH Referrals Made

Priority Queue client who is eligible for current program opening.

Referral Specialist

accesses the Community Queue to identify **eligible, documentation-ready households** for programs available through HUD funding.

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Types of Programs available through HUD funding:

Permanent Supportive Housing

Housing and supportive services designed to provide continuous support to participants.

Maximum length of stay is unlimited, although some participants may chose to exit or have displayed self-sufficiency and will successfully maintain stable housing.

~~Transitional Housing~~

~~Housing and supportive services designed to encourage stability for those who are most likely to achieve self-sufficiency through employment.~~

~~Maximum length of stay is 12 months.~~

Rapid Rehousing

Temporary housing Subsidy and supportive services designed to quickly rehouse and stabilize people experiencing homelessness.

Typical length of stay is 3 to 6 months; max 24 months.

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Coordinated Entry Eligibility Considerations

	PSH	RRH
VI-SPDAT Score	11+	5-9
Length of Time Homeless	✓	✓
Chronic	✓	✓
Severity of Needs (4 domains)	✓	✓
Consumer Self-Determination & Awareness	✓	✓
Doc Ready		
Homeless Cert	✓	✓
Disability Cert	✓	
Chronic Cert	✓	
3rd Party Verification	✓	

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Referral Process into PSH & RRH

1. Referral Specialist identifies eligible, documentation-ready households by appropriate criteria.

Consumer self determination and awareness of program type (shared living, accessibility, location) are considered.

Length of time homeless (current episode)

Chronicity (12 continuous months or 4 episodes of homelessness within 3 years, totaling 12 months).

Document ready: documents must be verified, and uploaded into HMIS

2. Referral Specialist sends referrals from Community Queue to designated point of contact at the receiving agency BY INCLUDING HOUSEHOLDS IN THE CES REFERRAL LOG

Please note: Rapid Rehousing Collaborative and SSF are in the process of revisiting policy of prioritization per HUD mandates. Further, SSF is piloting Housing Conferencing within the community. This includes more detailed examination of a households severity of need & program requirements.

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Referral Process into Programs with Voluntary CES Participants

- Transitional Housing (County and Veterans Affairs)
- Supportive Services for Veterans and Families (SSVF)
- Department of Human Assistance (HSP)
- Shelters (developing agreements currently)

➢ Eligibility is based in program requirements (ie employable, veteran, Cal-Works eligible, etc.); prioritization is based in CES standards.

*Note- Voluntary participants are not mandated by HUD to participate in CES.

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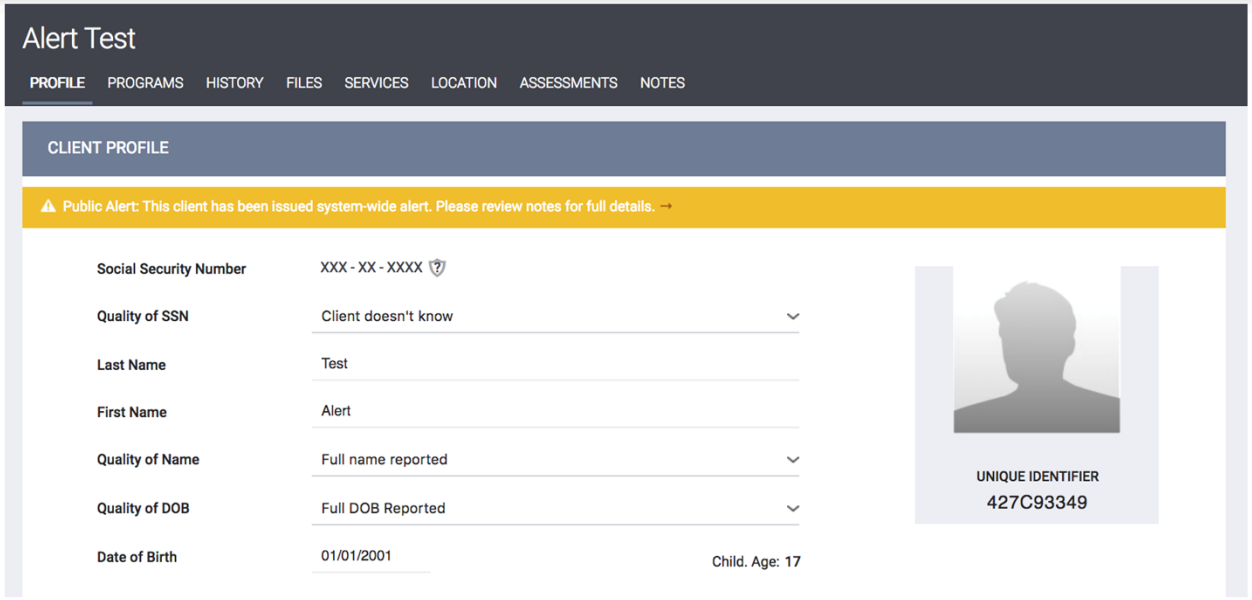
CoC Hotlist Alerts



Public Notes and Alerts

Notes:
Share critical information with your peers in different projects/agencies

Alerts:

- Time-sensitive housing opportunities (managed by SSF)
- Time-sensitive warnings regarding missing or dangerous persons

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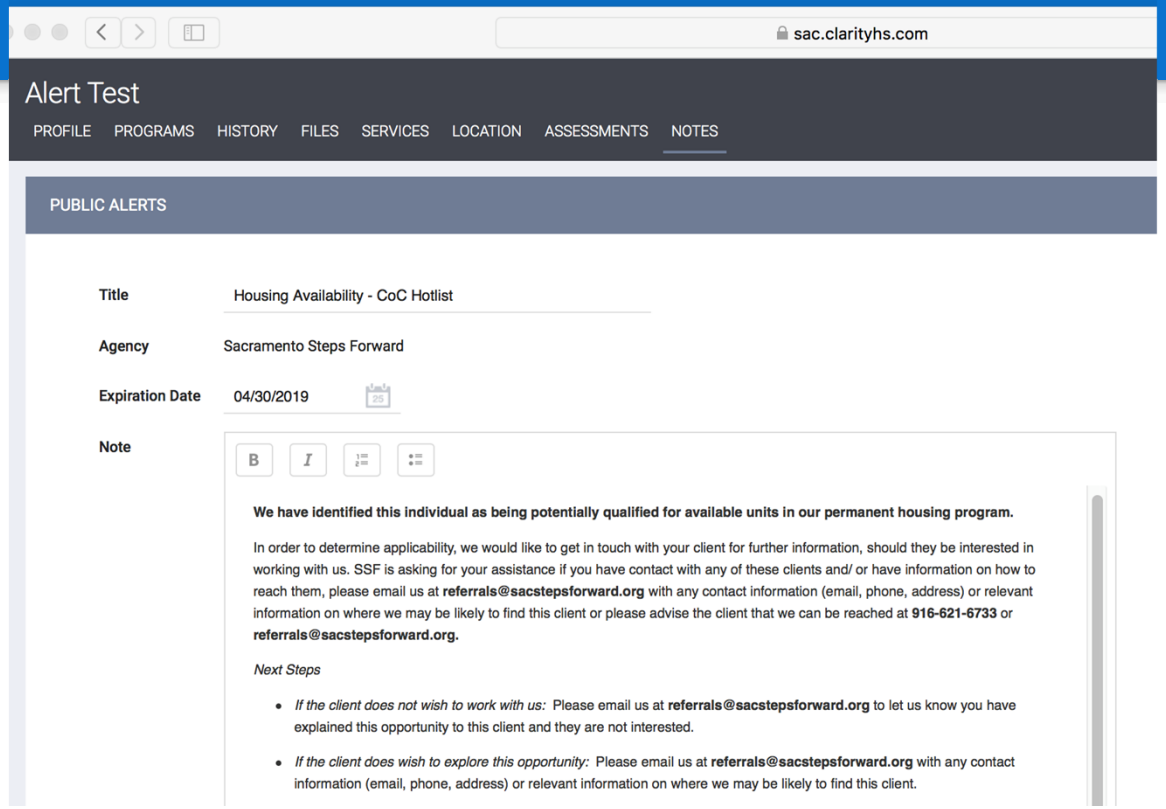
CoC Hotlist Alerts

What to do if you see an alert



What it means:

This client has been identified as potentially qualified for CoC permanent housing, and we need your help getting in touch.

What it doesn't mean:
They are guaranteed housing

How long are they considered 'hot'?
They'll be removed from hot list after 90 days with no contact/touches in HMIS

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CoC Hotlist Alerts

What to do if you see an alert : Inform & Contact

Inform this client that they may be qualified for permanent housing opportunity and SSF would like to speak with them

Make sure they understand this is not a guarantee of housing

If client is interested in exploring:	If the client is not interested:
Ask the client to contact us directly: 916-621-6733 / referrals@sacstepsforward.org **and** Contact us to let us know you advised the client and with any relevant contact information for client (location, phone, etc.)	Please contact us directly to let us know about your conversation. Indicate which of the noted reasons the client was not interested in pursuing the opportunity.

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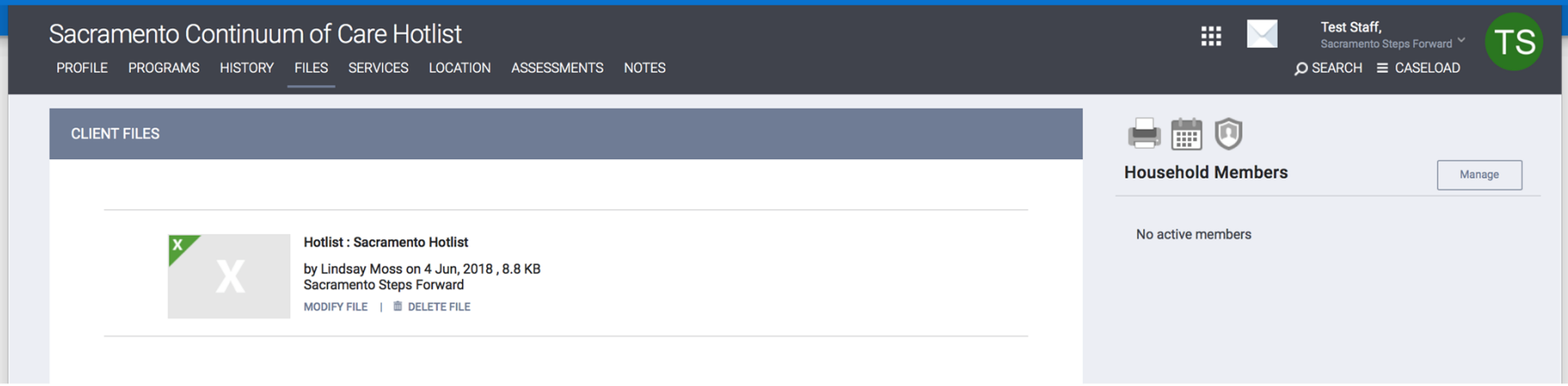
CoC Hotlist Alerts
Accessing the full list



If you'd like to see the current complete** Hot List, search for the client 'Sacramento Continuum of Care Hotlist'.

Visit **FILES >> 'Hotlist : Sacramento Hotlist'**

*(*does not include clients marked as 'private' by agency)*

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"Doc Ready" for Coordinated Entry

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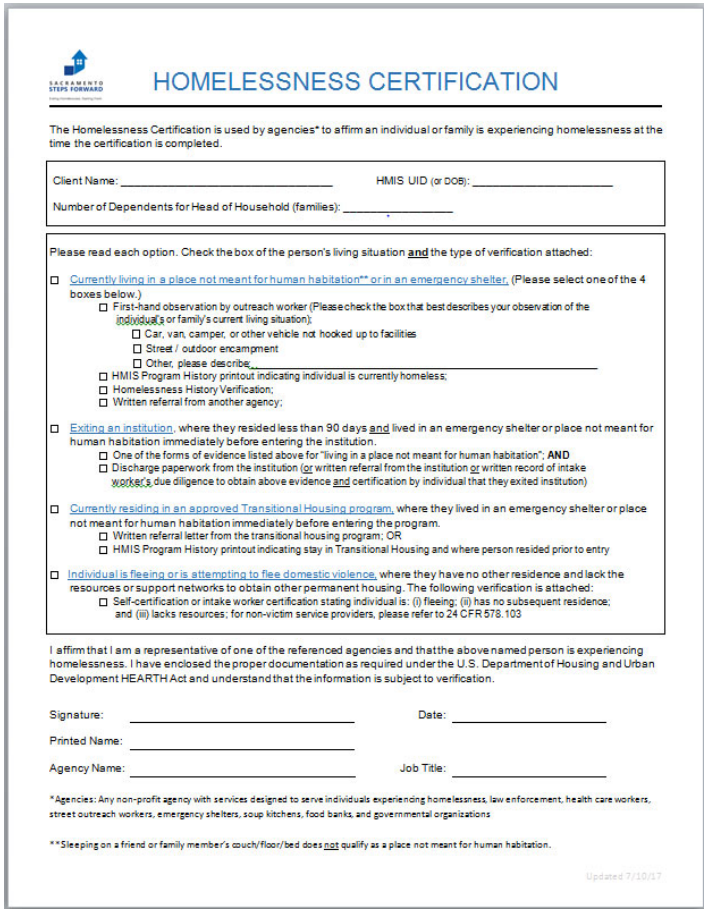
Homelessness Certification

Homelessness Certification for all Households.

Form may be completed by any Homeless Service Provider

All necessary supporting documentation attached. (Examples listed below.)

- First-hand observation
- HMIS Program History
- Third Party Homeless History Verification
- Written referral from another agency
- Discharge paperwork from an institution
- Documentation from a transitional housing program
- Documentation supporting fleeing DV



HOMELESSNESS CERTIFICATION

The Homelessness Certification is used by agencies* to affirm an individual or family is experiencing homelessness at the time the certification is completed.

Client Name: _____ HMIS UID (or DOB): _____

Number of Dependents for Head of Household (families): _____

Please read each option. Check the box of the person's living situation **and** the type of verification attached:

☐ Currently living in a place not meant for human habitation** or in an emergency shelter, (Please select one of the 4 boxes below.)
- ☐ First-hand observation by outreach worker (Please check the box that best describes your observation of the individual's or family's current living situation):
  - ☐ Car, van, camper, or other vehicle not hooked up to facilities
  - ☐ Street / outdoor encampment
  - ☐ Other, please describe: _____
- ☐ HMIS Program History printout indicating individual is currently homeless;
- ☐ Homelessness History Verification;
- ☐ Written referral from another agency;

☐ Exiting an institution, where they resided less than 90 days and lived in an emergency shelter or place not meant for human habitation immediately before entering the institution.
- ☐ One of the forms of evidence listed above for "living in a place not meant for human habitation"; **AND**
- ☐ Discharge paperwork from the institution (or written referral from the institution or written record of intake worker's due diligence to obtain above evidence and certification by individual that they exited institution)

☐ Currently residing in an approved Transitional Housing program, where they lived in an emergency shelter or place not meant for human habitation immediately before entering the program.
- ☐ Written referral letter from the transitional housing program; OR
- ☐ HMIS Program History printout indicating stay in Transitional Housing and where person resided prior to entry

☐ Individual is fleeing or is attempting to flee domestic violence, where they have no other residence and lack the resources or support networks to obtain other permanent housing. The following verification is attached:
- ☐ Self-certification or intake worker certification stating individual is: (i) fleeing; (ii) has no subsequent residence; and (iii) lacks resources; for non-victim service providers, please refer to 24 CFR 578.103

I affirm that I am a representative of one of the referenced agencies and that the above named person is experiencing homelessness. I have enclosed the proper documentation as required under the U.S. Department of Housing and Urban Development HEARTH Act and understand that the information is subject to verification.

Signature: _____ Date: _____

Printed Name: _____

Agency Name: _____ Job Title: _____

*Agencies: Any non-profit agency with services designed to serve individuals experiencing homelessness, law enforcement, health care workers, street outreach workers, emergency shelters, soup kitchens, food banks, and governmental organizations

**Sleeping on a friend or family member's couch/floor/bed does not qualify as a place not meant for human habitation.

Updated 7/10/17

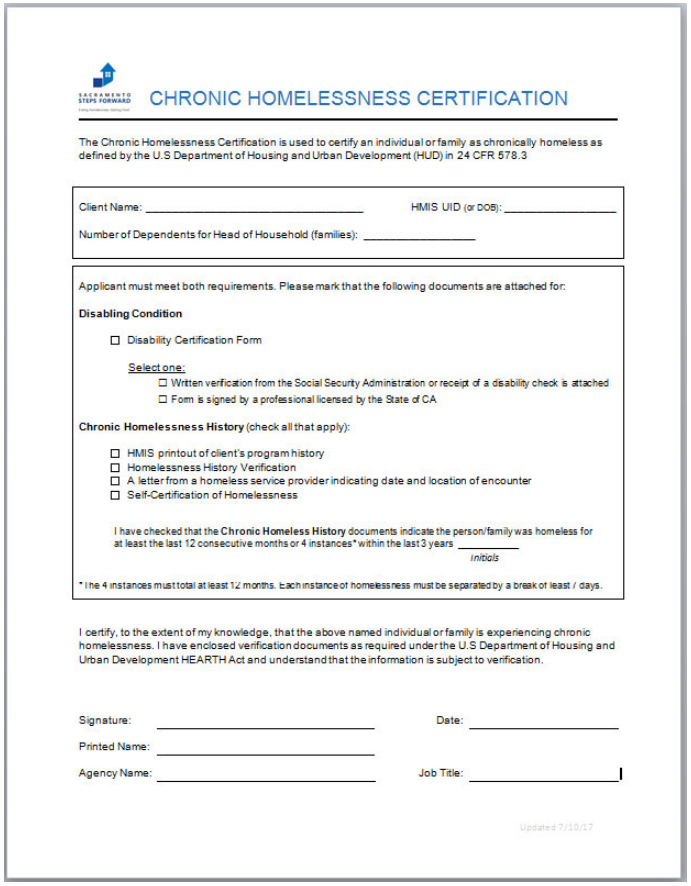
Chronic Homelessness Certification

Chronic Homelessness Certification for Individuals or Heads of Households needing to verify chronicity.

Form may be completed by any Homeless Service Provider

All necessary supporting documentation attached.

- Disability Certification
- Verification of Homelessness History



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CHRONIC HOMELESSNESS CERTIFICATION

The Chronic Homelessness Certification is used to certify an individual or family as chronically homeless as defined by the U.S Department of Housing and Urban Development (HUD) in 24 CFR 578.3

Client Name: _____ HMIS UID (or DOB): _____

Number of Dependents for Head of Household (families): _____

Applicant must meet both requirements. Please mark that the following documents are attached for:

Disabling Condition

☐ Disability Certification Form

Select one:

☐ Written verification from the Social Security Administration or receipt of a disability check is attached

☐ Form is signed by a professional licensed by the State of CA

Chronic Homelessness History (check all that apply):

☐ HMIS printout of client's program history

☐ Homelessness History Verification

☐ A letter from a homeless service provider indicating date and location of encounter

☐ Self-Certification of Homelessness

I have checked that the **Chronic Homeless History** documents indicate the person/family was homeless for at least the last 12 consecutive months or 4 instances* within the last 3 years _____

initials

* The 4 instances must total at least 12 months. Each instance of homelessness must be separated by a break of least 7 days.

I certify, to the extent of my knowledge, that the above named individual or family is experiencing chronic homelessness. I have enclosed verification documents as required under the U.S Department of Housing and Urban Development HEARTH Act and understand that the information is subject to verification.

Signature: _____ Date: _____

Printed Name: _____

Agency Name: _____ Job Title: _____

Updated 7/10/17

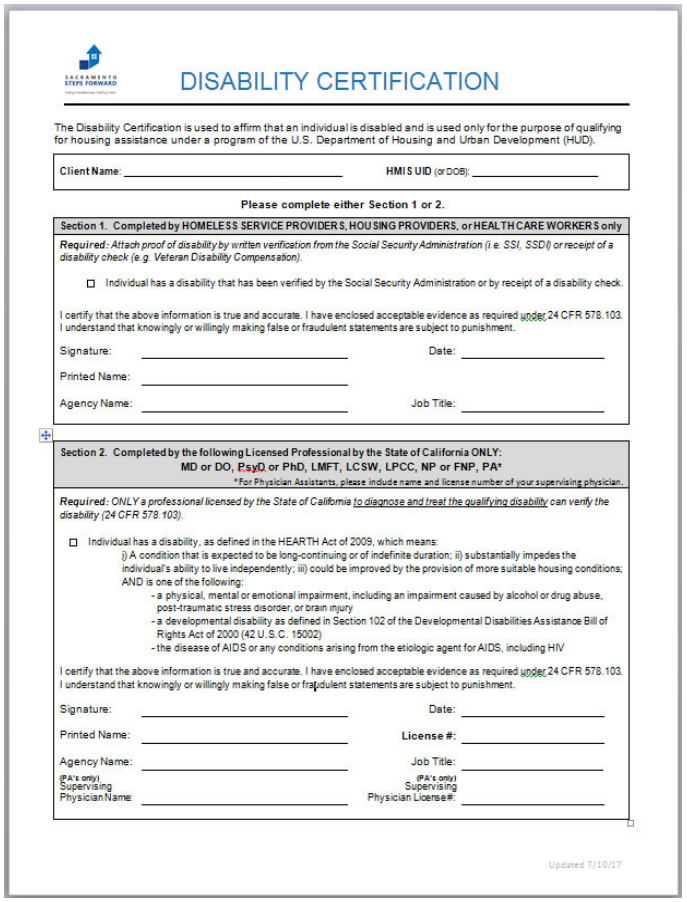
Disability Certification

Disability Certification for Individuals or Heads of Households needing to document a disability to establish Chronic Homelessness.

Form may be completed by any Homeless Service Provider with supporting documentation. (Typically a disability benefit award letter from the Social Security Office.)

-OR-

Homeless Service Provider **AND** a Licensed Professional by the State of CA to diagnosis and treat a disability



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DISABILITY CERTIFICATION

The Disability Certification is used to affirm that an individual is disabled and is used only for the purpose of qualifying for housing assistance under a program of the U.S. Department of Housing and Urban Development (HUD).

Client Name: _____ **HMIS UID** (or DOB): _____

Please complete either Section 1 or 2.

Section 1. Completed by HOMELESS SERVICE PROVIDERS, HOUSING PROVIDERS, or HEALTH CARE WORKERS only

Required: *Attach proof of disability by written verification from the Social Security Administration (i.e. SSI, SSDI) or receipt of a disability check (e.g. Veteran Disability Compensation).*

☐ Individual has a disability that has been verified by the Social Security Administration or by receipt of a disability check.

I certify that the above information is true and accurate. I have enclosed acceptable evidence as required under 24 CFR 578.103. I understand that knowingly or willingly making false or fraudulent statements are subject to punishment.

Signature: _____ Date: _____

Printed Name: _____

Agency Name: _____ Job Title: _____

Section 2. Completed by the following Licensed Professional by the State of California ONLY:
MD or DO, PsyD or PhD, LMFT, LCSW, LPCC, NP or FNP, PA*
*For Physician Assistants, please include name and license number of your supervising physician.

Required: *ONLY a professional licensed by the State of California to diagnose and treat the qualifying disability can verify the disability (24 CFR 578.103).*

☐ Individual has a disability, as defined in the HEARTH Act of 2009, which means:
i) A condition that is expected to be long-continuing or of indefinite duration; ii) substantially impedes the individual's ability to live independently; iii) could be improved by the provision of more suitable housing conditions; AND is one of the following:
- a physical, mental or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury
- a developmental disability as defined in Section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000 (42 U.S.C. 15002)
- the disease of AIDS or any conditions arising from the etiologic agent for AIDS, including HIV

I certify that the above information is true and accurate. I have enclosed acceptable evidence as required under 24 CFR 578.103. I understand that knowingly or willingly making false or fraudulent statements are subject to punishment.

Signature: _____ Date: _____

Printed Name: _____ **License #:** _____

Agency Name: _____ Job Title: _____

(PA's only) Supervising Physician Name: _____ (PA's only) Supervising Physician License#: _____

Updated 7/10/17

Supporting Documentation for Chronic Homeless History

- HMIS Record (Printout)
- Third Party Homelessness History Verification Form
- Third Party Homelessness History Verification Letter
- Self-Certification of Homelessness
  -Homeless History Mapping Tool

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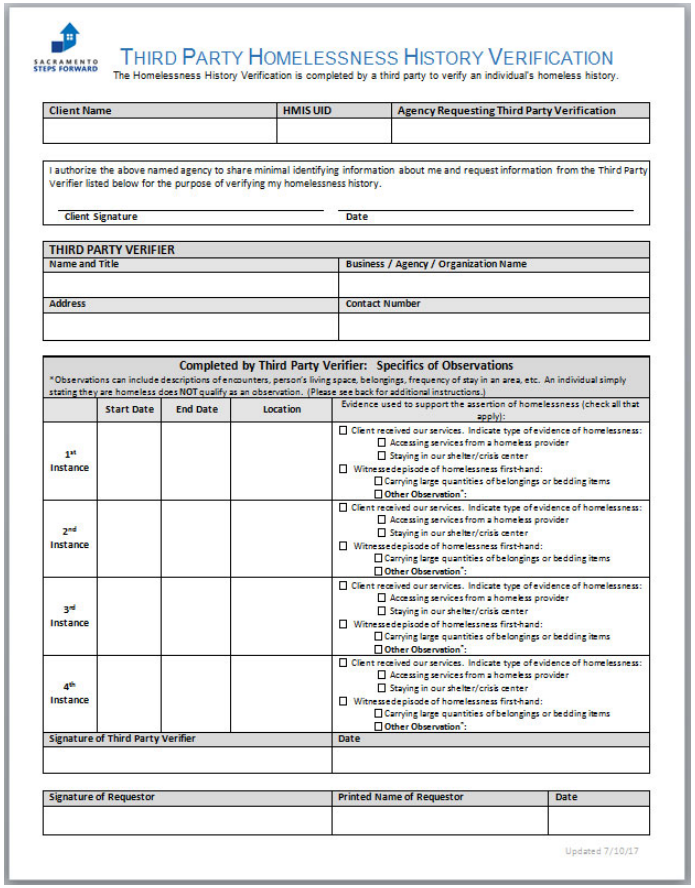
Third Party Homelessness History Verification

Form may be completed by any Homeless Service Provider with the Individual or Family and the Third Party Verifier.

This form requires 3 signatures.

- The individual or family experiencing homelessness providing consent.
- The Third Party witnessing the individual or family's homelessness.
- The staff person witnessing the Third Party signature to their statement.



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THIRD PARTY HOMELESSNESS HISTORY VERIFICATION

The Homelessness History Verification is completed by a third party to verify an individual's homeless history.

Client Name	HMIS UID	Agency Requesting Third Party Verification

I authorize the above named agency to share minimal identifying information about me and request information from the Third Party Verifier listed below for the purpose of verifying my homelessness history.

Client Signature _____ Date _____

THIRD PARTY VERIFIER

Name and Title	Business / Agency / Organization Name
Address	**Contact Number**

Completed by Third Party Verifier: Specifics of Observations

*Observations can include descriptions of encounters, person's living space, belongings, frequency of stay in an area, etc. An individual simply stating they are homeless does NOT qualify as an observation. (Please see back for additional instructions.)

	Start Date	End Date	Location	Evidence used to support the assertion of homelessness (check all that apply):
1st Instance				☐ Client received our services. Indicate type of evidence of homelessness: ☐ Accessing services from a homeless provider ☐ Staying in our shelter/crisis center ☐ Witnessed episode of homelessness first-hand: ☐ Carrying large quantities of belongings or bedding items ☐ Other Observation*:
2nd Instance				☐ Client received our services. Indicate type of evidence of homelessness: ☐ Accessing services from a homeless provider ☐ Staying in our shelter/crisis center ☐ Witnessed episode of homelessness first-hand: ☐ Carrying large quantities of belongings or bedding items ☐ Other Observation*:
3rd Instance				☐ Client received our services. Indicate type of evidence of homelessness: ☐ Accessing services from a homeless provider ☐ Staying in our shelter/crisis center ☐ Witnessed episode of homelessness first-hand: ☐ Carrying large quantities of belongings or bedding items ☐ Other Observation*:
4th Instance				☐ Client received our services. Indicate type of evidence of homelessness: ☐ Accessing services from a homeless provider ☐ Staying in our shelter/crisis center ☐ Witnessed episode of homelessness first-hand: ☐ Carrying large quantities of belongings or bedding items ☐ Other Observation*:

Signature of Third Party Verifier	Date

Signature of Requestor	Printed Name of Requestor	Date

Updated 7/10/17

Self-Certification of Homelessness

Up to 3 months without supporting documentation stating barriers and attempts to collect Third Party Verification.

Form may be completed by any Homeless Service Provider with the Individual or Family.

Note: This is the LEAST desired method of verification.

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SELF-CERTIFICATION OF HOMELESSNESS

The Self-Certification of Homelessness form is used to document homeless history and breaks in homelessness.

If the individual or family self-certifies for more than 3 months; a completed **Homelessness History Mapping Tool** must be attached documenting due diligence in attempting to obtain third party verification.

CLIENT NAME:			HMIS UID (or DOB):
Start Date	**End Date** (current date if residing in same location)	**Location of Stay**	**Location Type** (Check one only for each instance)
			☐ Car, van or camper not hooked up to facilities ☐ Streets/outdoor encampment ☐ Other location not meant for humans to live (e.g. storage shed) ☐ Hotel/motel paid for by non-profit/county funding ☐ Homeless or crisis shelter. Specify name(s): ☐ Institution (e.g. hospital, jail) ☐ Not Homeless/Break (e.g., stayed with friends, stayed in self-paid motel)
			☐ Car, van or camper not hooked up to facilities ☐ Streets/outdoor encampment ☐ Other location not meant for humans to live (e.g. storage shed) ☐ Hotel/motel paid for by non-profit/county funding ☐ Homeless or crisis shelter. Specify name(s): ☐ Institution (e.g. hospital, jail) ☐ Not Homeless/Break (e.g., stayed with friends, stayed in self-paid motel)
			☐ Car, van or camper not hooked up to facilities ☐ Streets/outdoor encampment ☐ Other location not meant for humans to live (e.g. storage shed) ☐ Hotel/motel paid for by non-profit/county funding ☐ Homeless or crisis shelter. Specify name(s): ☐ Institution (e.g. hospital, jail) ☐ Not Homeless/Break (e.g., stayed with friends, stayed in self-paid motel)
			☐ Car, van or camper not hooked up to facilities ☐ Streets/outdoor encampment ☐ Other location not meant for humans to live (e.g. storage shed) ☐ Hotel/motel paid for by non-profit/county funding ☐ Homeless or crisis shelter. Specify name(s): ☐ Institution (e.g. hospital, jail) ☐ Not Homeless/Break (e.g., stayed with friends, stayed in self-paid motel)
Client signature below certifies that the above information is correct			
Client Signature:			Date:

Staff Signature: ______________________ Date: ______________

Printed Name: ______________________

Agency Name: ______________________ Job Title: ______________

Updated 7/10/17

Community Best Pratices for obtaining other Necessary Documentation.

Photo Identification Cards

Social Security Cards

Certified Copies of Birth Certificates

DD214 Forms

Income Verification

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Case Conferencing for Coordinated Entry

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Case Conferencing

CoC Best Practice

Operating with sub-populations

- TAY
- Veterans

Targets most vulnerable

Cross-Agency Discussions on How to House Clients

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TAY CASE CONFERENCING OVERVIEW.

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How Case Conferencing is Working in the TAY Working Collaborative

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Agreements

Inter-agency participation

- Capital Stars
- FSP – Full Service Partnership (Michael Young; LSCW)
- Youth Health Network
- LGBTQ
- Wind Youth
- Waking the Village
- SSF – Sacramento Steps Forward

Front-line staff – i.e., those working directly with people experiencing homelessness are the primary participants at the meeting.

Client-centered – i.e., problem-solving; using the team's collective brain power in being mindful around housing placements and supportive services.

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Commitments

- Using the by-name list to identify the next TAY who are being prioritized for Permanent Supportive Housing.
- Using the by-name list to generate the agenda for the meeting.
- Case Conferencing agenda being sent out prior to the meetings. (First &Third Thursdays of each month).
- Generating housing related next steps for all of the clients being discussed in our case conferencing.
- Identifying program openings
- Accountability – notes and assignments are sent out after the meetings
- Recording steps and progress into HMIS which includes doc readiness.

How can we design a case conferencing for General Population?

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