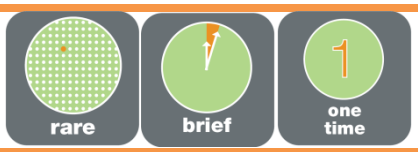
Homeless Investments RFP
Homeless Housing Project Models

Project Principles

Housing First
Low Barrier
Progressive Engagement
Participant Choice and Tailored Services



Homelessness Prevention

Homelessness Prevention aims to reduce the number of people who experience homelessness through financial assistance and case management supports to keep people in housing from experiencing homelessness.

Population	Targeting prevention resources is critical to ensuring the most effective use of funding to truly reduce the number of people newly becoming homeless. Assistance is aimed at families, individuals, and young adults.
Eligibility Requirements	Prevention resources must be used to assist those who are housed but at imminent risk of becoming homeless if they do not receive prevention supports.
Eligible Use of Funds	Eligible costs vary, but primarily include: • Short-term or one-time rental assistance • Rental/utility arrears • Utility assistance
Recommended Staff Roles and Staffing Levels	Case managers need to perform the following tasks: • Assess for level and type of assistance needed • Create Housing Stability Plans • Assist with household budgeting • Make connections and referrals • Work directly with landlords
Core Components/Best Practices	Key principles for effective prevention include: • Crisis resolution/mediation • Participant choice and empowerment • Progressive engagement • Connection with mainstream services • Effective targeting strategies
HSD Performance Indicators (Performance targets and minimum standards)	Service Level Targets/Minimum Standards: • Exit Rate to PH: 95%/90% • Return Rate to Homelessness: 3%/2%

Diversion

Diversion is a flexible short-term intervention that assists households experiencing homelessness with innovative solutions to overcome their housing crisis and avoid entering the shelter system whenever possible, moving quickly from homelessness to housing. Diversion is typically offered at the point households are seeking shelter or emergency housing options. Note: Because Diversion is a strategy that is most effective when offered at the entry point to the homelessness system, applicants are strongly encouraged to apply for a diversion project in coordination with an application for either the Outreach and Engagement project area or the Emergency Services project area.

Population	Diversion resources are designed to assist families, individuals, youth, and young adults.
Eligibility Requirements	Eligible households are currently homeless and seeking entry into shelter or housing and have not yet accessed homeless services. This includes individuals sleeping outside or in a place not meant for human habitation, actively fleeing domestic violence (DV) who are not connected with DV emergency shelter system, and individuals who are temporarily staying with friends or family. There are no other criteria or preconditions to diversion services other than homeless status.
Eligible Use of Funds	Diversion funds can be used in a variety of ways provided they directly result in a housing solution. Eligible financial assistance includes, but is not limited to: • Payment for background and credit checks • Costs associated with moving • Utility assistance • Rental/utility arrears • Transportation • Grocery cards • Fees for securing documentation or certifications • Work or education related assistance
Recommended Staff Roles and Staffing Levels	Crisis resolution is an essential component of diversion. Staffing ratio needs to support case management that focuses on partnering with participants to creatively problem-solve their housing situation. Problem-solving includes referrals to mainstream resources, and assisting participants with housing-related mediation and conflict resolution.
Core Components/Best Practices	• Services are flexible and tailored to the unique needs of each household. • Diversion assists with identifying immediate, alternative housing arrangements and, if necessary, provides short-term services and assistance to help secure housing. • Households are connected with safe, stable, creative housing solutions outside of the homeless housing and shelter system. • Diversion relies on participant choice, respect, and empowerment and utilizes crisis resolution and mediation to navigate stable housing options.

HSD Performance Indicators (Performance targets and minimum standards)	Service Level Targets/Minimum Standards: • Exit Rate to PH: 50%/40%
Additional Resources	King County Coordinated Entry for All (CEA) Path to Home Operations Manual (Path to Home includes Diversion services and flexible assistance to support households moving from emergency shelter directly to a safe stable housing opportunity outside of homeless housing resources)

Outreach & Engagement

Outreach & Engagement services are coordinated, person centered, and persistent, bringing services directly to the people experiencing homelessness who might not seek out services and connecting them to permanent housing and necessary supports.

Population	Outreach and Engagement services will support families, individuals, youth, and young adults who are experiencing homelessness. The focus is on those living unsheltered (street-based) and youth and young adults (housing navigators).
Eligibility Requirements	Eligibility for street-based outreach includes people living unsheltered in Seattle. Eligibility for Youth/Young Adult Housing Navigators includes homeless young adults, including young parents, who request a CEA housing assessment; ages 17.5 to 24; literally homeless (non-housing), in shelter, or within 14 days to eviction.
Eligible Use of Funds	Eligible costs vary, but primarily include meeting immediate needs (ex. transportation, food assistance), connections with supportive services (ex. documentation replacement), and placement into housing (ex. diversion, move-in costs).
Recommended Staff Roles and Staffing Levels	Staffing ratio needs to support relationship development and housing-focused services. Case management services should be tailored to meet the needs of people where they are, both their level of need and geographically. The role of the outreach staff is to develop relationships, engage in creative solutions to identify housing opportunities, and support movement to stable housing.
Core Components/Best Practices	Assessment and Service Provision Competency: • Able to establish a trusting relationship with the individual experiencing homelessness • Qualified to conduct and document a reliable needs assessment which includes: behavioral health; substance use, treatment status, and harm reduction measures; physical health; disability; housing; employment; household composition; and geographic considerations

	• Establish connections to community services that meet their needs, including providing intensive and ongoing support to navigate processes and systems that are often complex • Dedicate adequate resources to ensure staff can walk with participants through the referral process, as needed, including following up on referrals to confirm a successful connection and ensure the participant is receiving appropriate services. • Secure shelter/housing services based on what the participant wants, without prerequisites such as sobriety, project completion, or medication compliance <u>Housing System Competency</u>: • Ability to access the housing system in order to support participants to exit homelessness • Housing First: Coordinated Entry for All (CEA); By Name List coordination efforts; low barrier shelters; sanctioned encampments; motels; diversion funds • Housing navigation/Case management services • Flexible funds <u>Behavioral and Physical Health Competency</u>: • Directly refer participants to licensed behavioral health and/or physical health care services, verify services are provided either where the individual resides or at the behavioral health provider's location, and coordinate care with any existing provider working with the individual. • Trained in harm reduction practices including: providing information on rights related to drug overdose (e.g. Good Samaritan Law); drug treatment options, including Medication Assisted Treatment (Buprenorphine and Methadone); and focusing on minimizing physical, social, and legal harms. Street based outreach project staff should have additional training on safe needle exchange & disposal and carrying, using, and training others to use Narcan. • Execute harm reduction practices where needed and in accordance with the standards set forth by the National Health Care for the Homeless Council <u>Training, Supervision and Safety Competency</u>: • Trained in best practices, including: Engaging in person centered approach, trauma informed care, motivational interviewing, skill based assessments, stages of change/engagement; Clarity general training, Coordinated Entry for All (CEA) housing assessor training, and Diversion. • Perform duties in pairs to practice adequate safety and backup for outreach workers when providing street-based servicer, DMHPs, and WSDOT. • Trained in self-care practices related to secondary trauma and burn out. <u>Cultural Competency</u>: A provider must have a policy for how they will work with the following groups in compliance with City non-discrimination laws and racial equity principles: Those affected by domestic violence; physical disabilities; intellectual disabilities; LGBTQIA community and resources; immigrants/refugees.
HSD Performance Indicators (Performance targets and minimum standards)	Service Level Targets/Minimum Standards: System performance measures are currently under development. It is anticipated that applicants funded through this process may measure the following items, depending on project model:

	• Moving people into shelter, transitional, or permanent housing • Completing, or confirming the completion of, a Coordinated Entry for All assessment • Linking people to outpatient mental health, and physical health treatment, (e.g., confirmed attendance at a clinical visit). • Supporting participants, once in housing, with six months of aftercare support. Providers may also be required, depending on project objectives, to measure: • Syringe distribution • Narcan training and distribution • Referrals to medically assisted treatment (MAT) and other substance use treatment • Placement in employment • Obtaining IDs • Securing financial assistance, such as public benefits • Participant-centered goal setting related to physical or behavioral health.

Emergency Services

Emergency Services projects provide immediate and low barrier access through a Housing First approach. Emergency services will be provided through basic and enhanced overnight and daytime shelter (including up to 24-hour shelter), basic day centers, and basic hygiene services. Enhanced hours can be provided through a single-site project operated by one agency, or through two projects (such as an overnight shelter and daytime shelter) operated by one agency or operated jointly by two agencies in a partnership. Emergency services should be housing-focused and are not intended to provide a long-term living situation.

Services can be provided through either a basic or enhanced model, and more detail can be found below.

Population	Populations include households fitting the HUD definition of literal homelessness including families, individuals, youth, young adults, or individuals fleeing domestic violence. Projects should primarily serve people coming from an unsheltered situation. Projects should provide appropriate accommodations for the population to be served, including meeting the needs of couples, young adults, intergenerational families, families of choice, and families with adult children.
Project Access	Projects should clearly describe the method of access to the project, including specifics on how the project will ensure a seamless transition from the referral source, and ongoing coordination with services the participant may be co-enrolled in (ex. Rapid Re-Housing), as appropriate. Emergency Shelters: Emergency Shelters should prioritize access in this order: 1) Right of return 2) Outreach referral (if no other funder-designated set asides)

	3) Other referral (hospital discharge, etc.) 4) Self-referral
Eligibility Requirements	Eligibility varies and depends on the funding sources supporting the project. In general, projects should operate under a housing first, low barrier model with minimal or no requirements for entry. Emergency Shelters: Criteria must align with the standardized screening criteria guidance adopted by the All Home Funder Alignment Committee.
Eligible Use of Funds	The costs of project operations, personnel services, light-touch information and referral, and flexible funding to meet participant needs are eligible expenses. For Enhanced Projects, eligible expenses are the costs listed above as well as intensive supportive services, including housing navigation, mental/behavioral health, etc. Financial supports to assist residents in moving directly to housing (used in accordance with Diversion funding guidelines) are also included.
Recommended Staff Roles and Staffing Levels	Basic Projects: • Basic operations staffing, to ensure safety • Diversion – front-door diversion for people prior to entering the shelter, for those where an appropriate alternative can be identified. Enhanced Projects: • Staffing identified in Basic projects, above • Case management: Services appropriate to the identified shelter model which support rapid transitions to housing. Services can be either funded through the proposed project or leveraged through another project. • Housing Navigation: Facilitate housing search and placement, either directly or in partnership with another housing project (such as RRH), appropriate to the level of participant need.
Core Components/Best Practices	• Basic health and safety needs are addressed including food, clothing, and personal hygiene. In addition, some level of amenities such as locking storage, access to kitchen facilities, showers, and laundry are provided. • Rules are minimal and are designed to promote the physical and emotional safety of participants and staff in the least restrictive manner possible. When rules are not followed, participants are offered additional support to adjust their behavior and be successful in the program. • Participation in services is not required. • Housing-focused services are provided, connecting participants with CEA and alternative housing options as appropriate and assisting individuals with gathering needed documentation to assist with access to housing. ○ Projects should have a clear vision around how they fit within the homeless service system, including where participants come from prior to entry, where they will exit to, and what supportive services are needed while in shelter. This includes how projects will coordinate with other service providers (such as RRH) to coordinate care for participants, avoid duplication of services, and support exits to permanent housing.

	○ For projects focused on exits to permanent housing, all participants are considered "housing ready" upon project entry. • Shelter models vary and may have either fixed or flexible-capacity. • Shelters are indoors and range from mats on the floor or bunks in a common space to beds in individual units. Some shelters operate only overnight while others operate extended hours up to 24/7. HSD will prioritize projects that offer either 24/7 access or extended hours. • Offer right of return, without the need to line up, for all or a high percentage of beds.
Basic Services	HSD may fund basic services to meet people's immediate needs for shelter and services. Basic Shelters: tend to be overnight-only, mats on the floor. They tend to offer access to limited on-site amenities (hygiene, laundry, storage, meals), and provide limited to no case management services (information & referral). Basic Day Services: can include day and/or hygiene centers. They tend to provide supports that meet people's immediate needs for daytime respite, provide showers, laundry, storage, meals.
Enhanced Services	HSD strongly recommends day and hygiene services be integrated with daytime and evening shelter projects and include services that support exits to permanent housing. HSD will prioritize enhanced and coordinated day/night services, to provide 24/7 seamless services and supports. Enhanced Shelters: tend to be 24-hours or have extended overnight hours, provide bunks, offer full amenities, and have a low to medium case manager to participant ratio. Projects will provide intensive services that focus on housing search and placement. Enhanced Day Services: can include day and/or hygiene centers. Projects should provide intensive services that focus on housing search and placement, and access to full amenities.
System/HSD Performance Indicators (Performance targets and minimum standards)	Service Level Targets/Minimum Standards: Shelter and Enhanced Day Centers: • Exit Rate to PH: SA - 50%/40%; YYA - 50%/35%; Family - 80%/65% • Length of Stay: SA/Family – 30 days/90 days; YYA – 20 days/30 days • Return Rate to Homelessness: SA/Family – 8%/10%; YYA – 5%/20% • Entries from Homelessness: 95%/90% • Utilization Rate: SA/Family – 95%/85%; YYA – 95%/90%

	Service Level Targets: Basic Day and Hygiene Centers • Number of monthly service uses as proposed in RFP submission

Transitional Housing

Transitional Housing is a time-limited intervention intended to provide assistance to households who need more intensive or deeper levels of services in order to attain permanent housing.

Population	The population includes homeless households with specific barriers to attaining permanent housing (e.g. unaccompanied and pregnant or parenting youth ages 12 to 24, and individuals in early stages of recovery from substance abuse, etc.).
Eligibility Requirements	In general, projects should operate under a housing first, low barrier model with minimal or no requirements for entry. Transitional Housing projects must align with the standardized screening criteria guidance adopted by the All Home Funder Alignment Committee.
Eligible Use of Funds	Transitional Housing costs include the cost of operations, case management, and other services that support exits to permanent housing.
Recommended Staff Roles and Staffing Levels	Case management is essential to Transitional Housing. The role of the case manager is to prepare households to move into permanent housing by leveraging resources or working with them to increase household income. Staffing ratio needs to support housing-focused services assisting participants in gathering documentation and removing barriers to support a successful permanent housing placement. Transitional Housing on-site staff coverage varies depending on the housing model and population served.
Core Components/Best Practices	• Emphasis is placed on rapid exit to permanent housing through housing-focused assessment and housing stability planning, facilitated by the Transitional Housing service provider (since households are not eligible for permanent housing placements through CEA services should focus on gaining employment and/or increasing income. • Assistance to reduce barriers to housing, including assisting individuals with gathering needed documentation to access to permanent housing. • Lengths of stay are flexible and tailored to the unique needs of each household. • Connection to community-based resources to support on-going housing stability is provided. • All services are person-centered and tailored to the individual needs of each household. • Transitional Housing models can vary from congregate-style living to scattered site apartments.
System Performance Indicators (Performance	Service Level Targets/Minimum Standards: • Exit Rate to PH: 85%/80% • Length of Stay: SA/Family – 90 days/150 days

targets and minimum standards)	• Return Rate to Homelessness: YYA – 180 days/270 days SA/Family – 8%/10% YYA – 5%/20% • Entries from Homelessness: 95%/90% • Utilization Rate: 95%/85%

Rapid Re-Housing

Rapid Re-Housing (RRH) is designed to help households quickly exit homelessness and return to permanent housing. The core components of RRH are 1) Housing identification, 2) Move-in and rental assistance, and 3) Case management services and supports. RRH projects should view all households as 'housing ready' immediately upon entry into the project and not require sobriety, employment, mental health stability or any other pre-condition to housing search and placement.

Population	Homeless households seeking permanent housing are eligible and this includes families, individuals, and young adults.
Eligibility Requirements	Households must meet the HUD definition of literal homelessness including families or individuals in transitional housing are **not** eligible for RRH. There are no other criteria or preconditions to enrollment in RRH other than homeless status.
Eligible Use of Funds	RRH costs include the costs of case management supports and direct financial assistance. Allowable financial assistance may include: • Costs associated with moving • Deposits and application fees • Rental assistance • Utility assistance • Rental/utility arrears Financial assistance is based on a progressive engagement approach of initially offering the minimum amount of assistance needed to achieve housing stability and increasing incrementally if necessary.
Recommended Staff Roles and Staffing Levels	Intensive case management is essential to RRH. Services should be home-based and tailored to the needs of each household. Staffing supports housing-focused services assisting in gathering documentation, removing barriers to housing, housing search, and negotiating and mediating with landlords to support successful housing placement. Case management may continue up to 60 days after financial assistance ends.
Core Components/Best Practices	The 3 core components of RRH are: • Case management services and supports • Housing identification • Move-in and rental assistance Best practices include: Low barrier, housing first intervention offered with no preconditions to enrollment other than homeless status

	• Services and financial support tailored to the unique needs of the household through a progressive engagement approach where the minimum amount of services is provided before increasing support to meet the needs of the household • Pairing with Critical Time Intervention (CTI). CTI is a time-limited, evidence-based practice designed to support people with mental illness as they discharge from institutions into the community.
System Performance Indicators (Performance targets and minimum standards)	Service Level Targets/Minimum Standards: • Exit Rate to PH: 85%/80% • Length of Stay: 120 days/180 days • Return Rate to Homelessness: SA/Family – 3%/5%, YYA – 5%/20% • Entries from Homelessness: 95%/90% • Utilization Rate: N/A
Additional Resources	Seattle-King County Rapid Re-Housing Model Guidelines All Home Rapid Re-Housing Dashboard

Permanent Supportive Housing

Permanent Supportive Housing (PSH) pairs non-time limited affordable housing with wrap-around supportive services, ensuring access to services designed to support behavioral health needs, connections with community-based health care, treatment, and employment, independent living, and tenancy skills.

Population	Homeless households including families, individuals, and young adults.
Eligibility Requirements	Homeless households (Chronically Homeless if federally funded) that have a condition or disability that create multiple and serious ongoing barriers to housing stability (i.e. mental illness, substance abuse, or chronic health condition). Beyond federal requirements, PSH projects must align with the standardized screening criteria guidance adopted by the All Home Funder Alignment Committee.
Eligible Use of Funds	PSH costs include the cost of operations and case management and services.
Recommended Staff Roles and Staffing Levels	Staffing patterns in supportive housing vary based upon the population being served, the goals of the project, the number of tenants to be served and available resources. The ratio of direct service staff to tenants will vary based upon the anticipated intensity of tenants' need, but is often between 1:10 and 1:25. This ratio is for supportive service staff only and does not include housing or property management staff. Case management/service coordination is the most widely used form of services in supportive housing. The case manager does not provide every service a tenant needs but helps broker relationships between the tenant and other service providers. Case management can include new tenant orientation, assisting the tenant in accessing

	services such as child care or mental health treatment, and supporting the tenant in meeting all obligations of tenancy.
Core Components/Best Practices	• Affordable housing, meaning the tenant pays no more than 30% of income towards rent • Tenants hold a lease, just as in non-supportive housing, with no limits on length of tenancy as long as lease terms and conditions are met • Proactive engagement with residents to offer a comprehensive array of flexible services which are NOT required as a condition of tenancy such as medical and wellness, mental health, substance abuse, vocational/employment, and life skills • Coordination with key partners to address issues resulting from substance use, mental health and other crises, focused on housing stability • Support tenants in connecting with community-based resources and activities while building strong social support networks • May be facility-based or scattered-site
System Performance Indicators (Performance targets and minimum standards)	**Service Level Targets/Minimum Standards:** • Exit Rate to PH: 90% • Length of Stay: N/A • Return Rate to Homelessness: SA/Family – 3%/5%, YYA – 5%/20% • Entries from Homelessness: 95%/90% • Utilization Rate: 95%/85%
Additional Resources	**CSH Supportive Housing Quality Toolkit**