

**HOUSING AND URBAN DEVELOPMENT DEPARTMENT OF VETERANS AFFAIRS
SUPPORTIVE HOUSING PROGRAM**

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive revises VHA policy and procedures for implementing the Housing and Urban Development (HUD)-Veterans Affairs Supportive Housing (VASH) Program

2. SUMMARY OF MAJOR CHANGES: Major changes include:

(a) Paragraph 6: Clarifies the order in which chronically homeless and all other vulnerable homeless Veterans are to be prioritized for admission to HUD-VASH. This is in accordance with HUD Notice CPD-16-11, *Notice on Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing*. Please visit <https://www.hudexchange.info/resources/documents/notice-cpd-16-11-prioritizing-persons-experiencing-chronic-homelessness-and-other-vulnerable-homeless-persons-in-psh.pdf> for additional information. **NOTE:** *This linked document is outside VA control and may or may not conform to Section 508 of the Rehabilitation Act.*

(b) Paragraph 7: In December 2014, the Consolidated and Further Continuing Appropriations Act of 2015 authorized funding for Tribal HUD-VASH in order to expand HUD-VASH into Indian Country for the first time. This legislation authorized HUD to provide HUD-VASH vouchers from their fiscal year 2015 HUD-VASH allocation to be used on reservations and tribal lands. HUD provided \$4 million, which results in approximately 600 HUD-VASH vouchers for Tribal HUD-VASH.

(c) Paragraph 8: Clarifies the process for graduating a Veteran from HUD-VASH who retains their voucher for financial reasons. Additionally, it defines the expectation of case management for a Veteran who has graduated from HUD-VASH case management but still has a HUD-VASH voucher.

(d) Paragraph 9: Establishes what happens when a Veteran exits case management and the voucher is to be relinquished.

(e) Minor edits were made to ensure consistency with VHA Directive 1504, Tribal Housing and Urban Development Veterans Affairs Supportive HOUSING, pending publication.

3. RELATED ISSUES: VHA Directive 1162, dated March 25, 2009.

4. RESPONSIBLE OFFICE: The Deputy Under Secretary for Health Operations and Management (10N) is responsible for the contents of this directive. Questions may be directed to the Executive Director, VHA Homeless Services, 202-461-1635.

5. RESCISSIONS: VHA Handbook 1162.05 dated September 14, 2011 is rescinded.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of June 2022. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

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Acting Under Secretary for Health

DISTRIBUTION: Emailed to the VHA Publications Distribution List on July 3, 2017.

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HOUSING AND URBAN DEVELOPMENT-DEPARTMENT OF VETERANS AFFAIRS SUPPORTIVE HOUSING PROGRAM

1. PURPOSE

This Veterans Health Administration (VHA) directive establishes policy procedures for the Housing and Urban Development (HUD) Department of Veterans Affairs Supportive Housing Program (HUD-VASH) and sets forth the national authority and responsibilities for the Department of Veterans Affairs (VA) portion of administration, monitoring, and oversight of these services. **AUTHORITY:** 38 United States Code (U.S.C.) 2003(b).

2. DEFINITIONS

a. **Acuity.** The severity of illness or client condition that indicates the need for the intensity of the subsequent case management intervention.

b. **Assertive Community Treatment.** Assertive Community Treatment (ACT) is an evidence-based service-rich team approach designed to provide comprehensive, community based mental health treatment, rehabilitation, and support to individuals with serious and persistent mental illness, who have not responded well to traditional treatment program approaches. For additional educational materials and information please visit the following Operational Planning Web site <http://vhaindwebsim.v11.med.va.gov/hub2/hp/>. **NOTE:** *This is an internal VA Web site not available to the public.*

c. **Bridge Housing.** Transitional housing used as a short-term stay when a Veteran has been offered and accepted a permanent housing intervention (e.g., Supportive Services for Veteran Families [SSVF], HUD-VASH, Housing Coalition/Continuum of Care [CoC]) but is not able to immediately enter the permanent housing. Bridge Housing is generally provided for up to 90 calendar days.

d. **Chronically Homeless.** HUD-VASH follows the definition of “chronically homeless” from the McKinney-Vento Homeless Assistance Act as amended by S. 896 The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act, published in the Federal Register on December 4, 2015. Pursuant to 24 CFR 91.5, the definition of “chronically homeless” is as follows:

(1) A “homeless individual with a disability” as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)) who:

(a) Lives either in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

(b) Has been homeless and living as described in paragraph (1)(a) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not

living as described in paragraph (1)(a) of this definition. Stays in institutional care facilities for fewer than 90 days will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility;

(2) An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or

(3) A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless or in an institutional care facility if the individual has been living in the facility for fewer than 90 days and had been living in a place not meant for human habitation, a safe haven, or in an emergency shelter immediately before entering the institutional care facility. In order to meet the “chronically homeless” definition, the individual also must have been living as described above continuously for at least 12 months, or on at least four separate occasions in the last 3 years. Each period separating the occasions must include at least 7 nights of living in a situation other than a place not meant for human habitation, in an emergency shelter, or in a safe haven.

(4) Chronically homeless families are families with adult heads of households who meet the definition of a chronically homeless individual. If there is no adult in the family, the family would still be considered chronically homeless if a minor head of household meets all criteria of a chronically homeless individual. A chronically homeless family includes those whose composition has fluctuated while the head of household has been homeless.

d. **Community Homeless Assessment, Local Education, and Networking Groups (CHALENG)**. A VA program designed to enhance the continuum of care for Veterans experiencing homelessness. Each VA medical facility is required to participate in CHALENG on an annual basis. Through CHALENG, VA medical facilities are required to collaborate with the community, other state and Federal partners and stakeholders, and Veteran Service Organizations (VSOs) to identify needs of local Veterans who are homeless. Homeless, and formerly homeless Veterans, also provide input regarding gaps in services.

e. **Critical Time Intervention (CTI)**. CTI is an empirically-supported, time-limited case management model designed to resolve homelessness and minimize adverse outcomes for individuals with mental illness. CTI, a low-barrier model, engages the Veteran through working on the Veteran’s goals. *For additional information visit <http://vhaindwebsim.v11.med.va.gov/hub2/hp/>.* **NOTE:** *This is an internal VA Web site not available to the public.*

f. **Harm Reduction.** Harm Reduction is a public health model focused on decreasing adverse events by looking to alternative ways to moderate the outcome of behavior or events that cannot be controlled or prevented, while working toward overall health and well-being. See *additional information* <http://vhaindwebsim.v11.med.va.gov/hub2/hp/>. **NOTE:** This is an internal VA Web site not available to the public.

g. **Homeless Veteran.** The term homeless veteran means a veteran who is homeless (as that term is defined in subsection (a) or (b) of section 103 of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11302)). See 38 U.S.C. 2002. The HUD-VASH definition of homeless as defined in 42 U.S.C. 11302 is as follows:

(1) An individual or family who lacks a fixed, regular, and adequate nighttime residence;

(2) An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;

(3) An individual or family living in a supervised publicly or privately operated shelter designed to provide temporary living arrangements (including hotels and motels paid for by Federal, State, or local government programs for low-income individuals or by charitable organizations, congregate shelters, and transitional housing);

(4) An individual who resided in a shelter or a place not meant for human habitation and who is exiting an institution where the individual temporarily resided;

(5) An individual or family who:

(a) Will imminently lose their housing, including housing they own, rent, or living in without paying rent, are sharing with others, and rooms in hotels or motels not paid for by Federal, State, or local government programs for low-income individuals or by charitable organizations, as evidenced by:

1. A court order resulting from an eviction action that notifies the individual or family that they must leave within 14 days;

2. The individual or family having a primary nighttime residence that is a room in a hotel or motel and where they lack the resources necessary to reside there for more than 14 days; or

3. Credible evidence indicating the owner or renter of the housing will not allow the individual or family to stay for more than 14 days, and any oral statement from an individual or family seeking homeless assistance found to be credible must be considered credible evidence for purposes of this clause.

(b) Has no subsequent residence identified; and

(c) Lacks the resources or support networks needed to obtain other permanent housing.

(6) Unaccompanied youth and homeless families with children and youth defined as homeless under other Federal statutes who:

(a) Have experienced a long-term period without living independently in permanent housing,

(b) Have experienced persistent instability as measured by frequent moves over such period, and

(c) Can be expected to continue in such status of an extended period of time because of chronic disabilities, chronic physical health or mental health conditions, substance addiction, histories of domestic violence or childhood abuse, the presence of a child or youth with a disability, or multiple barriers to employment.

(7) Domestic violence and other dangerous or life-threatening conditions. Notwithstanding any other provision of this section, the Secretary [of HUD] shall consider to be homeless any individual or family who is fleeing, or is attempting to flee domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions in the individual's or family's current housing situation, including where the health and safety of children is jeopardized, and who have no other residence and lack the resources or support networks to obtain other permanent housing.

NOTE: The term "homeless" or "homeless individual" does not include any individual imprisoned or otherwise detained pursuant to an Act of Congress or a state law.

h. **Homeless Management Information System (HMIS).** HMIS is a local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness.

i. **Homeless Operations Management and Evaluation System (HOMES).** HOMES is VA's primary platform for collecting intake, progress and outcome information for homeless Veterans as they move through VA's system of care.

j. **Homeless Program Operating Plan.** This is a planning tool utilized by VA medical facility homeless program staff members to turn strategies into actions. The tool is used to develop and update plans to maintain or improve homeless program performance measures at the VA medical facility level and develop and update plans to implement national, Veteran Integrated Service Network (VISN), and VA medical facility strategies related to provision of services to Veterans in homeless programs.

k. **Housing Choice Voucher (HCV).** The HCV program allows very low-income families to choose and lease or purchase safe, decent, and affordable privately-owned rental housing. HCVs allow the Veteran to locate scattered site housing allowing the Veteran choice in their locating of a suitable unit. These vouchers may also be referred

as being “tenant-based vouchers.”

l. **Housing First.** Housing First is an evidence-based clinical practice that centers on rapid housing for homeless people with high service needs, and then provides case management and supportive services to sustain housing. What differentiates a Housing First approach from other strategies is -there is an immediate and primary focus on helping individuals and families quickly access and sustain permanent housing. See additional information <http://vhaindwebsim.v11.med.va.gov/hub2/hp/>. **NOTE:** This is an internal VA Web site not available to the public.

m. **Housing Specialist.** The Housing Specialist is a professional who is responsible for providing assistance to the VA homeless programs acting as a liaison between the public housing authorities (PHA) and the local HUD-VASH Program and in identifying appropriate permanent housing and landlords willing to work with homeless Veterans.

n. **HUD-VASH Veteran or Veteran Family.** A HUD-VASH Veteran or Veteran family refers to either a single Veteran or a Veteran with a household composed of two or more related persons. It also includes one or more eligible persons living with the Veteran who are determined to be important to the Veteran’s care or well-being. A HUD-VASH or Veteran family also includes the surviving member(s) of a Veteran’s family, described in this definition, who were living with the Veteran in a unit assisted under HUD-VASH at the time of the Veteran’s death. The composition of the household must be approved by the PHA. The family must promptly inform the PHA of the birth, adoption, or court-ordered custody of a child. Other persons may not be added to the household without prior written approval of the owner and the PHA. **NOTE:** HUD referenced “Family” in their regulations for HUD-VASH (Notice Public and Indian Housing (PIH) 2010-12 HA, http://portal.hud.gov/hudportal/documents/huddoc?id=DOC_9006.pdf. **NOTE:** This linked document is outside VA control and may or may not conform to Section 508 of the Rehabilitation Act.

NOTE: The partnerships with HUD and PHA require an understanding of their terminology to improve cross agency communication.

o. **Intensive Case Management (ICM).** ICM is a team-based approach that offers a coordinated and brokered approach -delivering therapeutic services utilizing a strengths-based model of care. For additional information visit <http://vhaindwebsim.v11.med.va.gov/hub2/hp/>. **NOTE:** This is an internal VA Web site not available to the public.

p. **Linear Model.** The Linear Model is a staged treatment approach incentivizing housing and other benefits and requires successful completion of one program before moving to another program with a different level of care in a step-wise series with “housing readiness” as on goal at the end of the last program. The model often includes threshold elements such as –prescribed lengths of sobriety, medication compliance, or treatment completion prior to acceptance into another program. The

model is in contrast to Housing First, which does not require a treatment program prior to housing.

q. **Motivational Interviewing (MI)**. MI is a client-centered and semi-directive clinical engagement approach which attempts to increase the Veteran's awareness of the potential problems and complications caused, consequences experienced, and risks faced as a result of the harmful behavior in question. Clients are encouraged to envision a better future by considering what might be gained through change, in hopes of increasingly motivating them to achieve it. The discrepancy between how clients want their lives to be versus how they currently are (or between their deeply-held values and their day-to-day behavior) is explored. The reluctance to change is viewed as natural rather than pathological and client self-efficacy and autonomy is supported.

r. **Peer Support Specialist**. A person with a mental health and/or substance use disorder, who has been trained and certified to help others with these conditions identify and achieve specific life and recovery goals. In HUD-VASH, Peer Support Specialists may also have a personal history of homelessness. In the VA, Peer Support Specialists need to be Veterans.

s. **Point in Time Count (PIT)**. The PIT count is a survey of sheltered and unsheltered homeless persons on a single night in January. HUD requires that Continuums of Care (CoCs) conduct an annual count of homeless persons who are sheltered in emergency shelter, transitional housing, and safe havens on a single night. Unsheltered counts are encouraged to be done annually with the sheltered count but is only required every other year.

t. **Portability**. Portability provides Veterans the opportunity to transfer their HCV to live in the community of their choice, within certain limits. In addition to local VA guidelines, Federal Register Notice of May 6, 2008 addresses portability in HUD-VASH. The Notice can be found by clicking the following link:

<https://www.federalregister.gov/documents/2014/06/18/2014-14167/section-8-housing-choice-vouchers-revised-implementation-of-the-hud-va-supportive-housing-program>.

NOTE: *This linked document is outside VA control and may or may not conform to Section 508 of the Rehabilitation Act.*

u. **Project-Based Voucher (PBV)**. PBVs are a component of the PHA's housing support program. Under the PBV program, a Public Housing Agency (PHA) enters into an assistance contract with the owner of a property for a specified number of units and for a specified term. The assistance is tied to a unit. A family who moves from a PBV unit does not have any right to continued housing assistance unless they are eligible to receive a HCV when one becomes available.

v. **Public Housing Agency (PHA)**. Public housing was established to provide decent and safe rental housing for eligible low-income families, the elderly, and persons with disabilities. A public housing agency (PHA) is a specific city, county, or state agency that receives Federal funds from HUD to administer the Section 8 HCV to provide housing for low-income residents at rents they can afford. Each PHA has

developed independent operating procedures that must comply with HUD regulations and the law. PHA is responsible for determining eligibility for this program based on income eligibility and lifetime sex offender status.

w. **Rural Access Network for Growth Enhancement Team (RANGE)**. The RANGE program provides intensive case management services to seriously mentally ill (SMI) Veterans residing in rural and small market areas.

x. **State**. State refers to any of the states of the United States (U.S.), the District of Columbia, the Commonwealth of Puerto Rico, any territory or possession of the U.S., or any agency or instrumentality of a state, exclusive of local governments. The term does not include any Public and Indian Housing agency under the United States Housing Authority of 1937.

y. **Substance Use Disorder Specialist**. A clinical professional who is responsible for providing expert guidance on Substance Use Disorder (SUD) to the HUD-VASH team, to other providers in the VA medical facility, and in the community. The SUD Specialist also provides assessments and treatment to certain high-risk Veterans who are using substances and provides support and after care to Veterans who have achieved sobriety. It is recommended that the SUD Specialist have a Master's degree and an independent license.

z. **Tribal HUD-VASH**. Tribal HUD-VASH is a demonstration program implemented in fiscal year (FY) 2016 to provide HUD-VASH services to eligible Native American Veterans in 26 tribal locations. *For additional information on Tribal HUD-VASH please visit <http://vhaindwebsim.v11.med.va.gov/hub2/hp/>. A copy of the policy document will also be available at the VHA Forms and Publications Web site at <http://vaww.va.gov/vhapublications/publications.cfm?Pub=1> upon its publication.*
NOTE: *These are internal VA Web sites not available to the public.*

aa. **Veteran**. A Veteran is, for the purpose of HUD-VASH, a person whose length of service meets statutory requirements, and who served in the active military, naval, or air service, was discharged or released under conditions other than dishonorable and is eligible for VA health care.

bb. **Vulnerable Veteran**. A Vulnerable Veteran has:

(1) Underlying chronic medical or mental health conditions that will substantially impact the Veteran's life expectancy and/or ability to function that cannot be effectively cared for due to their homelessness;

(2) Advanced age and infirmity where the Veteran's unstable and unstructured homelessness places them at substantial risk for being unable to maintain independent activities of daily living; and/or

(3) Diminished cognitive capabilities that place the Veteran at increased risk of victimization physically, mentally, and/or through exploitation.

(4) This definition should be used to help in the assessment and admission of Veterans to the HUD-VASH program.

3. POLICY

a. It is VHA policy for HUD-VASH to provide clinical case management and supportive services to Veterans in HUD-VASH by utilizing the principles of Housing First, a team-based model of care, comprised of multi-disciplinary staff, and shared caseloads. Chronically homeless and other vulnerable homeless Veterans, based on the HUD Prioritization Notice, are admitted to case management to support the ongoing effort to end Veteran homelessness. A coordinated entry process will be performed in conjunction with the CoC(s) where possible.

b. Veterans will be treated with dignity, compassion, and respect as an individual. Consistent with Federal law and VA policy, Veterans will not be subject to discrimination for any reason, including for reasons of age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, or gender identity or expression.

4. RESPONSIBILITIES

a. **The Deputy Under Secretary for Health for Operations and Management, or designee.** The Deputy Under Secretary for Health for Operations and Management is responsible for ensuring:

(1) The execution and support to fulfill the operating needs of this directive.

(2) That the regulatory requirements of this directive are being met and related issues addressed through the appropriate clinical or administrative service.

b. **HUD-VASH Program Office, VHA Homeless Program Office, VA Central Office.** The HUD-VASH Program Office, VHA Homeless Program Office, VA Central Office is responsible for ensuring:

(1) Coordination with HUD Headquarters is consistent and continual for program implementation and administration.

(2) Appropriated funds for HUD-VASH, including support for VA staff, are distributed to VA medical facilities consistent with public laws, regulations, and VA directives and policies.

(3) Guidance and technical assistance based on relevant VA laws, rules, regulations, directives, and analysis of collected data is provided to VISN offices and VA medical facilities to ensure that HUD-VASH is maintained and sustained to ensure that appropriate services and case management are provided to Veterans.

(4) Quality services, which are in compliance with existing laws and policies, are provided and operated in accordance with this VHA directive.

(5) Providing subject matter expertise, consultation, and technical assistance to the VISN and VA medical facility HUD-VASH Program staff, as needed.

(6) Educating community partners about VA, VHA eligible Veterans, and VA services and resources, along with the statutes and regulations governing VA.

(7) Conducting three monthly calls with HUD-VASH staff: operations, orientation, and clinical. All HUD-VASH staff are expected to participate in the national HUD-VASH operations call.

(a) The operations call provides program nationwide updates and has presentations related to clinical practice, best practices, performance measures safety, ethics etc.

(b) The orientation call provides foundational training opportunities on HUD-VASH topics such as HOMES documentation, working with the PHA, workload, performance measures, the HUD-VASH Directive, etc. to provide staff with essential knowledge needed to achieve desired outcomes.

(c) The clinical call provides training in evidence-based clinical subject matters, such as Housing First, Trauma Informed Care, CTI, and other best practices to promote familiarity and use of these practices. Continuing Education Units (CEU) are frequently available for these clinical calls.

c. **HUD-VASH Regional Coordinators.** The HUD-VASH Regional Coordinators are responsible for:

(1) Serving as the HUD-VASH subject matter experts and lead points of contact for assigned VISNs.

(2) Ensuring HUD-VASH at each assigned VA medical facility is operating in compliance with existing laws and policies, as well as in accordance with this directive.

(3) Participating in monthly calls with the Network Homeless Coordinators (NHCs) and VA medical facility lead HUD-VASH Program staff to:

(a) Disseminating new information regarding the implementation of HUD-VASH, regularly reviewing performance measures and other data outcomes, and sharing best and innovative practices with the NHC and VA medical facility lead HUD-VASH Program staff.

(b) Providing technical assistance, resources, and support for systemic and consistent deployment of HUD-VASH.

(c) Providing support, guidance, training, and consultation to the NHC and HUD-VASH Program staff to assist with the coordination of services and care.

(d) Providing advocacy and assistance with communicating with HUD to resolve local barriers or clarification of HUD's "HUD-VASH Operating Requirements" found

here, <https://www.hudexchange.info/resources/documents/HUD-VASH-Operating-Requirements.pdf>. **NOTE:** This linked document is outside VA control and may or may not conform to Section 508 of the Rehabilitation Act.

(e) Reviewing critical incident issue briefs and initiating appropriate follow-up activities as necessary.

d. **VISN Director**. Each VISN Director is responsible for:

(1) Supporting the mission to end Veteran homelessness by:

(a) Ensuring resources are in place at each VA medical facility to increase and sustain the progress made on ending Veteran homelessness.

(b) Ensuring each VA medical facility is responsive to Veterans that are homeless or at risk of becoming homeless through the provision of appropriate services, resources, and case management to assist each Veteran to rapidly exit homelessness through permanent supportive housing, or the appropriate clinically indicated services, as determined by the Veteran's needs.

(c) Ensuring a low return to homelessness through the provision of ongoing supportive services and case management.

(2) Ensuring that HUD-VASH within the VISN is:

(a) Operating in compliance with relevant public law, regulations, VHA policies and procedures, and the guidance put forth in this directive.

(b) Fully implementing and utilizing Housing First and other best and innovative practices as demonstrated through data to improve desired outcomes.

(c) Supporting a multidisciplinary case management team or teams.

(d) Supporting VA medical facility staff working with community partners to achieve and sustain the mission of ending Veteran homelessness.

(e) Meeting established VHA performance and descriptive measures.

(3) Hiring and maintaining sufficient staff to meet the mission of ending Veteran homelessness and providing the appropriate level of clinical engagement to help Veterans move out of homelessness and maintain housing.

(4) Ensuring timely documentation of the prevalence of those who are homeless or at risk of homelessness and timely and accurate entry of required HOMES forms. HOMES forms are to be updated within three business days of a change in status for the Veteran.

e. **Network Homeless Coordinator (NHC)**. Each NHC has VISN-level

responsibility for oversight and monitoring of HUD-VASH in their respective VISN. Each NHC is responsible for:

- (1) Ensuring HUD-VASH is monitored and evaluated for adherence to this directive.
- (2) Consulting, collaborating with, and apprising the HUD-VASH Regional Coordinator of any issues or concerns pertaining to the operation of HUD-VASH in their respective VISN.
- (3) Providing support, guidance, orientation, training, consultation, and advice to HUD-VASH Program staff through regular communications, including site visits, VISN calls, etc. to facilitate mentoring, problem solving, and compliance.
- (4) Confirming staff training for all new HUD-VASH staff has been conducted within 90 calendar days of the initial start date. This includes orientation to HUD-VASH. The facility can do this through self-certification to the Network Homeless Coordinator.
- (5) Disseminating new information regarding the implementation of HUD-VASH, regularly reviewing performance measures and other data outcomes, and best and innovative practices.
- (6) Assisting medical facilities with assessing their staffing needs when there are new vouchers allocated or staff turnover to support a multidisciplinary team approach.
- (7) Reviewing HOMES reports, updated Homeless Operating Plans, Gap Analysis, Homeless Services Scorecard, and other evaluation data to optimize program performance, provide support to VA medical facilities to meet established thresholds, and to develop corrective action plans when necessary.
- (8) Reviewing HOMES timeliness reports to ensure required data is entered into HOMES within three business days. If needed, working with the facilities to improve processes for timely entries.
- (9) Tracking use of obligated HUD-VASH funds, and ensuring all funds are used for specified purposes.
- (10) Working with VA medical facilities and HUD-VASH case management teams, along with Quality Improvement and Performance Management staff, to include HUD-VASH Programs in risk management and reporting systems.
- (11) Reviewing HUD-VASH Programs' critical incidents and initiating appropriate investigation and follow-up activities in collaboration with the respective VA medical facility.
- (12) Working strategically with VA and community partners to establish partnerships to reduce barriers and silos, including a common language and understanding of the mission goals, strategies, and plans to achieve and measure the objectives.

f. **VA Medical Facility Director.** Each VA Medical Facility Director is responsible for:

(1) Supporting the mission to end Veteran homelessness and sustaining the efforts to prevent Veterans from returning to homelessness.

(a) Supporting additional HUD-VASH vouchers where and when the need is evident, based on available data, within the VA medical facility's catchment area.

(b) Ensuring Housing First and other best and innovative practices are implemented and utilized to rapidly house homeless Veterans.

(c) Sustaining HUD-VASH to include ongoing case management and supportive services in support of program goals.

(d) Engaging with community partners, as needed, to end Veteran homelessness.

(2) Ensuring adequate access to HUD-VASH through timely hiring of facility or contracted staff. Maintaining adequate staffing levels to safely and appropriately provide the necessary clinical services for the vulnerable Veterans served in HUD-VASH. **NOTE:** *For purposes of maintaining adequate staffing the Homeless Program Office generates reports and metrics [timely hiring and assessing needs].*

(a) Ensuring that staffing levels are sustained in support of Veteran safety, recovery, and maximum independence within the varied levels of acuity.

(b) Ensuring the expeditious release of an internal candidate if a candidate is selected for a HUD-VASH position.

(c) Ensuring multidisciplinary case management teams are established and sufficiently staffed to provide integrated services to Veterans in HUD-VASH. This includes the ability to provide services in the community and Veterans' homes. Case management teams must be able to provide comprehensive services to address high acuity needs, physical and mental health diagnoses, SUDs, and other psychosocial needs.

(3) Ensuring VA medical facility staff assigned to HUD-VASH has the appropriate clinical backgrounds, education, and experience necessary to provide community-based case management services. This includes:

(a) Ensuring managers and clinicians are competent to address the complex, often co-occurring severe mental and physical health needs specific to the population served in HUD-VASH.

(b) Ensuring clinicians have the required training, including training available through the VA Talent Management System (TMS).

(4) Providing appropriate administrative support and timely issuance of resources needed to guarantee HUD-VASH is able to safely accomplish its stated mission, goals, and objectives. This includes office space, information technology (IT) equipment (including mobile phones, laptop computers, air cards, or other Wi-Fi access), and car allocations for work in the community and transporting Veterans.

(5) Providing and maintaining program oversight to ensure quality clinical services and compliance with VHA policy and procedures, to include Computerized Patient Record System (CPRS) documentation and workload policies.

(6) Ensuring performance improvement activities take place to improve access and sustain Veterans in HUD-VASH.

(7) Providing adequate clinical staff support for assessments to determine the medical and psychiatric needs of Veterans referred to HUD-VASH, including risk management and other clinical and ethical consultations as needed for safe and appropriate clinical care, ongoing case management and supportive services.

(8) Ensuring the timely completion of all mandating reporting, monitoring, evaluation, and accreditation requirements. This includes full-time equivalent (FTE) employee tracking and performance measures.

(9) Ensuring HUD-VASH meets all accreditation requirements, to include The Joint Commission (TJC) and the Commission on Accreditation of Rehabilitation Facilities (CARF).

(10) Ensuring VA participation in and collaboration with local community endeavors to end homelessness.

(a) Participating in local CoCs strategic planning meetings and PIT Count surveys of homeless individuals.

(b) Engaging in community activities such as Action and Boot Camps, Registry Weeks, Mayor Challenges, the Built for Zero Initiative, and the 25 City Initiative.

(c) Supporting a coordinated entry process for the identification and referral of homeless Veterans.

(11) Verifying VA medical facility staff provides timely and accurate documentation within three business days of Veteran activity in the HOMES database. Staff must regularly use HOMES Reports to verify accuracy of caseloads.

(12) Verifying VA medical facility staff reconcile their data with their partner PHA(s) at least quarterly.

(13) Creating a culture of safety, meaning leadership openly focuses on safety as a top priority, where system-wide learning occurs as to the causes of adverse events are

openly shared, where investments are made in the resource and training to ensure safe practices, and where employees freely report and communicate safety concerns.

(a) HUD-VASH is a community based program and the safety concerns raised by staff may differ as a result.

(b) This includes empowering VA employees to identify and report their concerns about patient safety without fear of reprisal.

g. **HUD-VASH Program Coordinator.** The HUD-VASH Program Coordinator is responsible for:

(1) Supervision of the program including orientation and training, ongoing use of data for purposes of program improvement and staff education, training, and development.

(2) Training for HUD-VASH Staff:

(a) Guaranteeing all HUD-VASH case management staff members have training in Critical Time Intervention (CTI), Assertive Community Treatment (ACT), Motivational Interviewing (MI), Housing First, Low-Demand Model of Care, and other clinical approaches relevant to the population. Training must be completed within 90 calendar days of initial start date.

(b) Monthly clinical calls provided by the HUD-VASH Office are available in TMS and can be accessed for training purposes from the Operational Planning Hub.

(c) Training obtained in and outside of TMS can be uploaded into TMS via the Record Learning Wizard in the Links section. If an internal item is selected, the search option can assist with locating the training by using the exact phrase or keywords. Required fields for external items include description, completion date, completion time, and time.

(d) Documenting that all staff complete appropriate ethics training as required by respective professional licensure or credentialing boards, with an emphasis on dual relationships and conflict of interest circumstances.

(e) Ensuring all orientation processes meet TJC and CARF standards, including the documentation of completion of orientation.

(3) Establishing internal working partnerships to reduce barriers and silos across all homeless and VA medical facility programs to ensure a seamless transition between providers for Veterans served in HUD-VASH.

(4) Engaging in community outreach and developing community partnerships, particularly with the local Homeless CoC.

(5) Coordinating with the local PHA to provide streamlined and timely processes for HUD-VASH voucher utilization. This includes the referral process, voucher issuance, and the leasing process. At minimum, there needs to be a quarterly reconciliation of data between the HUD-VASH Coordinator, or their designee, and the PHA(s) to determine the status of all HUD-VASH vouchers and processing times between referral to the PHA and lease up.

(6) Reconciling voucher status with the PHA, including any vouchers that are marked as graduated, on a minimum of a quarterly basis.

(7) Providing programmatic direction to all staff assigned to HUD-VASH, including case manager, program support, and associated providers.

(8) Assisting in the development of administrative and personnel documents such as position descriptions, functional statements, and performance appraisals.

(9) Establishing and maintaining a process for referral, evaluation, and admission to HUD-VASH to ensure that the most vulnerable Veterans are prioritized. Performing a review of the program process to improve efficiency and further refine the rapid housing process at least annually.

(10) Managing and ensuring an even distribution of caseloads with consideration to the ACT, ICM, and CTI models of care.

(11) Ensuring the implementation of Housing First principles consistently across all HUD-VASH teams.

(12) Supporting a multidisciplinary team model of care wherever possible to expand the provision of support for Veterans to improve stability and housing retention.

(a) Determining current staffing needs as the Veteran population served can change over time. This may be due to a change in the overall acuity of the population, specific needs of the population (such as health needs associated with aging), and number of Veterans sustaining stability and independence over time.

(b) Regularly reassessing team staffing effectiveness to determine changes to the disciplines or level of staffing would improve services as vacancies or opportunities to add new staff occur. Staffing changes are made by submitting the appropriate memorandum request to add, remove or change positions.

(13) Establishing huddles, clinical case reviews, and staff meetings with assignments for follow-up action.

(14) Providing case consultation, especially around high-risk situations.

(15) Conducting appropriate program audits, such as but not limited to:

(a) Chart reviews to ensure documentation meets TJC and CARF standards of care;

(b) Performance measures and descriptive measures;

(c) Frequency of clinical contacts based on the stage of case management being provided; and HOMES data reviews to ensure policy adherence, including that data is entered within three business days.

(16) Coordinating accreditation activities and ensuring compliance with accreditation requirements.

(17) Guaranteeing regular and ongoing reconciliation of data in HOMES against internal tracking mechanisms and with the PHA(s) on the status of vouchers, including those for Veterans who have graduated from case management but maintain a HUD-VASH voucher.

(18) Ensuring effective systems are in place related to personnel, fiscal, acquisition and material management, contracting, and staff vehicles.

(19) Working closely with community partners to eliminate Veteran homelessness. Establish practices to rapidly identify and assess homeless Veterans for HUD-VASH.

(20) Outreach and Access.

(a) Establishing internal and external partnerships to build functional, cooperative relationships that work seamlessly to enhance HUD-VASH's efficiency and effectiveness in outreach and service delivery.

(b) Modeling effective Housing First principles.

(c) Establishing procedures with other VA Homeless Programs and with community-based homeless programs to provide assistance to Veterans who are not eligible for HUD-VASH or who are not interested in pursuing HUD-VASH.

(d) Developing relationships with other VA programs to improve access to the full range of health care services needed by homeless Veterans. This is particularly important for vesting physicals, mental health evaluations, and other services utilized by this population.

(e) Have the flexibility to develop innovative practices to reach out to the community and assist homeless Veterans.

1. Non-traditional approaches may include casual dress, irregular tours of duty, the use of office space donated by community agencies, and the coordination of activities with community groups.

2. Staff independence may necessitate medical facilities to recognize additional considerations for program safety, employee security, and job effectiveness (available vehicles for outreach and case management activities, cellular phones, laptop connectivity, additional security services, etc.).

h. **Case Management Team.** The Case Management Team is responsible for:

(1) Providing outreach services to engage homeless Veterans, especially those who are chronically homeless and are highly vulnerable.

(2) Verifying a Veteran's status, eligibility for VA health care through the Eligibility Office, family income, and clinical need for program participation.

(3) Accepting referrals for screening and admission to HUD-VASH. Referrals can be received from:

(a) The local CoC, community partners or other community-based stakeholders;

(b) VA's National Homeless Call Center (1-877-4AID VET or 1-877-424-3838);

(c) Veteran self-referral;

(d) Other VA Homeless Programs; or

(e) Other VA or community medical facilities and programs including CBOCs and Vet Centers.

(4) Screening and conducting an assessment to ensure appropriateness of placement into the program.

(5) Assessing Veterans through comprehensive bio-psychosocial evaluations to determine acuity status.

(6) Admitting Veterans into HUD-VASH. Admission is by clinical decision of HUD-VASH staff, or, if indicated, in more complex situations, with consultation of homeless program leadership or other appropriate service.

(a) Veterans are considered admitted into HUD-VASH when accepted for case management. Admission decisions need to occur within 24 hours or one business day of a completed referral interview with the appropriate documentation in HOMES.

(b) HUD-VASH Programs may be associated with their community in coordinated entry efforts. Utilization of any specialized screening tools for purposes of assessment and admission do not replace documentation requirements in HOMES.

(c) In the case of a two-Veteran household, the individual identified as head of household with the primary need for case management is the voucher holder. If both Veterans require case management, there will be two separate entries in HOMES showing that they are case managed although only one Veteran has a HUD-VASH voucher issued.

(7) Providing appropriate services as needed based on Veterans' needs, acuity level, and preferences for care. Veterans need to be reassessed on a regular basis, no

less than quarterly and in accordance with local policy, for changes in their needs, acuity level, and preferences for care.

(8) Developing a Housing Stability Plan, or treatment plan, with each Veteran served by the team. The Housing Stability Plan provides a case management and supportive services framework for the Veteran's sustainability in HUD-VASH, and identifies the Veteran's goals with steps to achieve those goals.

(a) The Housing Stability Plan addresses what the Veteran determines they need to maintain housing successfully.

(b) Veterans lead the direction of the Housing Stability Plans, and are encouraged to work with their case management team in the development of this plan with specific, individualized goals that focus the direction of case management. Goals in this plan are in the Veteran's words.

(c) Case managers will empower and respect the Veteran's self-determination in those areas most important to the Veteran. When developing plans, case managers help the Veteran identify and articulate their strengths, needs, abilities, and preferences.

(d) The Veterans' participation, along with family and other agency involvement in developing the plan, must be documented. A copy shall be provided to the Veteran and documented in the medical record. The plan may need to be requested through Patient Records.

(e) The Housing Stability Plan is to be reviewed and updated regularly as significant changes occur, goals are accomplished, and new goals are set in accordance with the local documentation policy.

(f) The Housing Stability Plan is to be integrated with the Veteran's overall care plan developed by the treating VA medical facility.

(9) Reviewing changes and updates in Veteran care with the entire case management team and documenting appropriately in the Veteran's CPRS record.

(10) Facilitating and providing access to appropriate treatment and supportive case management services to Veterans in HUD-VASH by coordinating Veteran-centered care across service providers, including VA and non-VA providers. **NOTE:** *This can be done individually or in groups.*

(11) Providing the appropriate level of case management and supportive services, primarily in the community or in the home, to Veterans based on their needs and wants. There are five basic levels of case management:

(a) Intensive. The HUD-VASH Case Management team works with the Veteran to obtain clinical stability. At a minimum, weekly home visits are required, but even more frequent interactions may be needed.

(b) Stabilization. At this stage, Veterans are more adept at managing their housing responsibilities and their physical, mental health, and substance use disorders are more stable as the Veteran works on addressing those issues that are most likely to lead to housing instability. At least twice a month home visits are required, with additional interactions as needed.

(c) Maintenance. Case management services ensure that needed treatment, support, and mentoring assistance continue after placement in housing. Home visits need to occur at least every month, once the Veteran demonstrates stability, independence, and improved coping skill use and recovery. Other interactions, such as phone calls, may be indicated.

(d) Preparation for Discharge. Veterans who have functioned at a very independent level for at least 6 to 12 months and sustained a low acuity level may be considered for this phase to practice and plan for discharge from HUD-VASH. Case management can be provided in the home, community, or at the medical center. During this phase, contacts are to occur at least quarterly and the focus of case management would address steps towards graduation from case management, and/or discharge planning.

(e) Graduation/Discharge. Graduation is for Veterans who no longer need the case management services in HUD-VASH, and thus, the Veteran is not required to participate in case management. A Veteran is discharged from HUD-VASH when they are no longer participating in case management. If the Veteran is retaining the HUD-VASH voucher for financial purposes only, they are considered in graduation status. For more information on case management visit <http://vhaindwebsim.v11.med.va.gov/hub2/hp/>. **NOTE:** This is an internal VA Web site not available to the public.

(12) Providing groups based on need or specific areas of focus, such as understanding the PHA, the housing search process, tenancy rights and responsibilities, developing interpersonal skills, budgeting, and maintaining sobriety and/or harm reduction strategies.

(13) Utilizing Housing First and other evidence-based practice models to promote Veteran engagement and self-efficacy.

(14) Helping Veterans obtain all necessary documentation required by the PHA for voucher issuance.

(15) Assisting Veterans through the voucher application process, from referral to voucher issuance.

(16) Providing housing search assistance to Veterans in HUD-VASH, including choices from an array of housing within the Veteran's preferred community. Additional assistance and peer support can be provided in a housing resource group.

(17) Responsible for assisting the Veteran with housing placement, beginning with the process of obtaining a HUD-VASH voucher from the PHA through the lease up process.

(a) Developing a collaborative relationship with the PHA, including but not limited to:

1. Streamlining the voucher application process by minimizing the number of meetings and assessments where possible;

2. Obtaining forms and proper execution of those forms;

3. Communicating on housing status frequently to expedite solutions to barriers/delays'

4. Maintaining a list of Veterans in program and reconciling with the PHA at regular intervals; and

5. Confirming housing status of Veterans who are no longer in case management but are still using a voucher.

(b) Assisting the Veteran with the entire process from referral to the PHA to voucher issuance. This can include, but not limited to the following:

1. Obtaining signature on Release of Information (ROI) to ensure proper information exchange with PHA. **NOTE:** *Examples of this kind of exchange would be notification of appointments, notification of additional needed documentation, or resolving concerns or issues;*

2. Assisting the Veteran in obtaining the needed documentation (provision of checklists for required documents is a good practice to help organize Veterans);

3. Helping the Veteran complete the PHA voucher application to ensure that only accurate and fully completed application packets are forwarded to decrease the time between referral to the PHA and issuance of a HUD-VASH voucher;

4. Supporting the Veteran during voucher briefing and landlord package appointment(s) at PHA. Veterans may need support from the HUD-VASH team to attend appointments at the PHA;

5. The HUD-VASH team must be actively involved in assisting, where needed, in the housing search process with the Veteran. Assistance may include helping the Veteran to determine the geographic areas where they may be interested in living, researching types of housing best suited for their needs, collaborating on the actual search and consideration of access to services and public transportation to better target their search. Transportation to view units and negotiate with landlords may be key to quickly identify a unit for lease; and

6. The HUD-VASH team must be informed about the Housing Quality Standards (HQS) utilized in the inspection process to help determine if a unit is likely to pass inspection or not. Providing the landlord with the HQS prior to the inspection will permit the landlord to determine if they are able to meet HQS or are willing to improve the unit to pass the inspection process.

(18) Assisting Veterans with pursuing employment to increase their income and integrate into the community. This can be done in conjunction with the Community Employment Coordinator (CEC), HUD-VASH employment specialists, and other VA and non-VA programs providing employment services to homeless individuals and individuals with disabilities.

(19) Assisting Veterans in determining eligibility and applying for non-service connected pension, service connected compensation, applying for mainstream entitlement benefits, such as Social Security, and/or state and county benefits including Temporary Aid to Needy Families (TANF) and Special Needs Assistance Program (SNAP).

(20) Working with Veterans to develop structure and a meaningful purpose to their day. This may include but not limited to working, volunteering, being involved in a civic organization, or participating in religious or cultural activities.

(21) Making regular home visits, based on the acuity level of the Veteran, to assess Veterans' housing stability, social and community integration, and recovery process. Additionally, home visits help ensure the residences are safe environments and in compliance with HQS.

(22) Advocating on behalf of Veterans and their families with landlords, PHAs, and community providers.

(23) Assisting Veterans in development of their self-identified goals and Housing Stability Plans. Ensuring regular re-assessment and revision of the Housing Stability Plan to cater it to the Veterans' needs and preference and assist Veterans in removing barriers and achieving their stated goals.

(24) Promoting housing retention and stability. This includes reviewing lease obligations, developing money management and budgeting strategies, helping Veterans develop healthy boundaries with others, skills and approaches to support housing retention, and assisting with the recertification process as needed.

(25) Promoting a safe and respectful culture by:

(a) Scheduling home visits with Veterans and their family at times convenient to them;

(b) Involving Veterans in the development of disaster planning and providing relevant local resources to support the household; and

(c) Discussing when unscheduled visits will occur, but emphasizing their use as safety measures in emergency situations, such as when Veterans have not been in contact, and for wellness checks within established parameters.

(26) Coordinating among team members to ensure that all Veterans are served during staff absences as appropriate to the acuity and needs of each Veteran.

(27) Obtaining ROI consents from Veterans, when possible, with all community providers and housing stakeholders, to ensure comprehensive coordination and collaboration towards maintaining housing permanency.

(28) Being knowledgeable of the relevant HUD regulations regarding HCV and HUD-VASH as well as local PHA administrative plans.

(29) Meeting regularly with landlords and PHA officials to ensure the availability of affordable, safe housing stock that will accept the HCV subsidy. Collaborative efforts to conduct "landlord fairs" or other housing stock outreach efforts is encouraged and may identify additional HCV subsidy opportunities.

(30) Facilitating the portability process with originating and receiving VA medical facilities and PHAs to help ensure a smooth transition for Veterans.

(31) Ensuring all HOMES documentation is completed within three business days and all contacts are documented in the Veteran's CPRS file in accordance with local documentation policies.

(32) Ensuring there is no conflict of interest in dealings with Veterans, landlord, and other entities by adhering by professional ethical guidelines. It is required that all VA medical facility staff complete annual ethics training, to include conflicts of interest.

(33) Participating in program specific conference calls, broadcasts, and trainings. This includes but not limited to the monthly national HUD-VASH operations, clinical, and orientation calls as well as VISN calls.

(34) Developing relationships and processes with the CoC and other community providers, VA providers, and other VA homeless programs.

(35) Coordinating care of Veterans with high-acuity and high-risk mental health and behavioral factors with relevant providers throughout the VA medical facility and within the community.

(36) Responsible for ensuring that a culture of safety exists among team members and Veterans by:

(a) Participating in the mandatory Prevention and Management of Disruptive Behavior Training (PMDTB) and all other pertinent safety trainings as required by the local VA medical facility;

(b) Obtaining all required safety training, including training related to suicide risk reduction and working safely with high-risk Veterans, in both office and community settings, such as but not limited to: those with severe mental illness and SUD, those with a history of violence, and those with an involvement with the justice system;

(c) Reporting all incidents of Veteran threats, aggression or violence, including those witnessed in the community, to the VA medical facility's Disruptive Behavior Committee through the disruptive behavior reporting system for tracking and assistance;

(d) Utilizing safe practices while performing duties;

(e) Working with the Disruptive Behavior Committee, leadership, peers, supervisors, and VA police to ensure safety in questionable circumstances; and

(f) Adhering to local and national VA policies and procedures related to management of high-risk safety issues.

i. **Nursing.** The responsibilities of the nursing staff will vary based on specific classification and scope of practice. Responsibilities may include:

(a) Actively participating as a HUD-VASH team member; nurses are to provide case management services and promote integration with medical and mental health care providers across the medical facility.

(b) Providing outreach services to engage homeless Veterans, especially those who are chronically homeless with complex medical and mental health needs.

(c) Utilizing the nursing process which includes systematic data gathering, assessment, appropriate nursing judgment, and evaluation of human responses to actual or potential health problems.

(d) Providing health teaching, health counseling; provision of care supportive to or restorative of life and well-being; and executing medical regimens including administering medications and treatments prescribed by a licensed or otherwise legally authorized provider. The nurse's primary commitment is to the patient, whether an individual, family, group, or community.

(e) Helping each Veteran access all needed medical and mental health care. This may include accompanying Veterans to appointments to facilitate information sharing of symptoms experienced by the Veteran and promoting Veteran comprehension of the treatment recommendations made by the provider.

(f) Engaging HUD-VASH Veterans in understanding the nature and extent of their complex comorbid diagnosis of mental health and medical concerns (potentially unrecognized and untreated), discuss the impact of the Veteran's symptoms, and develop a plan to address these concerns. The nurse must develop an engaging, therapeutic relationship with the Veteran to assist each Veteran participant with exploring, as ready, the impact of their condition on health, functioning, relationships,

and housing access/sustainment and advance strategies to access needed care.

(g) Assisting Veterans by simplifying their treatment recommendations and medication regimens in order to promote Veteran agreement and cooperation to enhance positive treatment outcomes for the Veteran who may have multiple providers, medications or appointments.

NOTE: *The nurse may provide service to the HUD-VASH Veterans in a consultative role and/or may carry an individual case load of complex care Veterans depending on how the local team is organized.*

j. **Substance Use Disorder Specialist.** The Substance Use Disorder (SUD) Specialist is responsible for:

(1) Actively participating as a HUD-VASH team member with direct interaction with SUD specialty services. SUD Specialists are to provide case management services and promote integration with SUD care providers across VA.

(2) Engaging HUD-VASH Veterans with SUDs to discuss the impact of their substance use and developing a therapeutic relationship that assists Veteran participants with exploring, as ready, the impact of their use on health, functioning, relationships, and housing access/maintenance, and develop strategies to decrease or end such use.

(3) Providing direct, concurrent clinical care using established evidence-based practices, for Veterans with co-occurring conditions of homelessness and SUD.

(4) Assisting, as needed, with education on Harm Reduction as it relates to substance use and recovery.

NOTE: *The SUD Specialist is not necessarily assigned to provide ongoing case management services to every Veteran in HUD-VASH who presents with a SUD, but assignment of care needs to be based on the complexity of the care required, and the competencies of available staff to meet the specific needs related to SUD.*

(5) Facilitating recovery groups for Veterans with significant SUD concerns. As much as possible, these offerings will be located in the community in locations easily accessed by public transportation.

(6) Serving as the liaison between HUD-VASH, specialty SUD services at the VA medical facility, and community agencies. Regular attendance at SUD specialty services' case conferences will be beneficial.

(7) Providing Veterans and staff with education about SUDs, including a range of approaches that can assist the Veteran with maintaining their housing while reducing their substance use.

(8) Coordinating with existing SUD specialty services to ensure that HUD-VASH Veterans receive continuing care for SUD, as appropriate and as needed.

(9) Consulting with providers both within HUD-VASH and throughout the VA medical facility who may directly interact with Veterans who are homeless and have SUD (e.g., primary care, acute psychiatry, inpatient or residential mental health programs).

(10) Engaging the Veteran in discussions regarding a variety of evidence-based SUD treatment options, ranging from harm reduction strategies through inpatient treatment/abstinence.

(11) Utilizing evidenced-based clinical techniques such as MI to help Veterans address their SUD concerns.

(12) Participating in HUD-VASH national and VISN level conference calls.

(13) Documenting Veteran contacts in CPRS in accordance with local documentation policy.

(14) Accurate and timely recording of workload for Veteran contacts in accordance with local policy and procedure.

NOTE: *The Homeless Productivity and Procedure Coding Guide provides reference information on encounter codes for services offered. It can be found at <http://vhaindwebsim.v11.med.va.gov/hub/app/library/record/visit?id=10425>. NOTE: This is an internal VA Web site not available to the public.*

k. **Peer Support Specialist.** The Peer Support Specialist is responsible for:

(1) Providing emotional support to encourage positive change during the Veteran's recovery process, including checking in with the Veteran on how they are feeling and managing and regularly asking about the Veteran's current needs.

(2) Keeping the HUD-VASH team informed of high-risk behaviors and other concerns for the Veteran by attending and participating in scheduled case conferences and team meetings.

(3) Providing practical assistance, as needed and appropriate, to HUD-VASH Veterans, including but not limited to:

(a) Accompanying the Veteran to clinical appointments and self-help group meetings and assisting with obtaining a sponsor if the Veteran chooses to participate in a 12-step program;

(b) Helping with the housing search and move-in process;

(c) Assisting the Veteran with access to vocational training, and employment resources;

(d) Assisting Veterans in obtaining furniture and other necessities for their apartment, through collaboration with Voluntary Services and community providers;

(e) Identifying Veteran interest, encouraging participation in and connecting to appropriate recreational activities;

(f) Helping Veterans articulate concerns and advocate effectively for themselves with providers;

(g) Modeling skills for a positive lifestyle and community engagement;

(h) Assisting with linkages to mental health and substance abuse services in VA and the community; and

(i) Facilitating groups as appropriate to the knowledge and skill of the Peer Support Specialists.

(4) Documenting Veteran contacts in CPRS in accordance with local documentation policy.

(5) Accurate and timely recording of workload for Veteran contacts in accordance with local policy and procedure.

NOTE: *The Homeless Productivity and Procedure Coding Guide provides reference information on encounter codes for services offered. It can be found at <http://vhaindwebsim.v11.med.va.gov/hub/app/library/record/visit?id=10425>. NOTE: This is an internal VA Web site not available to the public.*

I. **Housing Specialist.** If there is no designated housing specialist, the HUD-VASH team needs to share these responsibilities. The Housing Specialist is responsible for:

(1) Acting as a liaison between all parties, including but not limited to the VA, PHA, landlord, and Veteran, to address housing needs.

(2) Educating the community on HUD-VASH.

(3) Identifying and contacting local landlords and realtors to find potential housing units for Veterans to lease.

(4) Maintaining a database of landlords and property management companies that accept HCV subsidies. This should be reviewed and updated at least monthly.

(5) Organizing and conducting housing fairs in collaboration with local PHA to increase landlords' awareness and interest in HUD-VASH. HUD-VASH staff may also wish to include SSVF grantees in the development of housing fairs, as appropriate.

(6) Conducting a walk-through of apartments, using the HQS form and any local PHA requirements, to help ensure all units meet requirements for lease up.

(7) Obtaining releases of information and working with the PHA to create processes to expedite inspections, such as pre-inspection of units and rapid re-inspections.

(8) Serving as the point of contact and liaison for the PHA to ensure that housing packets are complete, processed, and vouchers are processed and issued in a timely manner.

(9) Developing and/or utilizing tools to track voucher utilization within the HUD-VASH catchment area.

(10) Assisting Veterans with the housing search process, including helping Veterans fill out housing applications and assisting with transportation to units for lease signing.

(11) Conducting groups on tenancy rights and responsibilities.

(12) Working with team members to obtain needed funds for security and utility deposits and furnishings needed for the unit. This may include working closely with SSVF grantees, Veteran Service Organizations, and other community partners.

(13) Assisting a Veteran with their move into housing. This includes, but is not limited to, obtaining necessities and furniture, scheduling furniture move in, and turning on utilities. This may be done through collaboration with Voluntary Services and community providers.

(14) Identifying potential or existing problems in apartments and assisting Veterans in requesting repairs.

(15) Maintaining regular contact with landlords to ensure that concerns are addressed immediately with case management including any potential or actual lease requirements.

(16) Contacting Veterans with upcoming PHA recertification for their unit, educating them on this PHA requirement and assisting them with the process.

(17) Accurate and timely recording of workload for Veteran contacts in accordance with local policy and procedure.

NOTE: *The Homeless Productivity and Procedure Coding Guide provides reference information on encounter codes for services offered. This information can be found at <http://vhaindwebsim.v11.med.va.gov/hub/app/library/record/visit?id=10425>. **NOTE:** This is an internal VA Web site not available to the public.*

m. **Administrative Support Specialist.** The Administrative Support Specialist is responsible for:

(1) Providing a welcoming environment for Veterans and connecting Veterans with clinicians.

(2) Providing administrative support to HUD-VASH and clinicians, including keeping minutes and records, pulling appropriate reports and data, and procuring needed resources.

(3) Developing relationships with community partners, attending meetings, and providing basic education about HUD-VASH, when indicated.

(4) Assisting with preparations for TJC and CARF reviews.

n. **Veteran.** The Veteran, with the help of the HUD-VASH case management team, is responsible for finding a suitable rental unit, paying rent and utilities on time, following rules of tenancy, participating in case management services, and complying with PHA requirements. The procedure sequence is as follows:

(1) Upon locating a suitable apartment, the Veteran or case management team submits the Request for Tenancy Approval to the local PHA to request an inspection and to approve the dwelling. The form HUD-52517 is available at:

<https://www.hud.gov/offices/pih/pha/approved/pdf/02/fl005v05.pdf>. **NOTE:** This linked document is outside VA control and may or may not conform to Section 508 of the Rehabilitation Act.

(2) When the unit passes inspection, a Housing Assistance Payment (HAP) contract is signed by the PHA and landlord. Once the HAP is executed, the Veteran contacts the landlord and, if all parties agree, a standard lease is executed.

(3) The Veteran, assisted by the case manager, moves into the housing unit on the agreed upon date.

NOTE: The Veteran may need the case manager's assistance to plan the steps involved in the move including obtaining furniture, cleaning supplies, dishes, as well as how the Veteran will physically move those items. Case managers are encouraged to work with their local Voluntary Service Program, community programs, and other appropriate resources to assist the Veteran with this step and the physical move. Case managers are not authorized to physically move the Veteran into the apartment.

(4) The Veteran follows the rules of tenancy.

(5) The Veteran notifies the case management team of issues or concerns with the unit, other tenants, landlord, PHA and develops a plan to resolve the concerns.

(6) The Veteran and case management team utilize the housing stability plan and other strategies to sustain the Veteran in housing.

o. **Public Housing Authority (PHA).** HUD has legislative and regulatory authority of HUD-VASH vouchers and public housing agencies. Generally, the HUD-VASH

program is administered in accordance with regular HCV program requirements (24 CFR, Section 982). However, the 2008 Consolidated Appropriations Act (Public Law 110-161) allows HUD to waive or specify alternative requirements for any provision of any statute or regulation affecting the HCV program in order to effectively deliver and administer HUD-VASH voucher assistance. The alternative requirements are established in the HUD-VASH Operating Requirements (including the waivers and alternative requirements from HCV program rules), which were published in the Federal Register on May 6, 2008 and updated March 23, 2012. The Operating Requirements can be found here, <https://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-7081.pdf>.

NOTE: This linked document is outside VA control and may or may not conform to Section 508 of the Rehabilitation Act.

The PHAs local discretionary policies adopted in the PHA's Administrative Plan, apply to HUD-VASH vouchers. If there is a conflict between the program regulations and the agency's administrative plan, the program regulations have precedence.

By agreeing to administer HUD-VASH, PHAs are responsible for:

(1) Accepting Veterans referred by the VA Medical Center only. PHAs do not maintain a separate waiting list for the HUD-VASH program.

(2) Determining/Verifying income eligibility. If the Veteran is over income they are ineligible for HUD-VASH.

(3) Completing a background check to ensure that the Veteran (or household member) is not a lifetime registered sex offender under a State sex offender registry

(4) Conducting briefing sessions and issuing vouchers for all eligible VASH applicants. The initial search term for a HUD-VASH vouchers is at least 120 days to search for a unit.

(5) Providing housing-search resources to HUD-VASH Veterans.

(6) Assisting with landlord recruitment and housing stock availability.

(7) Inspecting housing units to ensure that HUD-assisted are in compliance with Housing Quality Standards. To expedite the leasing process, PHAs may choose to "pre-inspect" units. If a family selects a unit that passed an HQS inspection (without intervening occupancy) within 45 days of the date of the Request for Tenancy Approval, the unit may be approved.

(8) Executing HAP Contracts.

(9) Making timely housing assistance payments.

(10) Assisting with the mobility/portability process, whereby a Veteran is using a voucher to lease a unit in another jurisdiction where a PHA operates a Housing Choice Voucher (HCV) program.

(11) Notifying the HUD-VASH Case Management Team of all upcoming appointments to help guarantee attendance.

(12) Providing housing-search resources to HUD-VASH Veterans.

(13) Providing assistance to case managers regarding program rules, local PHA policies written in the agency's Administrative Plan, including but not limited to procedural guidelines and performance standards for conducting HQS inspections, revising payment standards, determining rent reasonableness, interim redeterminations informal reviews/hearing procedures (appeals).

(14) Communicating housing status of Veteran participants to resolve concerns and maintain accurate participant accounting.

(15) Helping maintain positive relationship with landlords and resolving PHA/HAP related issues.

(16) Addressing issues with the Veteran following their PHA procedures.

(17) Communicating the Denial of Assistance notice. If the PHA denies assistance to an HUD-VASH applicant, the PHA must provide:

(a) Providing Notification of Termination or Denial of Assistance. If the PHA is denying or terminating assistance the PHA must provide (1) Family obligations of the program; (2) the grounds on which the PHA may deny or terminate assistance because of a family action or failure to act and (3) the informal hearing procedures. A copy of the notification letter should be sent to the VA HUD-VASH case manager. For applicants, the written notification must provide: a brief statement of the reason for denial; and an opportunity for the Veteran to request an informal review.

(b) A brief statement of the reason for denial; and

(c) An opportunity for the Veteran to request an informal review in accordance with 24 CFR 982.554(a) and (b). A copy of this denial of assistance notice must be sent to a VA HUD-VASH team member.

NOTE: *The PHA cannot deny HUD-VASH assistance to a Veteran for any grounds under 24 CFR 982.522 and 982.553. Additionally, a PHA cannot refuse to reissue vouchers to Veterans that have been previously terminated from HUD-VASH. The only reasons for denial of assistance by PHA are failure to meet the income eligibility requirements or if any member of the Veteran's household is subject to a lifetime registration requirement under a state sex-offender registration program, according to HUD's regulations.*

(18) Ensuring a violation of PHA Rules does not occur. Once a Veteran participant has been issued a voucher, they must follow the usual PHA rules or face possible suspension or termination of their voucher assistance. The PHA must follow their usual procedure in terminating assistance, to include an informal hearing Case managers

are expected to work with the Veteran and PHA to ensure that all measures are taken to address options that allow the Veteran to maintain housing. This may include assisting the Veteran with making necessary changes in behavior while advocating for flexibility with the PHA.

(19) Terminating Assistance. HUD has not established any alternative requirements for termination of assistance for HUD-VASH participants. However, prior to terminating HUD-VASH participants, HUD strongly encourages PHAs to exercise their discretion under 24 CFR 983.552 (c)(2) and consider all relevant circumstances of the specific case, including granting reasonable accommodations for persons with disabilities in accordance with 24 CFR Part 8, as well as including the role of the case manager and the impact that ongoing case management services can have on mitigating the conditions that led to the potential termination, prior to determining whether to terminate assistance.

(20) Documenting changes in the family.

(a) Death of the Veteran. When a Veteran, who is under lease with a HUD-VASH voucher dies, then the family members who are also registered on the voucher and lease are able to continue to utilize the HUD-VASH voucher for as long as they remain otherwise eligible. The PHA is encouraged, though not required, to move the Veteran's family to a non-HUD-VASH, or "regular," HCV when one is available. Once the family moves to a regular HCV then the HUD-VASH voucher becomes available for a new Veteran. Case management is not available through this program without the Veteran, but it can be arranged for the family if needed through referral to community or other programs.

(b) Separation/Divorce of the Veteran. Since the set-aside of HUD-VASH vouchers is for Veterans, the voucher must remain with the Veteran in the case of separation or divorce. This in effect overrides the PHA's policies on how to determine who remains in the program when a family breaks up (24 CFR Section 982.59(d) (11)).

(c) Imprisonment of the Veteran. Veterans who are leasing a unit with their HUD-VASH voucher and are imprisoned may be able to continue to sustain their housing. When the Veteran has been terminated from VA case management, the PHA must terminate HUD-VASH assistance. PHAs may use its discretion under 24 CFR 982.552 (c)(2)(ii) to allow other members of the participant family to continue receiving assistance subject to the condition that the offender will not reside in the unit. The family may retain the HUD-VASH voucher, or the PHA may offer the family a non-VASH voucher to free up the HUD-VASH vouchers for another homeless Veteran. Once the VASH voucher turns over, it must be issued to another homeless Veteran.

(21) Single Veterans may retain their housing as long as they are not absent from the unit longer than 180 calendar days for continued assistance, and the Veteran's rent portion continues to be paid to the landlord.

(22) Veteran families where the Veteran is not expected to return to the family unit

may request the PHA to provide them with a regular voucher, if available. The family, already a program participant, would not be subject to a waiting list. However, the PHA determines availability of their regular HCV for the family. If the PHA is not able to move the family to a regular HCV, the family would continue to utilize the HUD-VASH voucher.

(23) Veterans who have exited HUD-VASH case management and whose voucher was terminated due to excessive lengths of incarceration may be evaluated upon release for readmission to HUD-VASH.

(24) Veterans who are incarcerated may not receive services from the HUD-VASH team. Consultation with VA's Veteran Justice Program staff and Fugitive Felon point of contact is recommended.

(25) Protection for the Victim. When a Veteran's family member is under lease with a HUD-VASH voucher and is receiving protection as a victim of domestic violence, dating violence, or stalking, and the Veteran is the perpetrator of such violence, the victim must continue to be assisted by PHA.

(a) Dating violence, domestic violence, and stalking are each violations of the family obligations under 24 CFR 982.551(l). Therefore, the perpetrator may be terminated from PHA voucher assistance for committing such acts.

(b) Upon termination of a perpetrator's HUD-VASH voucher due to acts of domestic violence, the victim receiving protection is to be given a regular HCV by PHA, if one is available. If a regular HCV is not available for the victim, the victim continues to utilize the HUD-VASH voucher until another subsidy can be utilized. Case management associated with any remaining household members utilizing this voucher is terminated. The Veteran's victim and family would not be subject to the PHA's voucher waiting list as they are already participants in the voucher program.

(c) In the case of the victim utilizing the HUD-VASH voucher, upon release of the voucher by the victim, the HCV must be returned to HUD-VASH for re-issue by PHA to another eligible Veteran family. NOTE: HUD is currently developing guidance that will provide PHAs with further procedures for the implementation of Violence Against Women Act (VAWA) protections under 24 CFR part 5, subpart L.

(d) The Veteran perpetrator may continue to be served by the HUD-VASH team, have a new voucher issued, and work towards becoming rehoused as appropriate.

(e) Where appropriate referrals need to be made to the medical facility's local Intimate Partner Violence/Domestic Violence coordinator or point of contact.

5. PORTABILITY

a. **HUD-VASH HCVs.** A HUD-VASH participant that has been issued a HUD-VASH voucher may use the voucher to lease a unit, in a community of their choice – with some limitations. HUD-VASH participants may only reside in those jurisdictional areas

that are accessible to case management services as determined by the VA medical facility catchment area.

b. **Rules.** The rules pertaining to portability moves in the HUD-VASH program are dependent on whether the family moves within or outside of the referring VA medical facility's catchment area.

NOTE: For more information on Portability, see *Mobility and Portability of HUD-VASH vouchers, in the HUD-VASH Operating Requirements* (<https://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-7081.pdf>). The Portability Attachment on HUD's HUD-VASH Web page at: <https://portal.hud.gov/hudportal/documents/huddoc?id=pih2011-53.pdf> NOTE: This linked document is outside VA control and may or may not conform to Section 508 of the Rehabilitation Act.

c. **Delivery Systems.** The standard HUD-VASH Program and the Tribal HUD-VASH Program have different housing subsidy delivery systems and are not transferable or portable from one to the other. Tribal HUD-VASH vouchers are not portable.

d. **A Move Within a VA Medical Facility's Catchment Area.** This type of porting is from the Veteran family who wishes to live in a town within the catchment area of the VA medical facility, but is covered by a different PHA than the one who originally provided the voucher. If the move is within a VA medical facility's catchment area:

(1) The Veteran can move to another community within the referring VA medical facility's catchment area if the same VA medical facility can continue to provide case management.

(2) Some VA medical facilities have more than one PHA partner. If the receiving PHA does not have its own allocation of HUD-VASH vouchers, the receiving PHA must bill the initial PHA.

(3) If the receiving PHA has its own allocation of HUD-VASH vouchers, the receiving PHA may either absorb the Veteran or bill the initial PHA. To absorb the family, the receiving PHA would use one of their allocated vouchers, thereby returning the ported voucher to the original PHA.

(4) Non-HUD-VASH PHAs need to be advised of program requirements including using the HUD-VASH code when preparing the form HUD-50058, Family Report, for the family.

(5) The receiving PHA needs to be given the name and contact information for the Veteran's VA case manager.

e. **A Move Outside of a VA Medical Facility's Catchment Area.** This type of porting is for the Veteran family who wishes to move outside of the catchment area to another VA medical facility's jurisdiction. If the move is outside the catchment area of

the referring VA medical facility:

(1) The referring VA medical facility must coordinate the referral and confirm that the new VA medical facility has an available case management slot and that new VA medical facility's PHA partner has an available HUD-VASH voucher.

(2) Every request for a HUD-VASH port needs to be clinically reviewed and evaluated for appropriateness by the receiving VA medical facility's HUD-VASH Coordinator, or designee.

(3) In all instances, HUD-VASH staff at the receiving VA medical facility must be consulted by the initiating VA medical facility's HUD-VASH Program prior to the move and agree that they can and will provide case management services. There may be instances when the new VA medical facility cannot accommodate the request, so it is imperative that the referring VA medical facility seek appropriate consultation regarding voucher availability with the receiving VA medical facility prior to initiating a referral.

(4) The receiving HUD-VASH PHA must use one of its own HUD-VASH vouchers to absorb the Veteran.

NOTE: *The portability process only occurs between two PHAs, and the act of absorption occurs when the Veteran enters a lease in the new location. In circumstances where the receiving HUD-VASH team approves the port, but the receiving PHA does not have their own HUD-VASH vouchers, the receiving HUD-VASH team is encouraged to seek consultation with the HUD-VASH Regional Coordinator to determine the appropriate method for handling the port.*

(a) When a receiving HUD-VASH Program accepts a Veteran from outside their VA medical facility catchment area, the treatment team must utilize clinical judgment in determining that Veteran's priority for receiving one of their vouchers. An assessment by the HUD-VASH Program being asked to accept the request to port will be completed. Decisions are to be based on whether the Veteran has a compelling reason for the request, the necessary resources, and a plan.

(b) When a port occurs the two VA medical facilities need to coordinate efforts with the Veteran to help ensure that the move and transition is seamless.

NOTE: *When a Veteran has a positive discharge from case management, the Veteran is able to port the voucher anywhere. The new PHA would bill the HUD-VASH participating PHA. The participating PHA would keep track of the Voucher's continued use, and would recycle the voucher when it was no longer being used by the Veteran family, notifying VA of the voucher status. In circumstances where the new PHA wishes to absorb the ported voucher, HUD-VASH staff is encouraged to contact their HUD-VASH Regional Coordinator for guidance as to how this is to be documented for the purposes of program and performance evaluation.*

(5) To ensure continuity of healthcare, Veterans who plan to move outside a medical facility's catchment area to another facility and who desire to transfer their VA

healthcare to the new medical facility needs to be educated to contact their primary care provider or other provider regarding coordinating health care between the current preferred medical facility and the new medical facility. The process for coordinated care can be found in VHA Handbook 1101.01 Coordinated Care for Traveling Veterans. If possible, this coordination should occur prior to the move.

6. PROGRAM PARTICIPANT TARGETING

The HUD-VASH team is responsible for program participant targeting.

a. Veteran participants in HUD-VASH must be homeless and meet VA health care eligibility as defined by law and regulation.

b. This resource is to be utilized for those Veterans who demonstrate the most need or vulnerability based on their unique clinical and/or psychosocial circumstances. Veterans with higher needs are served first.

c. HUD-VASH targets the chronically homeless Veteran who is the most vulnerable and often has severe mental or physical health problems and/or SUD, with frequent emergency room visits, multiple treatment attempts, and limited access to other social supports. However, other Veterans who are homeless with diminished functional capacity and resultant need for case management are also eligible for the program.

d. The HUD-VASH team must assess each applicant on an individual basis. Admission decisions are to be prioritized by highest need for HUD-VASH, based on Veteran's acuity per clinical judgment and resource availability. It must be demonstrated that the homeless Veteran has an identified need for case management services to obtain and sustain housing.

NOTE: *It is strongly recommended that an assessment tool is used to determine acuity. In situations where the Veteran's clinical profile is unclear, consultation with mental health leadership or primary care, or their clinical designee, must be utilized to ensure appropriate placements.*

e. Chronically homeless Veterans will be given the highest priority for admission.

NOTE: *For more information on the prioritization of non-chronically homeless Veterans please see the HUD Notice CPD-16-11, Notice on Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing, located at the following link <https://www.hudexchange.info/resources/documents/notice-cpd-16-11-prioritizing-persons-experiencing-chronic-homelessness-and-other-vulnerable-homeless-persons-in-psh.pdf>. **NOTE:** This linked document is outside VA control and may or may not conform to Section 508 of the Rehabilitation Act.*

f. Where there are no chronically homeless Veterans, admissions to HUD-VASH will use the HUD Notice CPD-16-11, Notice on Prioritizing Persons Experiencing

Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing, in the following order of priority:

(1) **First Priority.** Homeless persons with a disability with long periods of episodic homelessness and severe service needs.

(2) **Second Priority.** Homeless persons with a disability with severe service needs.

(3) **Third Priority.** Homeless persons with disability coming from places not meant for human habitation, safe havens, or emergency shelters without severe service needs.

(4) **Fourth Priority.** Homeless persons with a disability coming from transitional housing.

(5) **VA Priority Populations.** Homeless Veterans who do not meet criteria for chronic homelessness or the priority groups above may be prioritized for VA-funded PSH if they demonstrate a need for ongoing case management based on clinical assessment. Additional priority populations include, but are not limited to, the following Veterans: women, those with children, those who served in Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND), aging Veterans, those with a debilitating clinical condition that does not meet formal disability criteria, and those with an extensive homeless history that does not meet other criteria above.

g. If there are no available case management openings or vouchers, the Veteran will be placed on a HUD-VASH Interest List. The Veteran will be provided with information about HUD-VASH, and when appropriate, the HUD-VASH case management team will invite the Veteran to participate in any existing HUD-VASH pre-admission groups, as available. However, Veterans in this category must be referred to other VA and community resources to address their current needs. HUD-VASH staff must document the referral, in CPRS, and note that the reason for denial was a lack of an available voucher or case management openings. Denials for lack of an available voucher should be recorded as such in HOMES as well.

(1) Veterans who are placed on a HUD-VASH Interest List must be reassessed, by HUD-VASH Program Coordinator, or their designee, when a voucher becomes available so that the Veteran most in need is admitted to the program.

(2) Veterans on the HUD-VASH Interest List must have a warm handoff to other VA and/or community programs that can assist with ongoing clinical and housing needs.

7. TRIBAL HUD-VASH

The Tribal HUD-VASH policy document will be available at the VHA Forms and Publications Web site at <http://vaww.va.gov/vhapublications/publications.cfm?Pub=1> upon its publication. **NOTE:** *This is an internal VA Web site not available to the public.*

8. GRADUATION FROM HUD-VASH

a. Graduation from HUD-VASH is defined as exit from case management after the Veteran has achieved optimal functioning and demonstrates the ability to live independently in the community, but is retaining their HUD-VASH voucher for financial stability.

(1) While some Veterans achieve this goal quickly, others may remain in case management without discharge, as this may not be a goal for all Veterans who participate in HUD-VASH.

(2) Case management teams and other providers involved with the Veteran's care, in consultation with the Veteran, determine when the Veteran is ready to complete case management based on criteria listed in 8(d).

(3) Veterans who graduate from HUD-VASH will continue to utilize their healthcare services within the larger VA system of care.

b. Veterans who graduate are not required to participate in case management even though they are retaining their HUD-VASH voucher.

c. Veterans who are being graduated are exited from case management, as documented in CPRS and HOMES, and are fully integrated within the larger VA system of care and/or the community.

d. HUD-VASH staff must contact graduated Veterans at the time of recertification and inspection to offer assistance with this process. HUD-VASH staff must work with PHAs to obtain notice 60 calendar days prior to any recertifications or inspections.

e. Every Veterans Integrated Service Network (VISN) and/or VA medical facility must have a policy for discharge, including graduation. Many factors can influence the determination of graduation, including the Veteran:

(1) Voices a desire to graduate from HUD-VASH case management.

(2) Has been stably housed for at least one year, as evidenced by adherence to the lease agreement.

(3) Is knowledgeable of the recertification process with the PHA.

(4) Utilized knowledge and abilities in a recent crisis situation to access VA and/or community resources and services to address the crisis.

(5) Has functioned at a very independent level for at least one year and sustained a low acuity level; mental health symptoms are manageable; substance use is not problematic or the Veteran practices abstinence. The Veteran independently seeks assistance when there are changes in acuity level.

(6) Is connected with primary care, mental health and specialty services, as applicable, and has made significant progress on self-defined goals, as evidenced by treatment plan reviews and other documentation.

(7) Demonstrates fiscal responsibility as evidenced by sustainable income, timely payment of bills without prompting or assistance, saving money, and/or resources that will enable housing stability.

(8) Developed appropriate and approachable relationships with neighbors, landlord, and maintenance staff. The Veteran allows neighbors peaceful enjoyment of their units, and when the neighbor's behavior does not allow peaceful enjoyment of the Veteran's unit, the Veteran employs appropriate communication and response behaviors.

f. When it has been determined that the Veteran no longer needs case management and a regular HCV is not available, the Veteran remains eligible for rental assistance under the HUD-VASH voucher program.

(1) In cases where case management is no longer needed and the Veteran remains below the income limits, the PHA may permit use of one of its regular HCVs, if available, to continue assisting the Veteran and free up a voucher for another HUD-VASH eligible Veteran.

(2) When a HUD-VASH voucher is exchanged for a regular HCV, the Veteran is not subject to a PHA's waiting list, because the Veteran is already a participant in the PHA's HCV Program.

(3) If the Veteran retains their HUD-VASH voucher and is considered to be in graduation status, there are no further requirements for participation in the case management; however, HUD-VASH staff should contact the Veteran at the time of PHA recertification and offer assistance with the process. Veterans should be encouraged to participate in alumni activities and social events. The PHA must be notified of this change in case management status.

(4) Veterans who were previously in HUD-VASH and discharged from case management while continuing to use the HUD-VASH voucher must be given the opportunity to return to case management, if needed.

g. When a Veteran graduates from HUD-VASH and ports their voucher, systems must be able to address:

(1) If the original HUD-VASH program is made aware of the Veteran's decision to port, the program coordinator will notify their counterpart at the new VA medical facility. The HUD-VASH program at the new VA medical facility offers to assist the Veteran with enrollment.

(2) Veterans requesting readmission to case management must be assessed by the closest HUD-VASH program to determine clinical need and appropriateness. If the Veteran warrants readmission to case management, the two HUD-VASH programs

must coordinate the transferring of vouchers, so that the Veteran moves into an available voucher for the new VA medical facility.

(3) Veterans who do not meet criteria for readmission to HUD-VASH case management will be assisted with identifying and accessing appropriate VA and community resources to support their recovery and housing stability.

h. Case managers must document in CPRS and on the HOMES Exit Form when a Veteran graduates the program. When a Veteran graduates, the exit note in CPRS identifies a crisis management plan established by the Veteran and clinician that defines support systems to address needs. All members of the Veteran's multidisciplinary team will be co-signed on the graduation discharge summary note, which will provide at a minimum the following:

- (1) The date of discharge;
- (2) Reason for discharge;
- (3) Status of treatment plan and accomplishment of related goals;
- (4) Strengths, needs, abilities, and preferences;
- (5) Overall level of functioning;
- (6) Provider contacts or referrals for ongoing care, treatment, and services; and
- (7) Update in HOMES to reflect the Veteran's change in status.

i. Discharge planning in HUD-VASH is reflective of a recovery-oriented system of care and is based on the needs and aspirations of the Veteran. Determining graduation readiness requires the development of a post-discharge plan. A post discharge plan includes goals that support full community integration.

(1) Veterans are transitioned into the VA regular system of care which involves primary care, outpatient mental health and/or substance abuse services, and specialty care as needed.

(2) Ongoing engagement is offered as needed, and Veterans continue to have access to services within the larger VA system of care.

(3) If the Veteran elects to continue utilizing the voucher, the PHA may, at their discretion, transfer the Veteran into a regular HCV voucher.

(4) If there are no regular HCV vouchers made available by the PHA, the voucher is retained by the Veteran until such time they are no longer eligible for subsidy (typically increased income) or they elect to discontinue use of the voucher.

j. The Veteran may elect to continue case management, especially if they have goals or achievements that they are working towards.

(1) The determination of readiness to complete case management will be a joint decision between the Veteran, their case management team, and other providers that work with the Veteran.

(2) A Veteran must be able to demonstrate a sustained period of housing stability and have met their self-defined goals. Veterans will have different levels of acuity and their goals will vary based on their wants and needs, so each Veteran will need to be assessed individually.

(3) At this stage, the Veteran and the HUD-VASH case management team, as well as any other identified parties, will assess the Veteran's readiness to step down to quarterly case management contacts. It is also recommended that other providers who work with the Veteran regularly participate in the determination of readiness for graduation. This may include mental health providers, primary care teams, specialty care, and non-VA service providers.

k. The assessment process for graduation readiness must include a standardized tool and clinical review. The assessment and determination, along with the input of the Veteran, and any other identified parties, shall be recorded in the CPRS. Factors to be considered in an assessment, and documented in the medical record may include, but are not limited to:

(1) Demographic factors (age, sex, marital status, children);

(2) Clinical stability and acuity level;

(3) Veteran self-report of readiness;

(4) Collateral agreement from treatment providers, in addition to the HUD-VASH team (mental health, primary care, and community partners);

(5) Community integration with identified natural and community support system including social and emotional indicators (employment, life skills, friendships, familial supports);

(6) Economic indicators (income, ability to pay rent and other expenses, money management, employment, etc.);

(7) Extreme vulnerability indicators (mental health, substance use, medical needs, cognitive functioning); and

(8) Demonstrated a period of housing stability for 6-12 months with sustained graduation expectations.

I. Graduated Veterans should be encouraged to participate in alumni groups and other social opportunities that will help them remain connected to the VA system of care and services.

9. EXITING CASE MANAGEMENT

a. When the Veteran exits case management and the voucher is be relinquished, the PHA will initiate termination of assistance according to HUD regulation.

(1) In this case, the Veteran would no longer be provided with rental assistance. However, it is expected that, prior to termination, VA and HUD consider all relevant circumstances of the specific case, including granting reasonable accommodations for persons with disabilities.

(2) The Veteran may elect to voluntarily release the voucher due to various circumstances, such as moving to a more intensive level of care (such as assisted living), or an increase in income.

(3) Case management teams are expected to assist the Veteran with any unmet needs, as indicated on the treatment plan, and make all attempts to transfer care whenever possible to VA and community providers.

(4) If a Veteran has completed the HUD-VASH program and no longer has a HUD-VASH voucher, but is seeking case management, they will be assisted with identifying the resources and supports available to them in the larger VA system of care and community.

(5) If there are no other supports available, the HUD-VASH program could provide interim case management while making the appropriate warm hand-offs to a Patient Aligned Care Team (PACT), Health Care for Homeless Veterans (HCHV) Case Management, Women Veterans, etc.

(6) Any work provided by the HUD-VASH team must be coded under the HUD-VASH stop codes. The Stop Code Guide is available at <http://vhaindwebsim.v11.med.va.gov/hub/app/library/record/visit?id=10427>. **NOTE:** *This is an internal VA Web site not available to the public.*

(7) In cases where the Veteran no longer meets the income requirement, but still needs case management, the HUD-VASH program case management team should refer the Veteran to other programs within the larger system of VA care or community and provide a warm hand-off. This decision will be determined by the Veteran, the team, and other providers involved with the Veterans care.

10. INTERNAL ADMINISTRATION

a. **Local Written Policies and Procedures.** Local policies and Standard Operating Procedures (SOP) must be developed by HUD-VASH sites. These local documents may pertain to such things as: position descriptions and duties, staff

competency assessments, staff transportation and education policies, regulations and procedures for psychiatric and medical emergencies and routine care, documentation policies, program rules and regulations, Patient Advocate Services and grievance procedures, appeal for denial admission, discharge policy, and Quality and Performance Initiative reports.

NOTE: *It is encouraged to integrate these operating procedures with the other VA medical facility homeless programs, such as Health Care for Homeless Veterans (HCHV), Grant and Per Diem (GPD), Compensated Work Therapy-Transitional Residences (CWT-TR) and Domiciliary or Mental Health Residential Rehabilitation Treatment Program (MHR RTP) Programs, as HUD- VASH is a significant component in the homeless continuum of care and in meeting the intent of the VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, dated September 11, 2008, or subsequent policy document.*

b. **Medical Records.** Medical record documentation must comply with applicable TJC and CARF requirements, as well as local and national VA medical facility policy and procedures. Documentation must reflect the Veteran-centric model with clear indications of the Veteran's preferences, choices, priorities and goals.

c. **Housing Stability Plans.** Housing Stability Plans are treatment plans. They are to be reviewed for relevance and modified as needed in accordance with local VA medical facility documentation standards and program specific SOP. Documentation is to note progress toward achievement of goals and objectives in the plan, significant events in the Veteran's life, delivery of services, specific interventions, referrals, and discharges or transitions to other levels of care. Veteran's engagement in completing their housing stability plan, personal goals/objectives, and services offered to the Veteran (with Veteran's decision/interest noted) must also be part of documentation.

d. **Confidentiality.** HUD-VASH team members will facilitate a Release of Information (ROI) with the Veteran to coordinate care as appropriate. VA may disclose relevant health care information, including personally identifiable information and protected health information, to health and welfare agencies and other relevant agencies, such as housing resources, utility companies, and funding agencies. HUD-VASH case management team members may also disclose relevant health care information in situations where staff needs to act quickly in order to provide basic and/or emergency needs for the Veteran and Veteran family where the family resides with the Veteran or serves as a caregiver as outlined in the Federal Register/Vol.74, No. 222/Thursday, November 19, 2009/Notices Department of Veterans Affairs, Privacy Act of 1974, System of Records #40 found at the following link <https://www.gpo.gov/fdsys/pkg/FR-2009-11-19/pdf/E9-27786.pdf>. **NOTE:** *This linked document is outside VA control and may or may not conform to Section 508 of the Rehabilitation Act.* In instances of uncertainty, consult with the VA medical facility Privacy Officer.

e. **Conflicts of Interest.** In networking with not-for-profit agencies or other community- based providers, HUD-VASH Program teams must be aware of the

possibility of situations that could be perceived as, or lead to, conflicts of interest.

(1) HUD-VASH staff must ensure that there is no inherent conflict of interest. Examples of a possible conflict of interest are steering Veterans to housing that is owned by the staff person or a family member of the staff person; accepting a finder's fee bribe for utilizing certain housing; or accepting a gift of any sort for promoting certain housing.

(2) HUD-VASH staff must comply with all applicable laws, including the Government-wide "Standards of Ethical Conduct for Employees of the Executive Branch," found at 5 CFR Part 2635.

(a) Any questions related to potential conflicts of interest need to be directed to Regional Counsel.

(b) VA Central Office employees need to direct their questions to the Designated Agency Ethics Official, i.e., the Assistant General Counsel for Professional Staff Group III (023).

11. DOCUMENTATION AND HOMELESS OPERATIONS MANAGEMENT AND EVALUATION SYSTEM (HOMES):

a. **HUD-VASH Program Clinics.** HUD-VASH Program clinics, community-based clinics, or homeless visits must be entered into the 522 primary stop code. These clinic visits may be retrieved for management purposes at the local medical facility. They are routinely provided in conference call minutes and reports to Congress concerning the HUD-VASH Program.

b. **HUD-VASH SUD Specialists.** HUD-VASH SUD Specialists are to use 522 as the primary stop code and 514 as the secondary code to document their workload. If services are to be provided to an individual at the medical facility, 513 is to be the secondary stop code. If services are provided to a group at the medical facility, 507 is the primary stop code and 560 is the secondary stop code. Stop code 522 should not be used for group notes.

c. **Telephone Contacts.** Telephone contacts made by the HUD-VASH Program case managers with homeless Veterans with mental health or SUD are entered into the 530 primary stop code.

d. **Groups.** HUD-VASH groups must be entered into the 507 primary stop code.

e. **Workload.** Workload credit must be claimed by the HUD-VASH case manager for all clinical contacts with the Veteran before and after the date of formal admission, with appropriate documentation.

f. **Note Titles.** Specific local note titles for the HUD-VASH Program must be established at each site.

NOTE: HUD-VASH case managers frequently network with community-based organizations to leverage services or develop resources, participate in community meetings, and serve on local coalitions. As a result, HUD-VASH Program staff members do not necessarily meet the standards prescribed for office-based mental health staff. Facility Directors must recognize the unique nature of these duties when considering workload indicators and thresholds.

g. **HOMES.** HOMES is VA's primary platform for collecting intake, progress and outcome information for homeless Veterans as they move through VA's system of care. HOMES can be accessed online through at <https://vaww.homes.va.gov/VAHomes.aspx>.

NOTE: This is an internal VA Web site not available to the public.

h. **HOMES Episode.** A HOMES episode documents a Veteran's participation through VA homeless services. The episode begins when a full = Assessment Interview is completed and submitted. During the episode, a Veteran may be referred to, admitted to, and exited from various homeless services and programs. A HOMES episode closes:

(1) 30 calendar days after the date the last program exit data is submitted;

(2) On the expiration date of the last referral form, if no program entries were documented; or

(3) 30 calendar days after the full Assessment is submitted if no program referrals were documented.

(8) **Documentation.** All services, progress notes and housing progress dates must be entered within three business days of occurrence per the HOMES Reporting Policy. This is available at <http://vhaindwebsim.v11.med.va.gov/hub2/hp/>. **NOTE:** This is an internal VA Web site not available to the public.

12. REFERENCES

- a. Pub. L. 113-235
- b. 38 U.S.C. 2003(b)
- c. 42 U.S.C. 11302
- d. 42 U.S.C. 11360.
- e. 5 CFR 2635
- f. 24 CFR 5(L)
- g. 24 CFR 91.5.
- h. 24 CFR 982.59(d)(11).

- i. 24 CFR 982.522.
- j. 24 CFR 982.551(l).
- k. 24 CFR 982.553.
- l. 24 CFR 982.554(a) and (b).
- m. 24 CFR 983.552(c)(2).
- n. VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics.
- o. VHA Handbook 1101.01, Coordinated Care for Traveling Veterans.
- p. Section 8 Housing Choice Vouchers: Revised Implementation of the HUD-VA Supportive Housing Program Technical Correction, 79 Fed. Reg. 117 (June 18, 2014), Federal Register: The Daily Journal of the United States. Web. January 2017.
- q. Privacy Act of 1974 System of Records, 74 Fed. Reg. 222 (November 19, 2009), Federal Register: The Daily Journal of the United States. Web. January 2017.
- r. Tsemberis, Ph.D., S, Housing First: the Pathways model to end homelessness with mental illness and addiction City Center: first ed, Vol .1. Minnesota; 2010
- s. US Department of Housing and Urban Development, Notice CPD-16-11, *Notice on Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive House*, <https://www.hudexchange.info/resources/documents/notice-cpd-16-11-prioritizing-persons-experiencing-chronic-homelessness-and-other-vulnerable-homeless-persons-in-psh.pdf>.
- t. US Department of Housing and Urban Development, Notice PIH 2010-12 (HA), Reporting Requirements for HUD-Veterans Affairs Supportive Housing Program, US Department of Housing and Urban Development, https://portal.hud.gov/hudportal/documents/huddoc?id=DOC_9006.pdf.
- u. US Department of Housing and Urban Development, Notice PIH 2011-53 (HA), Reporting Requirements for HUD-Veterans Affairs Supportive Housing (VASH) Program, US Department of Housing and Urban Development, <https://portal.hud.gov/hudportal/documents/huddoc?id=pih2011-53.pdf>.
- v. http://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/programs/hcv
- w. <https://www.hud.gov/offices/pih/pha/approved/pdf/02/fl005v05.pdf>
- x. McKinney-Vento Homeless Assistance Act

June 29, 2017

VHA DIRECTIVE 1162.05

NOTE: *The preceding linked documents are outside VA control and may or may not conform to Section 508 of the Rehabilitation Act.*