The Community Partnership
For the Prevention of Homelessness

Coordinated Assessment and Housing Placement (CAHP) System Manual

District of Columbia CoC (DC-500) Coordinated Entry System

Contents

Purpose of the Manual 2
Overview of Coordinated Entry 2
Housing First 2
CAHP Subsystems 3
CAHP System Administration 4
CAHP-Participating Agencies 5
Types of Housing Models and Resources 8
Homeless Management Information System (HMIS) 9
Housing Match Prioritization 10
Grievances and Complaints Procedures 13
Single Adults System (I-CAHP) 15
Youth System 32
Veterans System 41
Family Subsystem 53

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Purpose of the Manual

This manual is a system guide for the District of Columbia's Coordinated Assessment and Housing Placement (CAHP) participating agencies and their staff throughout the District. It provides a description of the system and each component, the relationships between the components, and the general procedures that guide the District's CAHP system. This manual is updated after annual prioritization updates are made and implemented in each subsystem. The entire manual review will happen every three years, unless something very significant occurs that would change the system. The next full manual review will occur in Fall 2027.

Overview of Coordinated Entry

Coordinated Entry ensures that all people experiencing a housing crisis have fair and equitable access and are quickly identified, assessed for, and connected to housing and other services based on their strengths and needs. Coordinated Entry is a system that utilizes coordinated, comprehensive, and uniform assessment tools and practices to immediately respond to participant needs for housing services across the community. Coordinated Entry uses a locally designated population-specific assessment, a centralized data system, and a prioritization method. Coordinated Entry informs the Continuum of Care by gathering data and providing gap analysis and Coordinated Entry performance outcomes to ensure system accountability and inform change.

Coordinated Entry, in Washington, DC, is referred to as Coordinated Assessment and Housing Placement (CAHP), and the vision of CAHP is to ensure that individuals and households at-risk of or experiencing homelessness will have an equitable and centralized process for timely access to appropriate resources, in a person-centered approach that preserves choice and dignity.

The entire CAHP system intentionally utilizes a de-centralized "no wrong door" approach, while doing so through a standardized process from initial engagement to housing placement. This system is designed to allow anyone who needs assistance to know where to obtain services, to be assessed in a standard and consistent way, and to connect with the housing services that best meet their needs. It ensures clarity, transparency, consistency, and accountability for participants experiencing homelessness, referral sources, and homeless service providers through the assessment and referral process. The system facilitates exits from homelessness to stable housing in the most rapid manner possible given available resources. Lastly, it ensures that participants gain access as efficiently and effectively as possible to the type of intervention most appropriate to their immediate and long-term housing needs

The District of Columbia is committed to the continuous improvement of the Coordinated Assessment and Housing Placement (CAHP) as a key strategy to ensure homelessness in the District is rare, brief and non-recurring. It facilitates the continued evolution and coordination of all components of the homeless service system toward ending homelessness.

Housing First

The Coordinated Assessment and Housing Placement (CAHP) system is Housing First-oriented. That means it centers on providing participants experiencing homelessness with housing quickly and then

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providing services as needed using a low barrier approach that emphasizes community integration, stable tenancy, recovery, and individual choice.

A Housing First approach can benefit households and individuals with any degree of service needs. The flexible and responsive nature of a Housing First approach allows it to be tailored to help anyone. As such, a Housing First approach can be applied to help end homelessness for a household who became homeless due to a temporary personal or financial crisis and has limited service needs, only needing help accessing and securing permanent housing. At the same time, Housing First has been found to be particularly effective approach to end homelessness for high need populations, such as chronically homeless participants.[1]

CAHP Subsystems

Within the entire District's Coordinated Assessment and Housing Placement (CAHP) System, there are four defined CAHP subsystems that have separate entry points, diverse housing resources, and variations in assessment and prioritization processes.

Single Adults

The Single Adults CAHP Subsystem (I-CAHP) includes any unaccompanied participants over age 18 experiencing homelessness within the District of Columbia. This includes any combination of emergency shelter, transitional housing, locations outdoors not meant for human habitation, or fleeing domestic violence.

Youth

The Youth CAHP Subsystem includes unaccompanied youth ages 18-24 (also called Transition Aged Youth (TAY)) at risk of or experiencing homelessness in the District of Columbia. This includes participants living in emergency shelters, youth specific housing resources, in an unsheltered situation not meant for human habitation, or fleeing domestic violence. Additionally, unlike the other subsystems, the Youth subsystem includes participants who are couch surfing or otherwise precariously housed.

Veterans

The Veterans CAHP Subsystem includes any participant or household who has served in the US Military in any capacity or branch of service, regardless of how long they served or their discharge status at risk of or experiencing homelessness. This includes Veterans who did not finish basic training, who served in the military for training purposes only or were never activated, and those that served in the Reserves or National Guard.

Family

The Family CAHP Subsystem includes all households experiencing homelessness within the District of Columbia. A household is defined as a family consisting of at least one adult and one dependent. This

[1] NAEH. (2022). Housing First. Accessed on September 30, 2024 at https://endhomelessness.org/resource/housing-first/

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includes households living in emergency shelters, family specific housing programs, unsheltered situations not meant for human habitation, or fleeing domestic violence.

CAHP System Administration

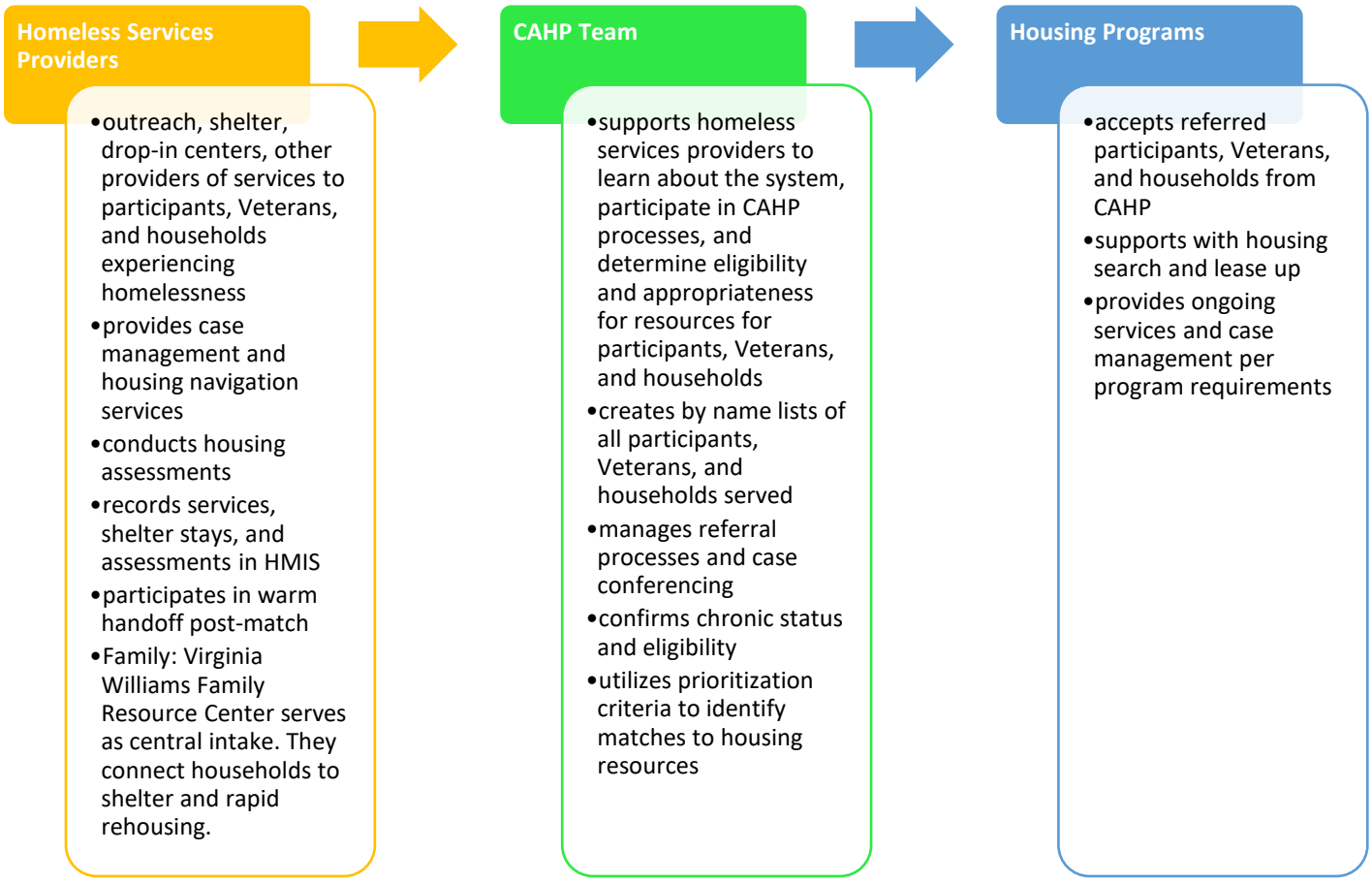
A team of CAHP Coordinators led by CAHP Administrators at The Community Partnership (TCP) lead and facilitate CAHP matching processes for the District of Columbia Continuum of Care (CoC). Their duties comprise of the following:

- Creating By Name Lists of all participants, Veterans, and households served within the subsystem,
- Maintaining referral processes for housing resources,
- Managing Case Conferencing procedures for matching,
- Confirming chronic status and other eligibility criteria for referred participants, Veterans, and households,
- Utilizing prioritization criteria to identify matches to housing resources,
- Training providers to deliver housing assessments, complete referrals, and participate in CAHP processes,
- Creating subpopulation-specific data reports and presentations based on HMIS and matching data, and
- Connecting providers across their subsystems to support warm handoffs and system collaboration.



The CAHP team serves as a middle inflection point within the coordinated entry process. The figure below demonstrates the interaction of homeless services providers, the CAHP team, and housing providers. No one function of the system can operate independently; CAHP is inherently a community collaboration to identify and connect participants, Veterans, and households experiencing homelessness to housing resources in a community-established, equitable process.

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CAHP-Participating Agencies

CAHP seeks to implement a "no-wrong door" approach to the system. In service of that, a wide range of agencies participate in CAHP processes. However, there is a minimum standard that agencies must meet to join the system. The CAHP team reviews interested agencies' applications and determines if they meet the eligibility criteria. Upon approval, agencies are required to complete HMIS requirements and complete a CAHP orientation.

Criteria

All Agencies (non-Domestic Violence Service Providers)

All agencies, regardless of service population or funding source, must fulfill all of the following criteria:

- Commits to abiding by the obligations and requirements of the District of Columbia HMIS Policies and Procedures
    - From Section 2.1:
        - Complete and adhere to agency agreement, business associate agreements, and qualified service organization agreements

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    - Meet the minimum technology requirements and provide adequate general tech support to staff
    - Have at least one staff member dedicated to the HMIS Agency Administrator role to provide oversight for data entry and quality as well as at least one other staff member who is eligible to become an HMIS user
- Has at least one staff member to act as CAHP liaison – serving as main point of contact for referral and matching processes (can be the same person as the Agency Administrator or any other HMIS user at the agency)

Single Adult, Youth, and Veteran Agencies

Agencies with contracts for providing services to persons experiencing or formerly experiencing homelessness in Washington, DC (e.g., contracts through TCP, DHS, VA, HHS, DOL, HUD) that include requirements to participate in HMIS are approved to participate in the CAHP system.

For all others, agencies must fulfill all of the following criteria

- The program provides case management and/or referral support to additional services such as behavioral health, housing, and employment
- Serve at least 20 participants per month experiencing literal homelessness (HUD definition found at https://www.hudexchange.info/homelessness-assistance/coc-esg-virtual-binders/coc-esg-homeless-eligibility/four-categories/category-1/)

Family Agencies

Due to the structure of the family homeless services system, no external CoC providers will be approved to be Family CAHP participating agencies. That is, only family providers contracted by TCP, DHS, or HUD will be approved to be CAHP participating agencies based on the requirements in their contracts.

Domestic Violence (DV) Victim Service Providers

Domestic Violence Victim Service Providers are not included in the guidelines and criteria detailed in this document. Such providers will continue to coordinate housing services through the DC Coalition Against Domestic Violence.

Review and Approval Process

Requests to join can be made via email to cahp@community-partnership.org.

When the request comes through, the CAHP Administrators will schedule an inquiry call with the agency and the HMIS System Administrator. During the call, the HMIS and CAHP Administrators will discuss the agency's services, staffing, and target populations, as well as their readiness to participate in both systems. The CAHP Administrators and HMIS System Administrator will make the final determination based on all information gathered. If the agency is not satisfied with the response, TCP CAHP team should review with Chief of Policy and Programs for additional communication as necessary.

Agencies or programs not approved to be CAHP participating will be provided information about all relevant resources available for referring participants, Veterans, and households at risk or experiencing homelessness, including but not limited to:

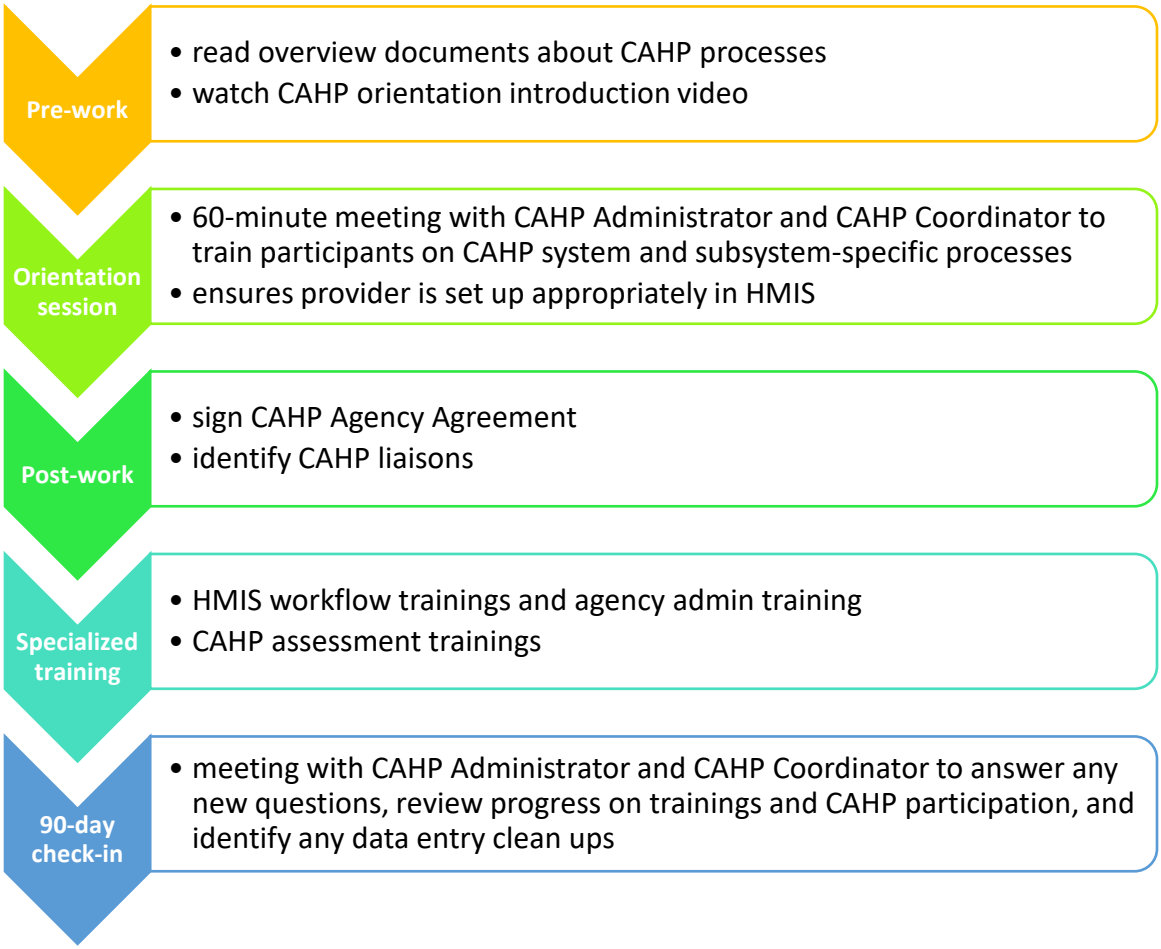
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- Project Reconnect
- Emergency Rental Assistance Program (ERAP)
- Low Barrier Shelter Locations
- Outreach Points of Contact
- Map and Resource List of CAHP Participating Agencies
- ICH information and resources.

If approved agencies or programs do not successfully complete orientation and all relevant requirements, such as identifying CAHP liaisons, they will be denied and will not move forward with orientation at the discretion of the CAHP Administrators and/or HMIS System Administrator.

CAHP Orientation

All new agencies and new programs within existing agencies are required to complete a CAHP orientation. This is a standard training plan that ensures staff are trained in the processes and have access to a toolbox of resources that will help them effectively participate, even in the event of staff turnover. The steps of the orientation are detailed in the diagram below.



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CAHP Liaisons

A key function of CAHP participation for all agencies is the CAHP liaison. Each agency and/or program will identify CAHP liaisons to serve as primary points of contact for that program. These individuals attend match meetings and coordinate with other case managers to participate in CAHP matching processes. They receive information from the CAHP team and distribute it amongst their coworkers. Agencies will determine who will fulfill this role. It is recommended they have one liaison per every 50 participants served by the program.

Types of Housing Models and Resources

The Coordinated Assessment and Housing Placement System includes housing resources of various types. Participants, Veterans, and households have the opportunity to be matched to a type of housing resource that is best suited for them based on the availability of housing resources within the District.

Housing Models:

- Site-Based (also called Unit-based)
    - Housing assistance is attached to a specific housing unit.
- Tenant-Based (also called Scattered Site)
    - Participants can choose to lease safe, decent, and affordable privately-owned rental housing.

Housing Resources

- Transitional Housing/Extended Transitional Housing (TH/ETH)
    - Transitional Housing is a short-term housing program with wrap-around services to prepare individuals and households experiencing homelessness to secure and maintain permanent housing at exit. Transitional Housing is intended to rapidly house and stabilize without barriers to enrollments (e.g., eligibility requirements such as income, sobriety, childcare, rental history). It is not permanent housing, and program participants are still considered to meet the regulatory definition of homelessness, making them eligible for permanent housing options in the District.
- Non-Congregate Bridge Housing
    - Target populations include participants already matched to a housing intervention and participants not well-served by traditional low barrier shelter. The latter is comprised of adult households (such as mixed gender couples, parent/adult child, and adult siblings), individuals requiring home health aide services, individuals living in encampments, and individuals whose disabling condition(s) limit their ability to function effectively at low barrier shelter. The resource is designed to respond to the needs of the single adult population and to facilitate system flow, helping participants stay engaged in services and shorten their time to lease-up.
- Joint Transitional Housing – Rapid Rehousing (Joint TH-RRH)
    - The Joint Transitional Housing/Rapid Rehousing program is a resource that combines transitional housing and rapid rehousing programs to help people experiencing homelessness move into permanent housing. The resources provide temporary housing, financial assistance, and supportive services. Participants begin in the transitional

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housing portion of the program and then move into the rapid rehousing portion of the program.

- Rapid Rehousing (RRH)
    - Rapid Rehousing is designed to quickly connect connects participants, Veterans, and households experiencing homelessness to permanent housing through a tailored package of assistance that may include the use of time-limited financial assistance and targeted supportive services. Rapid rehousing programs help participants, Veterans, and households living on the streets or in emergency shelters solve the practical and immediate challenges to obtaining permanent housing while reducing the amount of time they experience homelessness, avoiding a near-term return to homelessness, and linking to community resources that enable them to achieve housing stability in the long-term.
- Permanent Supportive Housing (PSH)
    - Permanent Supportive Housing is an evidence-based intervention that combines housing assistance through a permanent rental subsidy with supportive services to address the needs of chronically homeless individuals, Veterans, or households. The services are designed to build independent living and tenancy skills and connect participants with community-based health care, treatment, and employment services.
- Targeted Affordable Housing (TAH)
    - The Targeted Affordable Housing program provides a permanent housing subsidy with case management (i.e., typically a quarterly check-in) to ensure housing stability. TAH is designed to assist participants, Veterans, and households who are independent, but due to disability, age or other socio-economic factors require long-term subsidy to prevent homelessness. Such participants, Veterans, and households are appropriately engaged in community services and do not require intensive services to remain stably housed. As of this writing, while the Family system has traditionally matched to this program through CAHP, there are no plans to continue that practice.

Homeless Management Information System (HMIS)

Homeless Management Information System (HMIS) is a database used by homeless service agencies, CoC staff, housing programs, and DHS to maintain a record of participant-level information, including their characteristics and service needs. By utilizing a shared database across the community, our work as a CoC is more coordinated and effective.

The District's CoC's HMIS is staffed by the Policy and Programs Team at The Community Partnership for the Prevention of Homelessness (TCP). The software provider is WellSky. The HMIS staff is responsible for the administration of the HMIS software and providing technical assistance to participating agencies and end-users. Agencies that participate in the District's HMIS are referred to as "participating agencies." Each participating agency needs to follow certain guidelines to help maintain data and accuracy. The CAHP conducts regular data quality checks and coordinates with providers to support those efforts in ensuring their data is accurate.

For more information about DC's HMIS, please reference TCP's website.

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Housing Match Prioritization

The District of Columbia has developed local prioritization criteria through a community process, according to the core requirements set forth by the U.S. Department of Housing and Urban Development (HUD). These criteria are informed by data and trends seen in the community and include assessment score and information about factors such as length of time experiencing homelessness, length of stay in shelter, and health and wellness considerations. The VI-SPDAT, TAY VI-SPDAT, Family Full SPDAT, and Individuals Full SPDAT are the only common tools used to assess participants, Veterans, and households, and assessment scores are used to triage participants, Veterans, and households to the appropriate housing resource.

The prioritization criteria are the framework for equitably distributing limited housing resources amongst the populations experiencing homelessness in DC. These criteria are slightly different across subsystems and for each housing resource category. A summary of the criteria is provided in the subsystems' specific sections.

Note that emergency and low barrier shelter placements are not subject to prioritization criteria. They must be available for immediate crisis response and operate with the lowest barriers to entry possible.

Information gathered during the CAHP process, including referrals, case conferencing, and prioritization is not used to discriminate on the basis of actual or perceived race, color, sex, ethnicity, national origin, religion, age, marital status, personal appearance, sexual orientation, gender expression or identity, familial status, family responsibilities, matriculation, political affiliation, genetic information, disability, source of income, place of residence or business, in accordance with the D.C. Human Rights Act of 1977, as amended, D.C. Official Code Section 2-1401.01 et seq. The D.C. Human Rights Act of 1977, Section 2-1402.31(a) of the D.C. Code, prohibits acts performed wholly or partially for a discriminatory reason: "To deny, directly or indirectly, any person the full and equal enjoyment of the goods, services, facilities, privileges, advantages, and accommodations of any place of public accommodation…"

Exceptions to Prioritization

The CAHP team is responsible for ensuring the community adheres to the agreed upon prioritization policies. However, there are valid reasons to make rare exceptions to the criteria. These should truly be exceptions, not the rule. Examples of reasons to match outside of the prioritization criteria may be:

- Response to unexpected program closure, such as a fire at a housing program or loss of funds
- Health and safety concerns for a participant at their current housing program
- Address an administrative issue that removed a participant or household's match or misclassified their eligibility
- External policy decisions with a system-wide impact on a targeted population
- As directed by the funder of the resource, (e.g., DC Department of Human Services (DHS) requests a match outside of the CAHP process for one of their housing programs, Veterans Administration requires a focus on unsheltered Veterans for a specific intervention they fund).

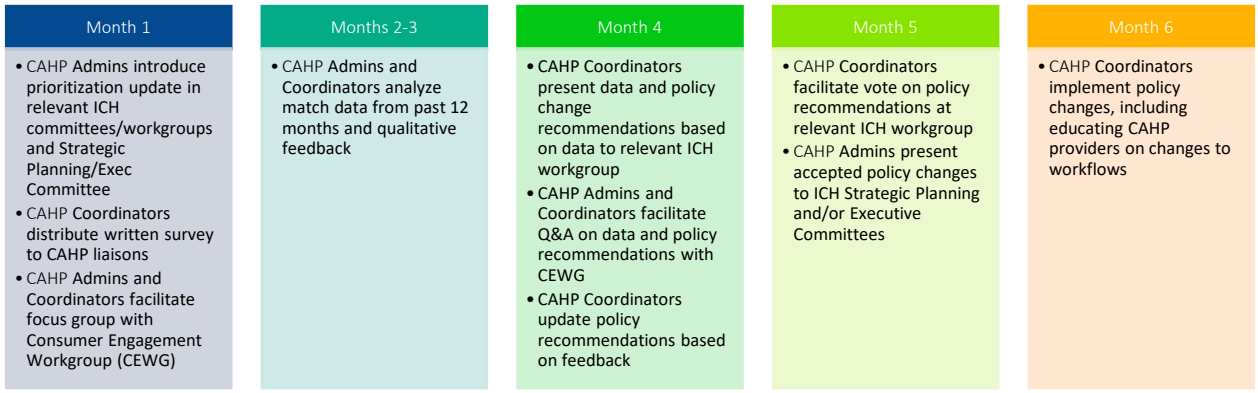
Requests to make an exception must be presented to the CAHP Administrator leading the subsystem. They will make the final determination in consultation with the Chief of Policy and Programs. Exceptions

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will be documented in match trackers and reported out during annual prioritization updates for community accountability.

Updating Prioritization Criteria and Matching Policies

Every twelve months, the CAHP team leads subsystems through a process to review and update prioritization criteria and matching policies. This ensures the system continues to reflect the needs of the population and respond to changes in policy and program capacity. While the content of the prioritization review will be unique to each subsystem, they all follow the same process. The CAHP Team leads the community through each step:



In the event there is a request to change prioritization policies outside of this regular schedule, the CAHP team will facilitate a discussion and decision-making process in the relevant subsystem ICH workgroup meeting. This discussion will review available data and discuss the pros and cons of making a change outside of the process. Some examples of reasons to change policies outside of the annual process may include:

- Significant change in the availability of housing resources
- External policy decisions with a system-wide impact on a targeted population
- Request from the funder of the resource
- Discovery of unintended implementation issues upon utilizing the new criteria.

Current Prioritization Update Schedule

Family/Vets Prioritization	**Family/Vets Implementation**		**Singles/Youth Prioritization**	**Singles/Youth Implementation**
October 2024-March 2025	April 2025-September 2026		April 2025-September 2025	October 2025-April 2027

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April 2026-September 2026	October 2026-April 2028		October 2026-March 2027	April 2027-September 2028
October 2027-March 2028	April 2028-September 2029		April 2028-September 2028	October 2028-April 2030

Service Prioritization Decision Assistance Tool

The Vulnerability Index Service Prioritization Decision Assistance Tool (VI-SPDAT) developed and owned by OrgCode is utilized for unaccompanied participants and Veterans to recommend the level of housing services necessary to resolve their homelessness. The VI-SPDAT is comprised of four components: (a) history of housing and homelessness (b) risks (c) socialization and daily functioning, (d) and wellness - including chronic health conditions, substance usage, mental illness, and trauma. This self-reported survey can help the CAHP team gain an initial understanding of the participants' barriers and service needs. Further assessment and referral information provides a clearer picture of the participant's level of vulnerability.

The Transition Aged Youth Vulnerability Index and Service Prioritization Decision Assistance Tool (TAY VI-SPDAT) developed and owned by OrgCode and Community Solutions is utilized for youth single participants under the age of 25 to recommend the level of housing services necessary to resolve their homelessness. The TAY-VI-SPDAT is comprised of four components: (a) history of housing and homelessness (b) risks (c) socialization and daily functioning, and (d) wellness - including chronic health conditions, substance usage, mental illness, and trauma. Similar to the VI-SPDAT, this self-reported survey can help the CAHP team gain an initial understanding of the participants' barriers and service needs. Like the VI-SPDAT, further assessment and referral information may be necessary to obtain a clearer picture of the participant's level of vulnerability.

The Service Prioritization Decision Assistance Tool (Full SPDAT) and Family Service Prioritization Decision Assistance Tool (F-SPDAT) were developed as assessment tools for frontline workers at agencies that work with homeless participants, Veterans, and households to gain further clarity on their level of vulnerability. It is an in-depth assessment that relies on the assessor's ability to interpret responses and corroborate those with evidence. In the Full SPDAT, there are four domains used to measure vulnerability: (a) wellness (b) risks (c) socialization and daily functions (d) history of housing. The Family SPDAT contains the same domains previously noted with a fifth domain incorporating details about the family unit.

All of the Service Prioritization Decision Assistance Tools are designed to help understand what type of housing assistance participants, Veterans, and households could benefit from and to assist in case management services. They allow program staff to establish priorities with the participants, Veterans, and households they are working with. Additionally, the SPDATs can track participant progress and changes to vulnerability over time. While the assessments can aid in various ways, the SPDAT cannot make decisions, provide any diagnosis, assess current risk, or be a predictive index for future risk.

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All CAHP participating staff must attend SPDAT training as appropriate for their subsystem. The CAHP team provides these trainings monthly. Training dates and how to register can be found on TCP's website.

Coordinated Assessment and Housing Placement Match Meetings

Throughout each month, the CAHP Coordinators facilitate CAHP Match Meetings in each subsystem. The CAHP liaisons or a designee of each shelter, street outreach program, housing provider, and Department of Human Services will be present for these meetings. During these meetings, the CAHP Coordinator discusses housing fit and placement, and CAHP liaisons and case managers are expected to provide information regarding each participant, Veteran, and household known to them to inform the match. All CAHP match meeting attendees must demonstrate professional judgment in this process, remaining objective in the reviews of the diverse cases.

Participants, Veterans, and households are matched from the By Name List (BNL) and Case Conferencing to all available housing resources. Participants, Veterans, and households will be matched according to the prioritization criteria for that resource type, with the understanding that further eligibility determinations may still need to be made.

By Name List

The By Name List (BNL) is the primary tool used to identify all participants, Veterans, and households currently experiencing homelessness in the CoC, to connect participants, Veterans, and households to services and resources, and to track assistance provided and housing outcomes.

The By Name List is compiled each month as part of the CAHP Match Meetings process in each subsystem. The BNL includes all participants, Veterans, and households that have engaged or been assessed by services providers within a defined time period. The BNL is used in each subsystem's match processes to identify participants, Veterans, and households that may be in need of a match to a housing resource.

Case Conferencing

While the By Name List is the primary mechanism used to identify referrals to the various housing resources, CAHP participating staff may also case conference a participant, Veteran, or household. Case conferencing provides additional information about participants, Veterans, and households not reflected in the SPDAT or HMIS data. In order to submit a case conference, the participant, household, or Veteran will need to meet at least one of the criteria listed in their specific subsystem. Please refer to each subsystem's section of this manual to learn the case conferencing criteria and processes.

Grievances and Complaints Procedures

Each CAHP participating agency maintains their own complaint and grievance procedure. Participants, Veterans, and households may seek remedies through those for any concerns they have. If they would like to escalate to the CoC level, please refer to the information below.

- To file a non-discrimination complaint:
    - Call The Community Partnership Complaint Hotline: 1 (877) 341-3702,
    - Send an email to feedback@community-partnership.org **OR**

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  - Call TCP's admin number at (202) 543-5298 (Mon-Fri 9a -5p)
- To submit a suggestion for improvement or a complaint related to a DHS program or service to the DHS Office of Program Review, Monitoring and Investigation (OPRMI):
  - Complete and submit the online Suggestions and Complaint Form,
  - Email a description of the suggestion or complaint to OPRMI@dc.gov,
  - Fax a description of the suggestion or complaint to (202) 671-4409,
  - Call the Complaint Hotline at (202) 673-4464, or
  - Mail or deliver a report to:
    - DHS Office of Program Review, Monitoring and Investigation (OPMRI) 64 New York Avenue, NE,6th Floor, Washington, DC 20002
- Complaints of possible violations of this law may be filed with:
  - Government of the District of Columbia Office of Human Rights
  - 441 4th Street, NW, 570N Washington, D.C. 20001
  - Telephone (202) 727-4559 Fax (202) 727-9589 www.ohr.dc.gov

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Single Adults System (I-CAHP)

Coordinated Assessment and Housing Placement (CAHP) System Manual

Contents

Matched through I-CAHP: Housing Resources 17
Tenant-based Permanent Supportive Housing (PSH) 17
Unit-based PSH 17
DHS-funded Unit-based PSH 17
TCP-funded PSH 17
Rapid Rehousing (RRH) 17
Joint Transitional Housing/Rapid Rehousing (TH/RRH) 17
Matched through I-CAHP: Non-congregate Bridge Housing (NCBH) 18
Not matched through I-CAHP: Transitional Housing 18
Collaboration Across Subsystems 18
Tenant-based PSH Matching Procedures 18
Definitions 18
Preparing for Matching 19
I-CAHP Communication Form 20
I-CAHP Case Conferencing Criteria 20
I-CAHP PSH Match Meetings 22
I-CAHP PSH Prioritization Criteria 23
Prioritization Criteria Sorts 23
Unit-based PSH Matching Procedures 23
Referral Procedure 23
DHS-funded Unit-based PSH Referral Procedure 24
TCP-funded PSH Referral Procedure 24
Unit-based PSH Matching 24
Vacancy Announcement 24
Offline Matching 25
Prioritization Criteria 25
RRH Matching Procedures 25

The Community Partnership for the Prevention of Homelessness | 14 Kennedy St. NW, Washington, DC 20011
Phone: (202) 543-5298 | Fax: (202) 543-5653 | Website: Community-Partnership.org

Definitions 25
Referral Procedure 25
RRH-I Matching 26
RRH-I Prioritization Criteria 27
Creating the Wait List 28
Joint TH/RRH Matching Procedures 28
Joint TH/RRH Prioritization Criteria 28
RRH Transfers to PSH 29
Non-congregate Bridge Housing (NCBH) Matching Procedures 30
Definitions 30
Referral Procedure 30
Target Populations 30
NCBH Matching Procedure 31
Prioritization Criteria 31

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Matched through I-CAHP: Housing Resources

Tenant-based Permanent Supportive Housing (PSH)

The District of Columbia's Department of Human Services (DHS) is the primary funder of tenant-based Permanent Supportive Housing (PSH) in the city. This resource is an ongoing housing intervention through which a participant receives: a housing voucher for rental assistance, housing case management support, and "participant choice" of rent-reasonable units on the private housing market (also referred to as scattered-site interventions). PSH vouchers limit the participant's rent contribution to 30% of their income with no income required. Case management can be billed to Medicaid through this program.

Unit-based PSH

DHS-funded unit-based and TCP-funded PSH are location-specific permanent supportive housing (PSH) resources matched through the DC CAHP system in which the unit itself is subsidized, rather than utilizing a voucher. At the national level, this type of resource is typically called "project-based PSH," but the DC CoC has adopted "unit-based PSH" to reduce stigma associated with the term "projects." Except for in certain circumstances, DHS-funded unit-based and TCP-funded PSH have the same eligibility requirements and prioritization criteria as tenant-based PSH. The primary difference between the two resources is the funding source.

DHS-funded Unit-based PSH

DHS-funded Unit-based PSH is a locally funded program, operated by DC DHS. It is a housing-first model and utilizes the same eligibility and prioritization criteria as tenant-based PSH. Some locations target specific subpopulations, generally by age, gender, and assisted living need. Descriptions of current programs can be found on the I-CAHP Toolbox, provided to all I-CAHP-participating providers.

TCP-funded PSH

TCP-funded PSH are HUD-funded programs operated by TCP and its subcontractors. It is also a housing-first model using the same eligibility and prioritization criteria as tenant-based PSH. Included in these matching procedures are a handful of resources that are scattered site resources, not location based. But, for administrative ease, they are matched through this procedure, not through the DHS tenant-based matching procedures. Descriptions of current programs can be found on the I-CAHP Toolbox, provided to all I-CAHP-participating providers.

Rapid Rehousing (RRH)

Rapid Rehousing (RRH) is a time-limited housing intervention which offers up to 12 months of rental assistance plus case management services. At the conclusion of services, participants assume full responsibility for their lease. The District of Columbia's Department of Human Services (DHS) is the primary funder of RRH in the city.

Joint Transitional Housing/Rapid Rehousing (TH/RRH)

TCP funds one joint transitional housing/rapid rehousing (TH/RRH) program, facilitated by Calvary Women's Services. This program offers participants space in a transitional housing program while they prepare to engage in RRH services. This is also a time-limited intervention that pairs rental assistance

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with case management services. At the conclusion of the participant's stay in the program, they assume full responsibility for their lease.

Matched through I-CAHP: Non-congregate Bridge Housing (NCBH)

The District of Columbia is proud to offer non-congregate bridge housing (NCBH) facilities at two new locations. Due to the funding source, matching to these resources is federally required to come through CAHP. Participants referred to and accepted into this resource stay in a two-person room. Target populations include participants already matched to a housing intervention (bridge housing) and participants not well-served by traditional low barrier shelter. The latter is comprised of adult households (such as mixed gender couples, parent/adult child, and adult siblings), individuals requiring home health aide services, individuals living in encampments, and individuals whose disabling condition(s) limit their ability to function effectively at low barrier shelter. The resource is designed to respond to the needs of the single adult population and to facilitate system flow, helping participants stay engaged in services and shorten their time to lease-up.

Not matched through I-CAHP: Transitional Housing

In other subsystems, the CAHP coordinator facilitates matches to transitional housing (TH). As of the writing of this manual, that is not the case in the I-CAHP subsystem. Case managers looking to connect a participant to TH for single adults should reach out to those programs directly for their current vacancies and intake process.

Collaboration Across Subsystems

The Single Adults (I-CAHP) subsystem serves all unaccompanied individuals age 18+ experiencing homelessness in Washington, DC. This means there is an inherent population overlap with both the Youth and Veterans subsystems. Some participants served in the Single Adults subsystem may be eligible for services in the Youth and the Veterans subsystems. The CAHP Coordinators from all three subsystems collaborate with case managers when a participant comes up in multiple systems to determine the best resource for them.

Tenant-based PSH Matching Procedures

Definitions

BNL: "by-name list"; list of all known information on participants who have engaged with the system in the month prior. BNL data is used to make matches based on prioritization policies.

Active: participant has at least one service engagement of any type over a month. This includes shelter stays, engagement through outreach or other services (excluding Project Reconnect), and any newly completed VI-SPDAT and Full SPDAT assessments.

Tenant-based Permanent Supportive Housing (PSH): Ongoing housing interventions for which a housing voucher subsidizes rent, housing case management support, and "participant choice" of rent-reasonable units on the private housing market (also referred to as scattered-site interventions). PSH vouchers limit the participant's rent contribution to 30% of their income with no income required.

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Prioritization Criteria: Community-approved combinations of different benchmarks used to determine prioritization order in selecting participants for highly limited housing resources.
Case Conferencing: Prioritization criteria label indicating a participant has been confirmed have one or more circumstances or conditions that allow for the participant to be included in a matching pool that includes only participants meeting criteria instead of the full BNL.
BNL Pre-check: A condensed, pre-sorted representation of the BNL which includes the 5-10% of participants most likely to be prioritized using all existing prioritization criteria. This list is sent to I-CAHP Liaisons and is used toward preparing responses to be used in the monthly Match Meetings.
Match Meeting: I-CAHP Coordinator-led meetings attended by the community of provider staff for the purpose of reviewing participants in order of prioritization and accumulating essential housing-related information and responses regarding whether a highlighted participant is well-suited for a tentative match to a PSH voucher. Match Meetings serve as the final opportunity each month to eliminate gaps in understanding the participants' needs and preferences before tentative matches are identified and sent back to DHS for final approval.
Medicaid Housing Stabilization Categories: Medicaid-specific categories highlighting basic justifications for why a participant may require a permanent housing intervention. DHS requires the reason(s) listed below to be collected in advance of a participant being placed in the Medicaid intake process following match approval:

- Mobility (walks with a cane, uses a rollator or a wheelchair, etc.)
- Decision Making (deciding to stay on the street instead of shelter, constant relapse of substance abuse, past evictions, etc.)
- Maintaining Healthy Social Relationships (repeat of DV issues, current assault charges, no relations with adult children or family members, etc.)
- Assistance with ADLs (needs help with at least one: self-care, money management, bathing, changing clothes, toileting, getting food or preparing meal)
- Managing challenging behaviors (Mental Health, behavioral health, substance abuse, evictions due to behavioral disturbances, etc.).

Preparing for Matching

Matching begins with the creation of the By Name List (BNL). Following the second business day of each month, the I-CAHP Coordinator pulls reports from HMIS to compile the BNL. The BNL will include all active participants known or assumed to be experiencing literal homelessness and not currently matched or assigned to a housing resource. Providers must have their HMIS data entry from the prior month completed by 11:59:59pm on the second business day of the month for their records of participant engagement to be reflected on the BNL.

By the second Wednesday of the month, the I-CAHP Coordinator prepares and distributes the BNL pre-check to I-CAHP liaisons. This is a direct representation of the BNL containing the names of the 5-10% of participants being prioritized most highly using the different combinations of match prioritization criteria. The pre-check is designed to allow staff working with participants to prepare responses used to determine whether to match a participant should they be prioritized under the monthly matching procedure. Staff may also use the pre-check to communicate these responses by entering them directly

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into the shared document. These responses make it possible for participants' needs and preferences to be reflected during match meetings even if the case manager is not able to attend. Completing the pre-check fulfills CAHP-participation requirements in agency contracts if attending the match meeting is not possible that month.

I-CAHP Communication Form

Throughout the month, staff at CAHP-participating providers submit case conferencing referrals, chronic homelessness attestations, and other additional case information using the I-CAHP Communication Form. The I-CAHP Coordinator reviews these submissions on a rolling basis until the deadline, ensuring they have been completed accurately. When compiling the BNL, the I-CAHP Coordinator incorporates this confirmed information to add context to each participant's data in preparation for prioritization. The final deadline for these submissions is 5:00pm ET on the third Tuesday of the month unless otherwise communicated.

Chronic Homelessness Attestations

Some participants' history of homelessness is not accurately reflected in HMIS. This could be for many reasons, so the I-CAHP system can accept attestations to length of homelessness from case managers to fill in the gaps. They may submit two types of attestations:

- Chronic homelessness: staff have documented knowledge of a participant experiencing chronic homelessness outside of what can be shown through HMIS engagement history.
- Long-stayer homelessness: staff have documented, demonstrable knowledge of a participant having experienced at least 36 months of continuous homelessness through the present.

BNL Information Submissions

Case managers may also submit additional information otherwise not reflected in HMIS related to a participant's needs and preferences regarding housing interventions. Examples include:

- Match recommendation: staff input regarding whether a PSH intervention is appropriate for a participant, including if the participant will accept the intervention
- Medicaid "Reasons for needing PSH": Medicaid language highlighting the different reasons a participant may require a PSH intervention
- Contact information: methods by which the DHS Intake team can get in touch with the participant directly and/or through staff members with current working relationships with the participant.

I-CAHP Case Conferencing Criteria

As part of the prioritization procedure and to gather additional vulnerability information that may not be reflected in HMIS data, the I-CAHP system established five case conferencing criteria. They are:

1. Exceptional medical vulnerability (EMV)
    - End stage renal disease (dialysis dependent)
    - Paralysis that impairs activities of daily living (ADLs), such as the result of a stroke
    - Congestive heart failure with exacerbations
    - Active cancer diagnosis/treatment

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- Difficult to control insulin-dependent diabetes mellitus (IDDM)
- Poorly controlled auto-immune disorder (including AIDS)
- Severe vision impairment
- Severe respiratory illness, such as COPD with O2 requirement
- Major neurocognitive disorder (formerly called dementia) causing severe impairment
- Severe neurodegenerative disorders, such as ALS and severe MS
- Other rare, potentially life-threatening illness

2. Serious mental illness (SMI) and/or substance use disorder (SUD)
    - Definition adapted from DC Department of Behavioral Health (DBH) Assertive Community Treatment (ACT) criteria
    - Participant must meet all three of the following:
        - An intractable, serious, and persistent mental illness and/or substance use disorder
        - One or more of the following:
            - High use of acute psychiatric hospitalization (two or more admissions per year) or F/EMS contacts; CPEP/mobile crisis visits; crisis stabilization services
            - Co-occurring substance use disorders of greater than 6 months
            - Recent history of criminal justice involvement (arrest or incarcerations) within the past 6 months
            - Chronically homeless
            - Residing in an inpatient setting for more than 3 months or supervised community residence but clinically assessed to live more independently with increased community-based services
            - Has documented inability to sustain involvement with or remain engaged in traditional office-based services
        - One or more of the following:
            - Significant difficulty consistently performing the range of daily tasks required to live in the community
            - Significant difficulty maintaining consistent employment
            - Significant difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing, or being burglarized or robbed due to mental instability)
3. Previously matched to PSH through CAHP
4. PSH transfer referral
    - Staff must specify reason for transfer referral:
        - Ongoing health/safety concerns - Participant needs higher level of care than such as assisted living or nursing home care
        - Ongoing health/safety concerns - participant requires on-site case management or other services
        - No longer suitable for shared-living PSH environment due to health/safety reasons

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- No longer suitable for shared-living due continuous conflicts with other residents and/or staff members
- Participants has issues/conflicts surrounding official program rules
- Requires ADA/UFAS unit to remain safely housed
- No longer suitable for independent-living environment (risk to self)
- Currently assigned to a PSH program that is no longer operating or scheduled to be discontinued due to loss of funding
- Currently assigned to a PSH program that no longer operates due to an emergency (fire or flood damage, hazardous conditions, inspection failure etc.).

I-CAHP PSH Match Meetings

The I-CAHP PSH match meeting is held on a monthly basis on the third Wednesday of the month, unless otherwise communicated. The goal of the meeting is to review the BNL in prioritization order and make matches to DHS-funded tenant-based PSH only. Participants are reviewed in the order resulting from the sorting methodologies within each prioritization group (see the prioritization criteria listed in the next section) to determine if they are appropriate for a match. Information considered includes pre-check responses and verbal reports during the meeting. Staff must report the following:

- Housing intervention recommendation
  - If offered, is the participant willing to accept a match to Tenant-based PSH
  - Is PSH a suitable/appropriate intervention for the participant?
    - Would the relative independence of a scattered-site intervention with intermittent check-ins by a housing case manager be a safe living situation for the participant?
    - Does the participant require a higher level of care (such as nursing home or assisted living needs) than PSH offers?
- Medicaid Housing Stability: Reasons for Needing PSH
  - Mobility
  - Decision-making
  - Maintaining healthy social relationships
  - Assistance with ADLs
  - Managing challenging behaviors
- Contact Information
  - Participant contact information for the DHS intake specialist to get in touch during the post-match process
    - Direct personal phone number
    - Direct personal mail address
    - Contact information for family members and friends who would be able to notify the matched participant if they cannot be reached directly
  - Primary and secondary contact information for agency staff members working most closely with the participant.

While going through the BNL, the I-CAHP Coordinator will identify prioritized participants who can be matched up to the limit of resources available that month plus three additional back-up matches. These

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are considered "tentative matches." Upon the conclusion of the meetings, the I-CAHP Coordinator sends the list of tentative matches to the DHS I-CAHP Liaison for review. If the DHS I-CAHP Liaison encounters any information or development showing any tentatively matched participant to be inappropriate for a tenant-based PSH match, they will flag that participant to be replaced by a back-up match. DHS sends the list of approved matches back to the I-CAHP Coordinator. The I-CAHP Coordinator records matches in HMIS and posts the new matches into the Tenant-based PSH Match Tracker, which is available to all I-CAHP liaisons and provides updates on the progress of each step in DHS's post-match process. Any questions regarding the post-match process, including updates from DCHA, should be directed to the DHS I-CAHP Liaison.

I-CAHP PSH Prioritization Criteria

Group 1: Case Conferencing – Participants meeting at least one case conferencing criterion

1. Up to 30% of all matches made that month
2. If the number of participants meeting criteria exceeds the allotted percentage of matches from case conferencing, participants are listed according to prioritization sorting criteria
3. Participants within the case conferencing pool falling outside of the 30% allotment are included in prioritization among the full list of long-stayers and chronically homeless participants.

Group 2: Long-stayers – Participants who meet the definition of "long-stayer" through HMIS data and/or attestation.

Group 3: Chronically homeless participants – Participants who meet the definition of "chronic homelessness."

Prioritization Criteria Sorts

Participants within each group listed above are sorted in three ways to determine matches.

1. Date of ID (oldest to newest) (50%)
2. VI-SPDAT score (highest to lowest) with Date of ID (oldest to newest) as a tie-breaker (20%)
3. Full SPDAT score (highest to lowest) with Date of ID (oldest to newest) as a tie-breaker (30%)
    a. Note: A Full SPDAT is not eligible to be used in prioritization unless/until the required explanations justifying the scores are completed within the Full SPDAT assessment. Full SPDAT entries without a majority of explanations for the assessment scores are marked "incomplete" and will not be used for prioritization.

Unit-based PSH Matching Procedures

Referral Procedure

Because these resources are tied to specific units, referrals are required. It is important that the location is a good fit for the participant's needs and preferences before making the referral. The referring provider is responsible for fully informing the participant of the program details and ensuring they have viewed the unit before submitting a referral on the participant's behalf.

Referrals can be submitted at any time. In fact, case managers are encouraged to routinely talk about these options with participants in need of PSH to gauge their interest in these resources. When the participant is interested, case managers can respond in real-time, submitting the referral right away.

DHS-funded Unit-based PSH Referral Procedure

1. The referring case manager confirms the participant meets chronic status through HMIS engagements.
    a. If not, the case manager obtains documentation to complete an attestation on their behalf.
2. The referring case manager submits any relevant case conferencing paperwork if the participant meets any case conferencing criteria (if not already submitted). Case conferencing criteria are the same as for tenant-based PSH.
3. After reviewing sites with the participant, either in-person or using the summary webpage, the referring case manager prepares the unit interest form (UIF) and supports the participant to sign it.
    a. Form is available on the I-CAHP Toolbox. It should be printed and signed.
    b. Then, the referring case manager should scan in the signed form to include as a PDF in the referral.
4. The referring case manager completes the referral form for the participant. Referral form available on the I-CAHP Toolbox.
    a. Attachments to include:
        i. UIF signed by participant; one UIF per location in referral
        ii. ID
        iii. Birth certificate
        iv. SSN card

TCP-funded PSH Referral Procedure

1. The referring case manager confirms the participant meets chronic status through HMIS engagements.
    a. If not, the case manager obtains documentation to complete an attestation on their behalf.
2. The referring case manager submits any relevant case conferencing paperwork if the participant meets any case conferencing criteria. Case conferencing criteria are the same as for tenant-based PSH.
3. After reviewing sites with the participant, either in-person or using the summary webpage, the referring case manager completes the referral form for the participant. Referral form found on the I-CAHP Toolbox.

Unit-based PSH Matching

Vacancy Announcement

All DHS-funded unit-based and TCP-funded PSH units are filled, meaning that, unless a new location comes online, there are only vacancies when a participant leaves a unit. As such, it is nearly impossible to predict when any participant will be matched to a resource.

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Vacancies are announced to the community via email on Fridays. Managers of all programs, including DHS-funded unit-based and TCP-funded PSH, must notify the I-CAHP Coordinators of their vacancy before Friday to be included in the announcement email. To be considered for that resource, the referral must be submitted by 11:59pm the following Thursday. This means there is essentially a one-week turnaround for vacancies.

In the event that a resource has new vacancies within a short window of time since the last call for vacancies, the DHS CAHP liaison and/or the TCP I-CAHP coordinators may elect to return to the most recent prioritization list for that program rather than send out a call for new referrals.

Offline Matching

Matching occurs weekly after the vacancy announcement due date on Friday. The I-CAHP Coordinator reviews all referrals submitted within the last six months and received by the due date. They review referred participants to confirm they meet eligibility for PSH and any site-specific criteria, such as gender or age. The I-CAHP Coordinator cross-references the list of referred participants with that month's BNL and prioritizes active participants for available vacancies.

Prioritization Criteria

Eligible, referred participants are sorted into one list in the following order:

1. Participants meeting case conference criteria, sorted by Date of ID (oldest to newest)
2. All referred participants meeting chronic status, sorted by Date of ID (oldest to newest).

RRH Matching Procedures

Definitions

BNL: "by-name list"; list of all known information on consumers who have engaged with the system over a 30-day period. BNL data is used to make matches based on prioritization principles.
Active: participant has had an engagement or shelter stay in HMIS in the past 30 days. This means the BNL can also be seen as a list of participants with active status. This status is determined by a review of the participant's profile and/or presence on the BNL.
Inactive: participant has NOT had an engagement or shelter stay in HMIS in the past 30 days. This status is determined by a review of the participant's profile and/or lack of presence on the BNL.
Employment status: Four categories are gathered for RRH matching: Employed, Searching, and Unemployed, not searching, and Unknown. Self-employed participants can be counted as employed. This is based on participant self-report.
Shared housing: A housing arrangement in which the participant is not the only tenant on the unit lease. This does not include couch-surfing; the participant must have a formal lease. Through the RRH referral procedure, participants will report to the referring provider if they have interest in pursuing shared housing and if they've already identified a roommate.

Referral Procedure

Because of the short-term nature of this intervention, referrals are required. It is important that the program is a good fit for the participant's needs and preferences before making the referral. The

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referring provider is responsible for fully informing the participant of the program details and ensuring they understand the program's limitations.

Referrals can be submitted at any time when the form is open. In fact, case managers are encouraged to routinely talk about housing options with participants to gauge their interest in these resources. When the participant is interested, case managers can respond in real-time, submitting the referral right away.

1. Outreach workers/shelter case managers refer eligible participants to RRH using the referral form (found on the I-CAHP Toolbox). Referrals can be submitted at any point when the form is open.
2. CAHP coordinator reviews referrals for eligibility and appropriateness and emails referring providers for any questions. Participants are reviewed in order of referral date.
    a. Eligibility
        i. Literal homelessness
        ii. Single adult
        iii. Living in DC
    b. Appropriateness indicators
        i. VI-SPDAT score: 4-7 (recommended but not required)
        ii. Employed or interest in/capacity for employment; known work history
            1. Because DC's CoC does not have progressive engagement for RRH, if participant indicates no interest in or ability to work and does not have sufficient income from other sources to rent in DC, refer to PSH or higher level of care (HLC) as appropriate
        iii. Already has income of some sort
        iv. No known barriers preventing ability to live independently and work.
            1. These will be found in the VI-SPDAT, SPDAT, HMIS case notes, CAHP team notes from past referrals/matching, and/or the referral itself
3. Upon confirming eligibility and appropriateness, CAHP coordinator flags for match. If they are not eligible or appropriate, CAHP coordinator notifies referring provider via email and provides the denial reason.

RRH-I Matching

Matches are **made once per month**. The number of matches correlates to the number of exits from the program the month prior unless otherwise directed by DHS. Only participants referred and confirmed eligible and appropriate for RRH by the 25th of the month will be considered.

Participants are assigned at the time of match based on program capacity. There are no set pairings between referral source and RRH provider. However, recommended best practice is to match all participants at the same location or referred by the agency to the same RRH provider in the same matching cycle to lessen the administrative burden and improve the warm hand-off process.

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RRH-I Prioritization Criteria

RRH-I prioritization criteria are comprised of three components: 1) active status, 2) employment status, and 3) referral date. Participants flagged for a match are placed into one of six prioritization categories and then sorted by referral date:

1. Active Employed
2. Active Searching
3. Active Unemployed/Unknown
4. Inactive Employed
5. Inactive Searching
6. Inactive Unemployed/Unknown

Active participants are sorted and prioritized first.

- 80% of matches are made from the Active Employed category and 20% from the Active Searching category.
    - If there are more vacancies than employed and searching participants, then matches are made from the Active Unemployed/Unknown category.
- If any of the matched participants has an identified roommate on the working match sheet. The roommates will be matched together based on the first one to come up on the match list.

If there are more vacancies than active participants, inactive participants are sorted and prioritized.

- 80% of matches are made from the Inactive Employed category and 20% from the Inactive Searching category.
    - If there are more vacancies than employed and searching participants, then matches are made from the Inactive Unemployed/Unknown category.
- If any of the matched participants has an identified roommate on the working match sheet. The roommates will be matched together based on the first one to come up on the match list.

If there are still more vacancies than all referred participants, the I-CAHP Coordinator will fill the vacancies from the monthly I-CAHP BNL, following these steps:

1. Remaining vacancies are filled through this distribution:
    a. 35%: open shelter stay, sort Date of ID newest to oldest
    b. 15%: open shelter stay, sort Date of ID oldest to newest
    c. 35%: no open shelter stay, sort Date of ID newest to oldest
    d. 15%: no open shelter stay, sort Date of ID oldest to newest
2. I-CAHP Coordinator filters BNL to view participants with VI-SPDAT score 4-7.
3. I-CAHP Coordinator filters this group to view participants with open shelter stays.
    a. Within that group, the I-CAHP Coordinator sorts the list by Date of ID *newest to oldest.*
        i. I-CAHP Coordinator contacts shelter CAHP liaison about the participants that come up for match to determine if the participant is interested in and appropriate for RRH.
    b. Within that group, the I-CAHP Coordinator sorts the list by Date of ID *oldest to newest.*

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i. I-CAHP Coordinator contacts shelter CAHP liaison about the participants that come up for match to determine if the participant is interested in and appropriate for RRH.

4. I-CAHP Coordinator filters this group to view participants *without* open shelter stays.
    a. Within that group, the I-CAHP Coordinator sorts the list by Date of ID *newest to oldest.*
        i. I-CAHP Coordinator contacts CAHP liaison for program of last contact about the participants that come up for match to determine if the participant is interested in and appropriate for RRH.
    b. Within that group, the I-CAHP Coordinator sorts the list by Date of ID *oldest to newest.*
        i. I-CAHP Coordinator contacts CAHP liaison for program of last contact about the participants that come up for match to determine if the participant is interested in and appropriate for RRH.

Creating the Wait List

After creating the match list, the I-CAHP Coordinator creates the wait list of the remaining referred participants for the referring providers to anticipate when their participant might be matched and to provide updated information since submitting the referral. Referring providers must update information for participants by the 25th of the month for consideration in the next matching cycle.
This list includes

- All participants referred by the 25th of the month and have not been confirmed eligible/appropriate due to delays in case manager response.
- All participants referred by the 25th of the month and flagged for match but not assigned during this matching cycle for any reason.
- All participants referred after the 25th of the month.

Joint TH/RRH Matching Procedures

Referral and matching to joint transitional housing/rapid rehousing (TH/RRH) follows the same procedures as traditional RRH. There is one difference in the prioritization criteria, however, given the additional support offered through the TH portion of the program: 60% of matches are made from the "searching" category, while 30% are made from the "employed" category. Please find a summary below.

Joint TH/RRH Prioritization Criteria

Active participants are sorted and prioritized first.

- 20% of matches are made from the Active Employed category and 80% from the Active Searching category.
    - If there are more vacancies than employed and searching participants, then matches are made from the Active Unemployed/Unknown category.
- If any of the matched participants has an identified roommate on the working match sheet. The roommates will be matched together based on the first one to come up on the match list.

If there are more vacancies than active participants, inactive participants are sorted and prioritized.

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- 20% of matches are made from the Inactive Employed category and 80% from the Inactive Searching category.
    - If there are more vacancies than employed and searching participants, then matches are made from the Inactive Unemployed/Unknown category.
- If any of the matched participants has an identified roommate on the working match sheet. The roommates will be matched together based on the first one to come up on the match list.

If there are still more vacancies than all referred participants, the I-CAHP Coordinator will fill the vacancies from the monthly I-CAHP BNL, following these steps:

1. Remaining vacancies are filled through this distribution:
    a. 35%: open shelter stay, sort Date of ID newest to oldest
    b. 15%: open shelter stay, sort Date of ID oldest to newest
    c. 35%: no open shelter stay, sort Date of ID newest to oldest
    d. 15%: no open shelter stay, sort Date of ID oldest to newest
2. I-CAHP Coordinator filters BNL to view participants with VI-SPDAT score 4-7.
3. I-CAHP Coordinator filters this group to view participants with open shelter stays.
    a. Within that group, the I-CAHP Coordinator sorts the list by Date of ID *newest to oldest.*
        i. I-CAHP Coordinator contacts shelter CAHP liaison about the participants that come up for match to determine if the participant is interested in and appropriate for RRH.
    b. Within that group, the I-CAHP Coordinator sorts the list by Date of ID *oldest to newest.*
        i. I-CAHP Coordinator contacts shelter CAHP liaison about the participants that come up for match to determine if the participant is interested in and appropriate for RRH.
4. I-CAHP Coordinator filters this group to view participants *without* open shelter stays.
    a. Within that group, the I-CAHP Coordinator sorts the list by Date of ID *newest to oldest.*
        i. I-CAHP Coordinator contacts CAHP liaison for program of last contact about the participants that come up for match to determine if the participant is interested in and appropriate for RRH.
    b. Within that group, the I-CAHP Coordinator sorts the list by Date of ID *oldest to newest.*
        i. I-CAHP Coordinator contacts CAHP liaison for program of last contact about the participants that come up for match to determine if the participant is interested in and appropriate for RRH.

RRH Transfers to PSH

As of this writing, DHS is not processing transfers from RRH to PSH. However, the established protocols are listed here whenever we can resume the process.

In the event a RRH participant is found to be in need of PSH, the I-CAHP Coordinator partners with DHS to facilitate the DHS RRH to PSH transfer Procedure. Transfer referrals are processed during even numbered months (e.g., February, April, June). Referrals can only be submitted by RRH providers while the participant is enrolled in the program.

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To prepare for the transfer meeting, the I-CAHP Coordinator reviews referrals and confirms they meet DHS PSH transfer eligibility (see DHS transfer Procedure). They also prioritize the list of referrals by the criteria:

- Length of time housed in days (longest to shortest)
- SPDAT score (highest to lowest).

During the transfer meeting, DHS PSH and RRH staff and RRH providers review each case. Up to five participants are approved for transfer during the meeting unless otherwise specified by the DHS PSH team. If there are more participants eligible and appropriate for transfer than there are program vacancies, the I-CAHP Coordinator utilizes the prioritization criteria to determine who will transfer during that cycle. Participants remaining will be prioritized during the following transfer cycle.

Non-congregate Bridge Housing (NCBH) Matching Procedures

Definitions

Encampment: an informal community of individuals and households experiencing unsheltered homelessness within a defined area (adapted from USICH)
Home health aide: a professional who provides basic personal care to individuals who need assistance due to illness, injury, disability, or age-related impairments. These aides typically work in the home to assist patients in performing daily activities.
Disabling condition: any condition (physical, emotional, cognitive) that limits an individual's ability to function (adapted from HUD).
Adult household: a household configuration comprised solely of adults. May include couples, parents with adult children, or adult siblings.

Referral Procedure

Outreach, shelter, and drop-in center workers are able to submit a referral to the NCBH program at any time using the referral form (found on the I-CAHP Toolbox). Upon receiving the referral, the DHS NCBH team reviews them to ensure they meet the eligibility criteria. Referrals must specify which target population(s) the participant fits into.

Target Populations

Eligible participants fall into three general populations: 1) participants unable to be accommodated by low-barrier shelter, 2) adult households, or 3) participants who have secured a permanent housing resource and are awaiting move-in.

Population 1 is further broken down:

- Special populations: participants who are living in encampments
- Participants utilizing or in need of a home health aide
- Participants with a disabling condition.

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NCBH Matching Procedure

Prioritization Criteria

A top goal of the NCBH program is to serve the most vulnerable amongst the population. In service of that goal, the NCBH program does not use a first-come, first-served approach. Rather it uses the Unit-based PSH prioritization criteria for all bed types. Participants referred to the shelter will be sorted as follows. If one household member comes up for a match before the other, the household will be matched together based on the member with the highest vulnerability:

1. Participants meeting case conference criteria and chronic status, sorted by Date of ID (oldest to newest)
2. All referred participants meeting chronic status, sorted by Date of ID (oldest to newest).
3. Participants meeting case conference criteria but do not meet chronic status, sorted by Date of ID (oldest to newest)
4. All referred participants who do not meet chronic status, sorted by Date of ID (oldest to newest).

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Youth System

Coordinated Assessment and Housing Placement (CAHP) System Manual

Contents

Youth Housing Program Resources 33
- Transitional Housing 33
- Joint Transitional Housing/Rapid Rehousing 33
- Extended Transitional Housing 33
- Rapid Rehousing 33
- Permanent Supportive Housing 33

Preparing for Matching 33
- Youth CAHP By Name List 33
- Youth CAHP Pre-Checks 34
- Youth CAHP Vacancy Reporting 34

Youth CAHP Match Meetings 34

Matching Policies & Prioritization Criteria 35
- Transitional Housing & Joint Transitional Housing/Rapid Rehousing 35
  - Transitional Housing & Joint Transitional Housing/Rapid Rehousing: Age Out Prioritization 35
- Transitional Housing for Survivors of Domestic Violence 35
- Extended Transitional Housing 36
- Rapid Rehousing 36
- Permanent Supportive Housing 37

Case Conferencing 37

Post-Match Process 39

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Youth Housing Program Resources

Transitional Housing

Transitional Housing (TH) provides up to 24 months of housing in addition to wrap-around services to prepare participants that are experiencing homelessness to secure and maintain permanent housing at exit. TH is intended to rapidly house and stabilize without barriers to enrollment.

Joint Transitional Housing/Rapid Rehousing

The Joint Transitional Housing/Rapid Rehousing (Joint TH/RRH) resource is one that combines transitional housing and rapid rehousing resources to help people experiencing homelessness move into permanent housing. The program provides temporary housing, financial assistance, and supportive services. Participants begin in the transitional housing portion of the resource and then move into the rapid rehousing portion of the resource. The resource overall is 24 months with the distribution between TH and RRH dependent on the particular participant's needs.

Extended Transitional Housing

Extended Transitional Housing (ETH) provides up to three years of housing in addition to a full range of supportive services including case management, employment services, educational services, life skills, and housing navigation services.

Rapid Rehousing

Rapid Rehousing (RRH) in the Youth System provides up to 24 months of rental assistance and targeted supportive services. The goal of RRH is to help participants avoid a near-term return to homelessness and link them to community resources that will enable them to achieve housing stability in the long-term.

Permanent Supportive Housing

Permanent Supportive Housing (PSH) is an evidence-based intervention that combines housing assistance through a permanent rental subsidy with supportive services to address the needs of chronically homeless individuals or households. The services are designed to build independent living and tenancy skills and connect participants with community-based health care, treatment, and employment services.

Preparing for Matching

Youth CAHP By Name List

The Youth CAHP By Name List (BNL) includes the names of all participants ages 18-24 who have an engagement in HMIS (shelter stay, service engagement, SPDAT Assessment, etc.) within a 30-day period that may be experiencing homelessness. It also includes relevant information necessary to determine an appropriate housing resource for each participant including assessment scores, length of engagement history, demographic information, and information provided on the Pre-Check Form. Only two assessment scores will be included per participant: their most recent VI-SPDAT or TAY-VI-SPDAT and their most recent Full SPDAT. If there is a VI-SPDAT or TAY-VI-SPDAT assessment completed on the same day, then the TAY-VI-SPDAT assessment will be used.

The Youth CAHP Coordinator compiles a new BNL in advance of each Youth CAHP Match Meeting.

Youth CAHP Pre-Checks

After creating the BNL, the Youth CAHP Coordinator applies prioritization criteria to the BNL and compiles a list of those participants who may be identified for a match at the upcoming Youth CAHP Match Meeting. The Youth CAHP Coordinator sends this list to Youth CAHP Liaisons via email two Fridays before each Youth CAHP Match Meeting.

The Youth CAHP Liaisons and/or their team are expected to review the list and submit a Pre-Check Form for all of their clients by 5 PM on the Friday before each Youth CAHP Match Meeting. The Pre-Check Form can be accessed via the Youth CAHP Toolbox. Once the Pre-Check Forms are received, the Youth CAHP Coordinator integrates the information into the BNL for the upcoming Youth CAHP Match Meeting.

This process makes it possible for participants' needs and preferences to be reflected during match meetings even if the case manager cannot attend. Completion of the Pre-Check Form does not guarantee that the participant will be matched to a housing resource. Information gathered via the pre-check process is maintained on the BNL; if a Pre-Check Form was submitted and the participant has not been matched, the Youth CAHP Coordinator will not request a new submission *unless* the original submission is more than six months old.

Youth CAHP Vacancy Reporting

Representatives from each Youth CAHP-participating housing program are expected to report their current vacancies to the Youth CAHP Coordinator by 5 PM on the Tuesday one week before the Match Meeting. Vacancies reported after this deadline may be accepted at the Youth CAHP Coordinator's discretion. If a housing program has vacancies that need to be filled, they should identify the name of the program, the number of vacancies, and any information about the vacancy needed to make an appropriate match (gender, LGBTQ-identifying, etc.).

Youth CAHP Match Meetings

Youth CAHP Match Meetings are the primary forum where participants ages 18-24 are matched to housing resources within the Youth CAHP system. These meetings are hosted and facilitated by the Youth CAHP Coordinator. Meetings are typically held two times per month (on the first and third Tuesday); two months out of the year, meetings are only held once per month to accommodate holiday schedules. Match Meetings are open to any staff member at a CAHP-participating agency who wishes to attend and has signed the DC HMIS User License Agreement.

While efforts are made to fill all vacancies during the Match Meeting, the Youth CAHP Coordinator may make matches offline in rare circumstances.

Matching Policies & Prioritization Criteria

Transitional Housing & Joint Transitional Housing/Rapid Rehousing

Matches to TH and Joint TH/RRH are made primarily from the BNL, but case conference referrals are also accepted (see Case Conferencing section below for more details).

Participants who scored between a 4 and 8 (inclusive) on their most recent VI-SPDAT or TAY-VI-SPDAT assessment are targeted for matches to TH and Joint TH/RRH.

Matches are distributed as follows:

- 60% - participants accessing youth and/or adult shelters who are not already assigned to another housing resource.
- 40% - participants engaged with youth and/or adult outreach and/or drop-in centers who are not already assigned to another housing resource.

Participants are prioritized by Date of ID (oldest to newest), with Assessment Score (highest to lowest) used as a tiebreaker in cases where clients have the same Date of ID.

Transitional Housing & Joint Transitional Housing/Rapid Rehousing: Age Out Prioritization

Resources within the Youth CAHP system are intended for transition-aged youth ages 18-24. While participants can remain in a Youth CAHP resource after turning 25, they can only be matched while still in the 18-24 age range. The community has identified participants who are close to aging out (i.e., close to turning 25) as a priority population since they will soon face a reduced number of housing resource options.

As such, for two TH or Joint TH/RRH matches during the first meeting of the month and for one TH or Joint TH/RRH match during the second meeting of the month, prioritization is applied as follows: Length of Time Before Aging Out (shortest to longest), with Date of ID (oldest to newest) then Assessment Score (highest to lowest) used as tiebreakers if needed.

As with standard TH and Joint TH/RRH criteria, participants who scored between a 4 and 8 (inclusive) on their most recent VI-SPDAT or TAY-VI-SPDAT assessment are targeted, and youth who are only interacting with shelters, outreach teams, and/or drop-in centers may be matched. However, matches made via this special priority policy are not factored into the 60/40 distribution as described above.

Transitional Housing for Survivors of Domestic Violence

DHS funds a youth transitional housing program specifically for participants who are survivors of domestic violence, sexual violence, and/or sex trafficking. Due to the specialized population that this program serves, matching to this program follows its own set of policies and prioritization criteria.

Case managers can submit referrals for this program at any time using the referral form on the Youth CAHP Toolbox. Referrals are accepted for youth interacting with youth and/or adult shelters, outreach teams, and/or drop-in centers who are not already assigned to another housing resource.

The Youth CAHP Coordinator will review all referrals, and if the referral is complete and meets program eligibility requirements, it will be added to the referral list.

From the referral list, participants are prioritized by Date of ID (oldest to newest), with Assessment Score (highest to lowest) used as a tiebreaker in cases where clients have the same Date of ID.

If there are more vacancies than referred participants, the Youth CAHP Coordinator will match clients from the BNL. Participants who scored between a 4 and 8 (inclusive) on their most recent VI-SPDAT or TAY-VI-SPDAT assessment, are only interacting with shelters, outreach teams, and/or drop-in centers, and answered "Yes" to question 15f on the TAY-VI-SPDAT (Is your current lack of stable housing because of an unhealthy or abusive relationship, either at home or elsewhere?) are targeted for these matches. Participants are prioritized by Date of ID (oldest to newest), with Assessment Score (highest to lowest) used as a tiebreaker in cases where clients have the same Date of ID.

Extended Transitional Housing

Matches to ETH are made primarily from the BNL, but case conference referrals are also accepted (see Case Conferencing section below for more details).

Participants who scored between 35 and 60 (inclusive) on their most recent Full SPDAT assessment are targeted for matches to ETH.

Matches are distributed as follows:

- 35% - participants accessing youth and/or adult shelters who are not already assigned to another housing resource.
- 35% - participants engaged with youth and/or adult outreach and/or drop-in centers who are not already assigned to another housing resource.
- 30% - participants currently in a youth or adult transitional housing program.

For matches made from shelters and outreach/drop-in centers, participants are prioritized by Date of ID (oldest to newest), with Assessment Score (highest to lowest) as a tiebreaker in cases where clients have the same Date of ID.

For matches made from TH, participants are prioritized by Assessment Score (highest to lowest), with Date of ID (oldest to newest) as a tiebreaker in cases where clients have the same Assessment Score.

Rapid Rehousing

Because of the short-term nature of this intervention, referrals are required. It is important that the program is a good fit for the participant's needs and preferences before making the referral. The referring provider is responsible for fully informing the participant of the program details and ensuring they understand the program's limitations.

Referrals are accepted on a rolling basis and can be submitted by any CAHP participating provider using the referral form on the Youth CAHP Toolbox. In order to be considered for a match in the upcoming match meeting, the referral needs to be submitted by 5 PM on the Friday before the meeting.

Youth CAHP Coordinator will review the referrals for completeness, eligibility, and appropriateness. Some factors that may be considered when determining appropriateness include assessment score, employment status/work history, and ability to live independently when reviewing referrals. It should be

noted, though, that clients with any assessment score can be referred and active employment is not required for RRH. If any significant concerns arise, the Youth CAHP Coordinator will follow up with the referring provider for further discussion. All referrals that are deemed complete, eligible, and appropriate are added to a list of active referrals.

Matches will be made from the referral list. To be considered for a match at any given match meeting, referred participants must be on the current BNL. Participants will be prioritized by referral date (oldest to newest).

Permanent Supportive Housing

The Youth CAHP System has a limited number of Permanent Supportive Housing (PSH) resources available specifically to transition-aged youth. Matches to these resources are identified through case conference referrals, not the BNL.

Participants matched to these resources must meet the criteria for chronic homelessness as defined by HUD and/or long stayer status.

Matches are distributed as follows:

- 80% - participants currently in an extended transitional housing program.
- 20% - participants engaged with any other resource/service (i.e., shelter, outreach, drop-in centers, and transitional housing).

Case Conferencing

A participant may be referred for case conferencing in the Youth CAHP System if one or more of the following criteria are met:

1. The participant is recommended for a housing resource that they could not be matched to through current prioritization policies.
2. The youth was a participant in a Youth CAHP housing program, exited to permanent housing, and is now re-experiencing homelessness.
3. The individual has one or more unmanaged Serious Mental Illness (SMI), Exceptional Medical Vulnerability (EMV), or Substance Use Disorder (SUD) that directly impacts daily activities and ability to maintain housing.
    a. Exceptional Medical Vulnerability (EMV) is defined as one of the following:
        - End stage renal disease (dialysis dependent)
        - Paralysis that impairs activities of daily living (ADLs), such as the result of a stroke
        - Congestive heart failure with exacerbations
        - Active cancer diagnosis/treatment
        - Difficult to control insulin-dependent diabetes mellitus (IDDM)
        - Poorly controlled auto-immune disorder (including AIDS)
        - Severe vision impairment
        - Severe respiratory illness, such as COPD with O2 requirement

- Major neurocognitive disorder (formerly called dementia) causing severe impairment
- Severe neurodegenerative disorders, such as ALS and severe MS
- Other rare, potentially life-threatening illness

b. Serious mental illness (SMI) and/or substance use disorder (SUD) - definition adapted from DC Department of Behavioral Health (DBH) Assertive Community Treatment (ACT) criteria
   - Participant must meet all three of the following:
     1. An intractable, serious, and persistent mental illness and/or substance use disorder
     2. One or more of the following:
        - High use of acute psychiatric hospitalization (two or more admissions per year) or F/EMS contacts; CPEP/mobile crisis visits; crisis stabilization services
        - Co-occurring substance use disorders of greater than 6 months
        - Recent history of criminal justice involvement (arrest or incarcerations) within the past 6 months
        - Chronically homeless
        - Residing in an inpatient setting for more than 3 months or supervised community residence but clinically assessed to live more independently with increased community-based services
        - Has documented inability to sustain involvement with or remain engaged in traditional office-based services
     3. One or more of the following:
        - Significant difficulty consistently performing the range of daily tasks required to live in the community
        - Significant difficulty maintaining consistent employment
        - Significant difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing, or being burglarized or robbed due to mental instability)

4. The individual is actively fleeing or attempting to flee domestic violence; has no other residence; and lacks the resources or support networks to obtain other permanent housing.

Participants referred for case conferencing must also have both a TAY VI-SPDAT and a Full SPDAT completed and documented in HMIS which accurately reflect the client's current situation.

The case conference referral and review process is as follows:

1. Case managers will submit their referral via the Youth CAHP Case Conferencing Referral Form, which can be accessed in the Youth CAHP Toolbox. Referrals may be submitted at any time, but the deadline for consideration for a particular Match Meeting is 5 PM on the Tuesday one week prior to the meeting. Each provider is allowed to submit up to two case conference referrals per Match Meeting.

2. The Youth CAHP Coordinator will review all referrals in the order they were submitted. The CAHP Coordinator will determine if the referral is complete and meets the criteria selected. If the referral is incomplete, the CAHP Coordinator will notify the referring provider that additional information is needed. The referring provider will be given the opportunity to provide further details and resubmit the referral, if needed. If the referral does not meet the selected criteria, the CAHP Coordinator will notify the referring provider that the referral is denied and the reason behind the denial. If the referral is complete and meets the selected criteria, it will move to the next step.
3. The CAHP Coordinator will compare all complete and qualifying referrals against the vacancies available for the upcoming Match Meeting. Referrals will only move forward to the Match Meeting if there is a vacancy available for the recommended housing resource. When there are no appropriate vacancies available, the CAHP Coordinator will notify the referring provider that the referral will be held on a tracker sheet managed by the CAHP Coordinator until an appropriate vacancy becomes available.
    a. When determining which referrals will move forward for a particular meeting, the CAHP Coordinator will first consult the tracker sheet and select any and all referrals for which appropriate vacancies are available in the order in which they were submitted. If there are still vacancies available, the CAHP Coordinator will then pull from the new referrals.
4. On the Thursday prior to the Match Meeting, the CAHP Coordinator will send an email to the Community with information for all participants who will be reviewed via case conferencing during the upcoming Match Meeting.
5. During the Match Meeting, the referring provider will explain the participant's situation and the reason for the case conference to the Community. There will be an opportunity for a brief community discussion with an emphasis on providing space for other providers who know the participant to share their own experience/recommendation for the participant.
6. The participant will then be matched to the recommended housing resource as long as the referring provider maintains their original recommendation after the brief community discussion.

Post-Match Process

Within 48 hours of each Youth CAHP Match Meeting, the Youth CAHP Coordinator will send an email to the Youth CAHP Community with a list of the participants that were matched to a housing program. The list will include the client's names, HMIS IDs, the program matched to, the Current Point of Contact (POC), and the Housing Program's POC. This email signifies that the matches are confirmed and next steps in the post-match process should begin.

Upon receipt of this email, Current POCs will inform the participant of the match, explain the housing program and move-in process, ensure the participant is interested in the housing program, and help the participant gather vital documents and TB test results, if required by the program

Within 72 hours of receiving the match email from the Youth CAHP Coordinator, Current POCs will also complete the CAHP Warm Hand Off Form with the participant.

Once the CAHP Warm Hand Off Form is complete, the Current POCs will upload CAHP Warm Hand Off Form to HMIS and email it to the Housing Program's POC (with DHS & TCP CAHP teams copied).

The Housing Program POC and Current POC will collaborate to complete a warm handoff, meet and greet, and/or intake, according to the housing program's internal processes. Housing programs should not move forward with scheduling intake/move in until they receive the CAHP Warm Hand Off Form.

Participants should complete intake and enter their assigned housing program within two weeks of the match. While this may not always be possible, this should be the goal for every participant and every housing program.

Throughout the post-match process, both POCs will document all updates in the applicable month's Match Tracker. If no notes are documented on the Match Tracker or further information is required, the Youth CAHP Coordinator will email a request for updates to both POCs six business days from the match (i.e., the Wednesday one week after the Match Meeting).

Participants may be unassigned from the program in which they were matched to due to lack of engagement, declining placement, and/or other circumstances that the Youth CAHP Coordinator deems appropriate to unassign. Unassignments are confirmed and communicated by the Youth CAHP Coordinator.

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Veterans System

Coordinated Assessment and Housing Placement (CAHP) System Manual

Contents

Matched through Veterans CAHP: Housing Resources 42
Veterans Affairs Supportive Housing (VASH) 42
Non-VASH Permanent Supportive Housing (PSH) 42
Not matched through Veterans CAHP: SSVF 42
Veterans CAHP Case Conferencing and PSH Matching Procedures 42
Definitions 42
Preparing for Matching 44
Veterans CAHP Case Conferencing Criteria (PSH) 44
Veterans CAHP Prioritization Criteria 46
Prioritization Criteria for VASH Resources 46
Prioritization Criteria for Non-VASH Resources 47
Veterans CAHP Matching Process 48
Offline Matches 48
Veterans CAHP Match and Case Discussion Meeting 49
Revising the Veterans Prioritization and Case Conferencing Criteria 49
Veterans CAHP Outreach Strategy 50
Veterans Outreach Teams Schedules 50
VA Outreach 50
Friendship Place 50
Housing Counseling Services 50
Operation Renewed Hope Foundation 51
Veterans Outreach Meeting 51
Veterans By Name List Referral Process 51
Outreach Engagement Expectations and Best Practices 51
Removing a Veteran from the Outreach List 52

Matched through Veterans CAHP: Housing Resources

In the Veterans system, the CAHP Coordinator only makes matches to Permanent Supportive Housing (PSH) resources. These resources are ongoing housing interventions through which a Veteran receives rental assistance and housing case management support. Some programs are tenant-based – the Veteran has their choice of apartments on the private market – while others are unit-based, meaning the unit itself is subsidized. A summary of the current resources and programs will be available on the forthcoming Veterans CAHP Toolbox.

Veterans Affairs Supportive Housing (VASH)

The VASH program is the result of collaboration between two agencies' programs: the Department of Housing and Urban Development (HUD)'s Housing Choice Voucher (HCV) rental assistance program and the Department of Veterans Affairs (VA)'s case management and clinical services. Veterans and Veteran households matched to this program receive rental assistance and supportive services to resolve their homelessness. Similar to Permanent Supportive Housing (PSH), VASH allows unaccompanied Veterans and Veteran households to lease up in rent-reasonable units on the private housing market (tenant-based) or at specific buildings in which the unit itself is subsidized (unit-based).

Non-VASH Permanent Supportive Housing (PSH)

Unfortunately, not all Veterans in need of PSH-level support are eligible for VASH. To fill this gap, the District's CoC has established several programs that specifically serve Veterans who are denied VASH due to their service history, discharge status, or other reasons. We are pleased to be able to offer PSH resources through DHS and CoC/HUD funding. Like VASH or PSH in other subsystems, these programs offer rental assistance and supportive services. Resources in this category include both tenant-based or voucher resources and site-based resources for unaccompanied Veterans and Veteran households.

Not matched through Veterans CAHP: SSVF

Supportive Services for Veteran Families (SSVF) is the Veterans system's version of rapid rehousing. These programs do not take matches through CAHP. Rather, they enroll Veterans they engage through outreach, their screening lines, or who are referred to them.

Veterans CAHP Case Conferencing and PSH Matching Procedures

Veterans experiencing homelessness are eligible for resources in both the Single Adults and Family CAHP Systems. However, the following procedures and criteria are unique to the Veterans Coordinated Assessment and Housing Placement (CAHP) system and contain intentional, appropriate differences from the other CAHP case conferencing procedures and criteria. These guidelines have been developed, reviewed, and implemented by the Veterans NOW work group and Veterans CAHP community participants under the DC Interagency Council on Homelessness' (ICH) leadership and committee structure. For more information about matching and case conferencing in the other subsystems, please refer to their sections of this manual.

Definitions

Veteran: Anyone who has served in the US Military in any capacity or branch of service, regardless of how long served or discharge status. The Veterans system can support single adult Veterans and Veteran families.

Chronic homelessness: The Veterans CAHP system adheres to the HUD definition of chronic homelessness. This means Veterans must be:

1. Homeless for 12+ consecutive months
   OR
2. Homeless 4+ times in the last 3 years adding up to 12+ months
   AND
3. Have a disabling condition

According to VA HUD VASH policy, time spent in GPD programs does not count towards a Veteran's chronic status, but time spent in VA Contract Bed Transitional Housing program is counted towards chronic status.

Chronic status is typically confirmed using HMIS service engagements. However, in the event that a Veteran's history of homelessness is not adequately reflected in HMIS, providers may report chronic status to the Veterans CAHP Coordinator.

Date of ID: The Veterans CAHP system adheres to the USICH's definition of date of identification. This means that the date a Veteran is first identified as experiencing homelessness is the date a homeless Veteran first makes contact with a point of entry in the homeless services system according to DC's HMIS system. This includes Veterans experiencing homelessness for the first time and those who may be re-entering homelessness after having exited for at least 90 days.

BNL: "by-name list"; list of all known information on consumers who have engaged with the system in the month prior. BNL data is used to make matches based on prioritization policies.

Active: Veteran has at least one service engagement of any type over the past 3 months. This includes shelter stays, engagement through outreach or other services (excluding Project Reconnect), and any newly completed VI-SPDAT and Full SPDAT assessments.

Inactive: Veteran has NOT had an engagement of any sort over the course of the past 3 months.

Prioritization Criteria: Community-approved combinations of different benchmarks used to determine prioritization order in selecting Veterans for highly limited housing resources.

Case Conferencing: Process to add context and insights on consumers in instances where data falls short of communicating intensive needs and/or factors that may otherwise go overlooked in prioritization. Case managers submit referrals to let the CAHP team know about this additional information).

VA Priority Populations: Target populations for HUD-VASH per VHA Directive 1162.05(2), amended June 24, 2024 (available at https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=5437).

> "Chronically homeless Veterans will be given the highest priority for admission.
>
> *" 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. J

"(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."

Preparing for Matching

Matching begins with the creation of the By Name List (BNL). On the first day of the month (or closest business day), the Veterans CAHP Coordinator pulls reports from HMIS to compile the BNL. The BNL includes all active Veterans known or assumed to be experiencing literal homelessness in Washington, DC, including those with a current match to a housing intervention and those with an approved case conference referral. Agencies must have their HMIS data entry from the prior month completed by 11:59:59pm on the last calendar day of the month for their records of Veteran engagement to be reflected on the BNL.

Anyone in HMIS with an indication of possible military service history is included in the BNL. The Veterans CAHP Coordinator searches for those without verified service history in SQUARES and provides that same list to the VA Outreach Team to search their eligibility in VIS. Individuals remain on the Veterans BNL until it is confirmed that they do not have military service history through these search mechanisms or a DD214.

After compiling the BNL, the Veterans CAHP Coordinator sorts the list using the prioritization criteria. They send it to the VA Coordinated Entry Specialist by the first Friday of the month.

Veterans CAHP Case Conferencing Criteria (PSH)

Throughout the month, staff at CAHP-participating providers may submit case conference referrals using the Veterans CAHP Veteran Information Submission Form. Before creating the BNL, at the end of the previous month, the Veterans CAHP Coordinator reviews and approves case conferencing referrals to manually add to the BNL. They notify the referring provider and the VA Coordinated Entry Specialist of the referral's status upon review.

As part of the prioritization process and to gather additional vulnerability information that may not be reflected in HMIS data, the Veterans CAHP system established eight case conferencing criteria. They are:

1. The Veteran is housed in or matched to a PSH program but would benefit from connection to another PSH program to appropriately address service needs. Reasons for needing connection to another PSH program can include: eligibility, needing site-based housing as opposed to scattered site, or if housed, preventing the individual from re-experiencing homelessness, safety concerns, and accessibility accommodations.
2. The Veteran is re-experiencing homelessness after previously obtaining housing, through any resource, regardless of whether or not they were matched to this resource through Veterans CAHP.
3. The Veteran was previously matched to a PSH resource, but was unassigned, for any reason.
4. The Veteran has historically refused housing assistance, but is now interested in pursuing housing opportunities.
5. The Veteran is part of a household experiencing homelessness with minor children.
6. The Veteran would not correctly appear on the By Name List that is used to make matches for one or more of the following reasons
    a. Capacity constraints related to HMIS data entry where service engagements are not regularly recorded.
    b. HMIS data errors in the assignment, move in, and/or re-experience fields on a Veteran record
    c. Regional activity, where Veteran is currently experiencing homelessness in a surrounding county and would prefer to obtain housing in DC. Veterans meeting this criterion MUST have had a history of housing/homelessness in DC.
    d. Experiencing literal homelessness after enrollment with prevention or aftercare
    e. The Veteran is on the By Name List but their date of identification and/or chronic status is not accurately reflected in HMIS.
7. The Veteran is housed through SSVF (RRH or Shallow Subsidy) but would benefit from connection to PSH to appropriately address service needs and/or prevent the individual from re-experiencing homelessness.
    a. Veterans meeting this criterion MUST be assessed with a Full SPDAT before case conferencing.
    b. NOTE: It is recommended that SSVF providers begin reviewing Veterans enrolled with RRH to see if they should be case conferenced for a potential step up to PSH if they have not stabilized after being housed for five months. This includes completing a Full SPDAT as part of that decision-making process. Veterans enrolled with Shallow Subsidy who have not stabilized after 15-18 months of being housed through the program OR who have needed to exit Shallow Subsidy to re-enroll with RRH for additional rental assistance and CM should also be reviewed to see if they should be case conferenced for a potential step up to PSH.
8. The Veteran is housed and enrolled in SSVF Prevention or Aftercare but would benefit from connection to PSH to appropriately address serve needs and/or prevent the individual from re-experiencing homelessness.
    a. Veterans meeting this criterion MUST be assessed with a Full SPDAT before case conferencing.
    b. This criterion applies to HUD-VASH matches only. Veterans must belong to a VA Priority Population as defined above (VHA Directive 1162.05(2), amended June 24, 2024 (available at https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=5437)).

Veterans CAHP Prioritization Criteria

Prioritization criteria are split into two sets: for VASH resources and for non-VASH resources. The Veterans CAHP Coordinator and VA Coordinated Entry Specialist review the BNL in these orders.

Prioritization Criteria for VASH Resources

The Veterans CAHP Coordinator will organize the BNL include the following groups and sort them in accordance with the criteria.

1. **Group 1:** PSH Transfers. Veterans who meet case conference criterion #1
    a. All transfers are matched before moving forward with case conference referrals and the BNL.
2. **Group 2:** Non-chronic housing step ups. Veterans who meet case conference criterion #7 but do not meet the definition of chronic homelessness.
    a. Only utilized when there is at least more vacancy available for chronic Veterans than for non-chronic in the match cycle. For example, to match 3 non-chronic housing step ups, there must be 4 vacancies available for chronic Veterans, meaning a total of 7 available vacancies.
    b. VASH: Up to 3 Veterans in this group may be matched per match cycle.
    c. In the event there is more than one Veteran who meets this criterion, the Veterans CAHP Coordinator will sort them by Full SPDAT score. Length of time (number of months) remaining in SSVF (shortest to longest) will serve as the tie-breaker, if needed.
3. **Group 3:** Prevention. Veterans who meet case conference criterion #8.
    a. Only utilized when there is at least more vacancy available for chronic Veterans than for non-chronic in the match cycle. For example, to match 3 non-chronic housing step ups, there must be 4 vacancies available for chronic Veterans, meaning a total of 7 available vacancies.
    b. Only one Veteran in this group may be matched per match cycle.
    c. In the event there is more than one Veteran who meets this criterion, the Veterans CAHP Coordinator will sort them by Full SPDAT score. Length of time (number of months) remaining in SSVF (shortest to longest) will serve as the tie-breaker, if needed.
4. **Group 4:** Chronic, meets case conferencing criteria 2-5. Veterans whose case conference referrals have been approved and meet the definition of chronic homelessness.
    a. In the event there is more than one Veteran in this group, the Veterans CAHP Coordinator will sort them by Date of ID (oldest to newest). Full SPDAT scores (highest to lowest) will serve as the tie-breaker, if needed. In the unlikely event two or more Veterans have the same Date of ID and Full SPDAT score, their highest VI-SPDAT score will serve as the final tie-breaker.
5. **Group 5:** Chronic BNL (includes case conference criterion #6). Veterans who are on the BNL without a case conference referral and meet the definition of chronic homelessness.
    a. In the event there is more than one Veteran in this group, the Veterans CAHP Coordinator will sort them by Date of ID (oldest to newest). Full SPDAT scores (highest to lowest) will serve as the tie-breaker, if needed. In the unlikely event two or more Veterans have the same Date of ID and Full SPDAT score, their highest VI-SPDAT score will serve as the final tie-breaker.
6. **Group 6:** Chronic step ups. Veterans who meet case conference criterion #7 and met the definition of chronic homelessness prior to becoming housed.

   a. In the event there is more than one Veteran who meets this criterion, the Veterans CAHP Coordinator will sort them by Full SPDAT score. Length of time (number of months) remaining in SSVF (shortest to longest) will serve as the tie-breaker, if needed.
7. **Group 7:** Not chronic, meets case conferencing criteria 2-5. Veterans whose case conference referrals have been approved and do not meet the definition of chronic homelessness.
   a. In the event there is more than one Veteran in this group, the Veterans CAHP Coordinator will sort them by Date of ID (oldest to newest). Full SPDAT scores (highest to lowest) will serve as the tie-breaker, if needed. In the unlikely event two or more Veterans have the same Date of ID and Full SPDAT score, their highest VI-SPDAT score will serve as the final tie-breaker.
8. **Group 8:** Not chronic BNL (includes case conference criterion #6). Veterans who are on the BNL without a case conference referral and do not meet the definition of chronic homelessness.
   a. In the event there is more than one Veteran in this group, the Veterans CAHP Coordinator will sort them by Date of ID (oldest to newest). Full SPDAT scores (highest to lowest) will serve as the tie-breaker, if needed. In the unlikely event two or more Veterans have the same Date of ID and Full SPDAT score, their highest VI-SPDAT score will serve as the final tie-breaker.

Prioritization Criteria for Non-VASH Resources

1. **Group 1:** PSH Transfers. Veterans who meet case conference criterion #1
   a. All transfers are matched before moving forward with case conference referrals and the BNL.
2. **Group 2:** Non-chronic housing step ups. Veterans who meet case conference criterion #7 but do not meet the definition of chronic homelessness.
   a. Only utilized when there are at least five vacancies in the match cycle.
   b. Only one Veteran in this group may be matched per match cycle.
   c. In the event there is more than one Veteran who meets this criterion, the Veterans CAHP Coordinator will sort them by Full SPDAT score. Length of time (number of months) remaining in SSVF (shortest to longest) will serve as the tie-breaker, if needed.
3. **Group 3:** Chronic, meets case conferencing criteria 2-5. Veterans whose case conference referrals have been approved and meet the definition of chronic homelessness.
   a. In the event there is more than one Veteran in this group, the Veterans CAHP Coordinator will sort them by Date of ID (oldest to newest). Full SPDAT scores (highest to lowest) will serve as the tie-breaker, if needed. In the unlikely event two or more Veterans have the same Date of ID and Full SPDAT score, their highest VI-SPDAT score will serve as the final tie-breaker.
4. **Group 4:** Chronic BNL (includes case conference criterion #6). Veterans who are on the BNL without a case conference referral and meet the definition of chronic homelessness.
   a. In the event there is more than one Veteran in this group, the Veterans CAHP Coordinator will sort them by Date of ID (oldest to newest). Full SPDAT scores (highest to lowest) will serve as the tie-breaker, if needed. In the unlikely event two or more Veterans have the same Date of ID and Full SPDAT score, their highest VI-SPDAT score will serve as the final tie-breaker.
5. **Group 5:** Chronic step ups. Veterans who meet case conference criterion #7 and met the definition of chronic homelessness prior to becoming housed.

a. In the event there is more than one Veteran who meets this criterion, the Veterans CAHP Coordinator will sort them by Full SPDAT score. Length of time (number of months) remaining in SSVF (shortest to longest) will serve as the tie-breaker, if needed.

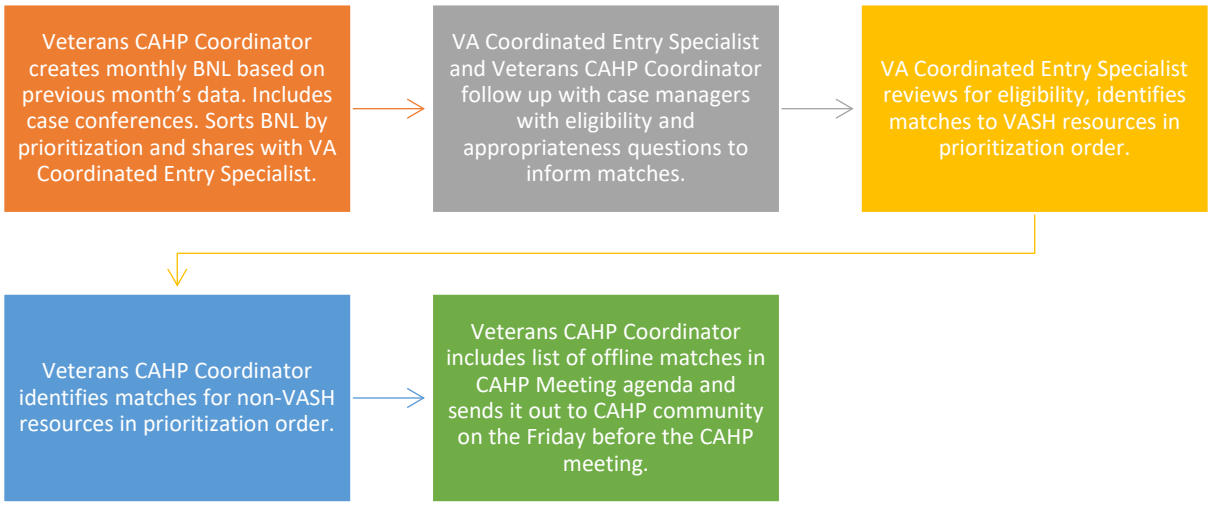
Under the HSRA, District-funded resources are open to Veterans at risk of chronic homelessness.

6. **Group 6:** Not chronic, meets case conferencing criteria 2-5. Veterans whose case conference referrals have been approved and do not meet the definition of chronic homelessness.
    a. In the event there is more than one Veteran in this group, the Veterans CAHP Coordinator will sort them by Date of ID (oldest to newest). Full SPDAT scores (highest to lowest) will serve as the tie-breaker, if needed. In the unlikely event two or more Veterans have the same Date of ID and Full SPDAT score, their highest VI-SPDAT score will serve as the final tie-breaker.
7. **Group 7:** Not chronic BNL (includes case conference criterion #6). Veterans who are on the BNL without a case conference referral and do not meet the definition of chronic homelessness.
    a. In the event there is more than one Veteran in this group, the Veterans CAHP Coordinator will sort them by Date of ID (oldest to newest). Full SPDAT scores (highest to lowest) will serve as the tie-breaker, if needed. In the unlikely event two or more Veterans have the same Date of ID and Full SPDAT score, their highest VI-SPDAT score will serve as the final tie-breaker.

Veterans CAHP Matching Process

Offline Matches

Tentative matches to all Veterans resources are made offline throughout the month following the process depicted in the figure below. Matches are considered tentative until confirmed during the monthly CAHP meeting.



Veterans CAHP Match and Case Discussion Meeting

Monthly, on the last Tuesday of the month, the Veterans CAHP Coordinator holds the Veterans CAHP Match and Case Discussion meeting virtually. It is open to anyone providing housing navigation case management to Veterans in the DC system who have DC HMIS access. This may include SSVF providers, outreach teams, shelter staff, GPD, and TH staff. They are not required to work at a Veterans-specific agency or program. The agenda includes:

- Announcements
    - Any upcoming events, new resources, update processes, and changes to contacts on teams
- Housed in previous month
    - Review the list of Veterans who show as housed during the previous month in HMIS.
    - Staff should comment if any of the information is incorrect or if anyone is missing from the list.
- Offline match review
    - Review the list of Veterans matched offline to all Veterans-specific housing resources over the month.
    - Staff should share:
        - If there is any reason not to move forward with the match
        - Any additional information that could help with the warm handoff process: contact information, new points of contact, location information, housing preferences, barriers, and needs.
- Case discussion
    - Designated time to troubleshoot any Veteran-specific challenges with housing navigation. Examples include determining eligibility, making a plan for an impending eviction, how to support a medically vulnerable Veteran.
- CAHP Q&A: How to participate in CAHP processes
    - Designated time to answer questions about how to utilize the CAHP tools and processes.

After the meeting, the Veterans CAHP Coordinator sends out the notes with confirmed matches to Veterans and records the matches in HMIS. Upon receiving the VASH case manager information from the VASH Team, they will also record that information in HMIS. Housing providers and homeless services responses teams are to collaborate on the warm handoff process and follow the appropriate post-match steps for each resource type.

Revising the Veterans Prioritization and Case Conferencing Criteria

These policies will be reviewed and revised in accordance with the process laid out in an earlier part of this manual. However, the system acknowledges that as it gets closer to reaching functional zero, policies may need to be revised outside of that established procedure. If the number of Veterans experiencing literal homelessness in Washington, DC reaches 100 or lower for two consecutive months, per the CAHP Veterans Inflow/Outflow Dashboard, then the CAHP Team will lead the Veterans Now Workgroup to review and revise these policies.

The Community Partnership
For the Prevention of Homelessness

Veterans CAHP Outreach Strategy

To drive toward functional zero, the Veterans CAHP system has designed an outreach strategy to ensure all Veterans in DC are offered Veterans-specific resources. This strategy enables collaboration between Friendship Place (FP) Supportive Services for Veteran Families (SSVF), Housing Counseling Services (HCS) Supportive Services for Veteran Families (SSVF), Operation Renewed Hope Foundation (ORHF) Supportive Services for Veteran Families (SSVF), and the VA's outreach team. While the SSVF teams may take their own direct referrals from entry points such as the VA CRRC, VAMC, MOVA, GPD, SSVF, providers in surrounding jurisdictions, landlords, and self-referral, this strategy includes assignments from the monthly DC Veterans BNL.

Veterans Outreach Teams Schedules

Outreach teams will maintain consistent schedules to ensure adequate coverage across the District. There are no assigned catchment areas, but teams will routinely visit known locations where Veterans are often found to increase engagement. While these schedules are subject to change, as of this writing in September 2026, outreach teams utilize the following schedule in addition to traditional street outreach. This schedule is subject to available staffing and may change. Anyone hoping to connect with a team is encouraged to call the provider to confirm they will be at a location that week.

VA Outreach

Location	Monthly Schedule
Miriam's Kitchen	2nd and 4th Tuesday
Georgetown Ministry Center	as needed
Adams Place Day Center	Every other Tuesday
801 East Shelter	as needed
Downtown Day Service Center	Every other Tuesday
Union Station	Every Tuesday
CCNV Shelter	Every Tuesday
Martin Luther King Jr. Memorial Library	Every Tuesday
Encampment visits and canvassing	Every Thursday and according to DMHHS schedule

Friendship Place

Location	Monthly Schedule
VA Community Resource and Referral Center (CRRC)	Every Tuesday
New York Avenue Shelter	1st and 3rd Wednesday
801 East Shelter	1st and 3rd Wednesday
DC VAMC, Downtown Day Service Center, Adams Place Day Center	Biweekly, no set day of the week

Housing Counseling Services

Location	Schedule

VA Community Resource and Referral Center (CRRC)	2nd and 4th Thursday
Access Housing GPD	1st Friday
Father McKenna Center	3rd Monday
Central Union Mission	3rd Monday

Operation Renewed Hope Foundation

Location	Schedule
VA Community Resource and Referral Center (CRRC)	1st and 3rd Friday

Veterans Outreach Meeting

On the second Wednesday of the month, the Veterans CAHP Coordinator hosts the Veterans Outreach Meeting. During this time, the outreach teams will review their caseloads and provide updates. This is also a great space to troubleshoot any challenges or barriers they are encountering with a Veteran's housing progress. The Veterans CAHP Coordinator will also bring relevant data points to discuss during the meeting to help guide our shared strategy. These may include current list of Veterans declining housing assistance, list of Veterans who went inactive since the previous month, list of Veterans experiencing homelessness for the first time this month, and Veterans with unknown eligibility status.

Veterans By Name List Referral Process

Each month, the VA Coordinated Entry Specialist assigns Veterans from the BNL to each case load based on their vacancies. The shared goal is to assign 25% of Veterans declining housing assistance to a case load each month to explore barriers to housing and support with Veterans' identified needs.

Outreach Engagement Expectations and Best Practices

The goal of engaging these Veterans is to help them move from the identification phase of the housing process to service connection for progressive engagement. Each outreach team must attempt to engage Veterans on their list at least once every two weeks and input updates before the monthly outreach meeting in the shared outreach spreadsheet maintained by the Veterans CAHP Coordinator. Outreach teams engaging Veterans will work on the following and more:

- Ensure all information is correct and up to date for Veterans in HMIS
- Verify missing identifying information for SQUARES/VIS look up and support Veterans to request copies of their DD214s
- Explore what kinds of services and housing the Veteran is interested in and eligible for
- Complete a VI-SPDAT and/or Full SPDAT with the Veteran to help determine what kinds of services and housing the Veteran is appropriate for
- Collect vital documents and upload them to HMIS to prepare for referral to housing resources
- Refer the Veteran to singles and/or Veteran-specific Transitional Housing
- Complete case conferencing referrals
- Refer Veterans to PSH opportunities in the Single Adults or Families systems if unable to be served in the Veterans system.

- Check for SSVF enrollment and schedule intakes into the program.

It is possible that Veterans may be engaged by multiple providers – outreach and shelter. Outreach teams should ask about who else the Veteran may be working with in order to coordinate care. Upon identifying that a Veteran is receiving services, outreach providers should send an email to the provider using established contact sheets or by reaching out to the Veterans CAHP Coordinator for connection assistance to notify the provider of the Veterans whereabouts, needs, and contact information.

Removing a Veteran from the Outreach List

If Veterans meet the following criteria, they will be exited from the outreach list:

- Unable to be located after meaningful outreach attempts over a 60-day period, including in person to their last known location, connection to known points of contact, reach out to Vets CAHP Coordinator for any updated points of contact and known locations, reach out to VA Outreach team to check for any services through the VA system, and checking with local hospitals/jail/morgue
- Successfully enters TH, as indicated by HMIS entry into TH or outreach provider verification of entry (unless outreach provider needed for continuity of care)
- Successfully enrolls with SSVF or Singles RRH, as indicated by HMIS enrollment and a warm hand-off between outreach provider and SSVF/RRH provider is completed
- Successfully intakes with PSH and a warm hand off between outreach provider and PSH provider is completed, as indicated by outreach provider verification
- Self-resolves, as indicated by HMIS information or outreach provider verification
- Determined to be not literally homeless, as indicated by HMIS information or outreach provider verification
- Determined to be a non-Veteran, as indicated by HMIS information or outreach provider verification
- Veterans and/or providers request for Veterans to be transferred from one outreach provider to another due to Veteran preference, provider capacity, etc.
- Adamantly declined housing assistance, meaning the Veteran requested not to be contacted further. After this, the Veterans CAHP Coordinator maintains responsibility to track their preference, in coordination with outreach teams and other providers, on a monthly basis.
- Declined assistance for six months and the outreach team has tried to complete all activities listed under the goals of outreach. After that, the Veteran will be referred to as a Veteran who has historically declined housing. The Veterans CAHP Coordinator will assign the Veteran to another outreach team and then maintains responsibility to track their preference, in coordination with outreach teams and other providers, on a monthly basis.

For Veterans known to be declining housing, if it comes time to exit them from an outreach team's case load, they will be assigned to a different outreach team to attempt engagement for an additional month.

The Community Partnership
For the Prevention of Homelessness

Family System

Coordinated Assessment and Housing Placement (CAHP) System Manual

Contents

Family CAHP Matching 54

Prioritization Criteria 54

Match Meeting Procedures 55

- Pre-Check Procedures 55
- Match Meeting Cadence 56
  - Family Re-Housing Stabilization Program (FRSP) 56
  - Short Term Family Housing (STFH)/ Transitional Housing (TH) 56
- Post-Match Meeting Process 56

Case Conferencing 57

- Case Conferencing Criteria: 57
- Case Conference Review Process: 58

Family CAHP Matching

The Family CAHP system utilizes the By Name List (BNL) and Case Conferencing to make matches to permanent housing resources that are available in the Family subsystem. Prioritization policies that are agreed upon by the community that are applied to the BNL to inform which families should be prioritized for a match to a housing resource. Matches within the Family CAHP system are made to Permanent Supportive Housing.

Prioritization Criteria

All matches to the available Tenant Based PSH vouchers come from Short Term Family Housing, Transitional Housing, and Family Rehousing Stabilization Program with the following allotment applied:

1. 90% of matches are made through FRSP
2. 10% of matches are made through STFH/TH

For FRSP Family CAHP Match Meetings, the following prioritization criteria is applied:

1. 20% of matches are made through case conference referrals.
2. 80% of matches are made from the BNL. The following prioritization criteria is applied to the BNL.
    a. 80% of matches are made by sorting by Length of Time (LOT) in FRSP and then Full SPDAT (F-SPDAT) Score.
        i. Length of Time: Families are identified for a possible match based on their LOT in FRSP. Priority is given to families with the longest LOT in FRSP.
        ii. Assessment Score: If there is more than one family with the same LOT, then the family's current F-SPDAT Score is used as a second level of prioritization.
    b. 20% of matches are made by sorting by Full SPDAT Score and then Length of Time (LOT) in FRSP.
        i. Assessment Score: Families are identified for a possible match based on their assessment score from the Family Full SPDAT. Priority is given to families with the highest F-SPDAT Score.
        ii. Length of Time: If there is more than one family with the same assessment score, the family's current length of time is used as a second level of prioritization.

For STFH/TH Family CAHP Match Meetings, the following prioritization criteria is applied:

1. All matches must meet chronicity requirements.
    a. Sorted by F-SPDAT Score (Largest to Smallest)

For matches available to DHS site-based PSH housing resources, the following prioritization criteria is applied:

1. All matches will be made by looking at all referrals submitted for a specific program, sorted by Length of Time then F-SPDAT Score.

a. Length of Time: If there is more than one family with the same assessment score, the family's current length of time is used as a second level of prioritization.
b. F-SPDAT Score: Families are identified for a possible match based on their assessment score from the Family Full SPDAT. Priority is given to families with the highest F-SPDAT Score.

For matches available to HUD/TCP site-based PSH housing resources, the following prioritization is applied:

1. All matches will be made by looking at all referrals submitted for a specific program, sorted by Length of Time then F-SPDAT Score.
    a. Length of Time: If there is more than one family with the same assessment score, the family's current length of time is used as a second level of prioritization.
    b. F-SPDAT Score: Families are identified for a possible match based on their assessment score from the Family Full SPDAT. Priority is given to families with the highest F-SPDAT Score.

Note: For all site-based PSH resources, a referral must be submitted to be considered for a match. The referral forms can be found on the Family CAHP toolbox. For Site Based PSH resources funded by DHS, matches are only made from FRSP referrals. For Site Based PSH resources funded by HUD/TCP, matches are made from FRSP and STFH/TH, but must meet the chronicity requirements.

Match Meeting Procedures

Pre-Check Procedures

The Pre-Check Form is a questionnaire formulated by the CAHP Coordinator to gather information on families that may come up for a match to a housing resource at the next Match Meeting. This form covers material that is not identified in the By Name List (BNL) which will help drive an informed match to a housing resource. In addition, the Pre-Check Form identifies who will be the point of contact for the individual if a match to a housing resource occurs. All providers have access to the Pre-Check Forms on the Family CAHP Toolbox.

The CAHP Coordinator will use the BNL to determine which families warrant the need to have a Pre-Check Form completed, based on prioritization. The families identified will be from the Family Re-Housing Stabilization Program (FRSP), Short Term Family Housing (STFH), and Transitional Housing (TH). The families are entered into a Microsoft Excel document which lists the HMIS IDs of the Head of Household's (HoH), the current program they are in, prioritization applied, and historical/current notes. The CAHP Coordinator sends this list to Family CAHP Liaisons via email at least one week before each Family CAHP Match Meeting. The CAHP Liaisons and/or their team are expected to complete all of the designated pre-checks by 12 PM on the following Wednesday before the Family CAHP Match Meeting.

Once the pre-checks are received, the CAHP Coordinator will review the pre-checks and integrate the information into the BNL prior to the next Family CAHP Match Meeting. **The completion of the Pre-Check Form does not guarantee that the family will be matched to a housing resource.** If there is a completed pre-check and the family has not been reviewed in a match meeting yet, then the providers do not need to complete a new one as that information will be maintained on the BNL for future

meetings should the family come up for a match. If there have been any changes in the family's situation or adjustments need to be made to the previous Pre-Check submitted, then the provider should submit a new Pre-Check to reflect those changes in order to be incorporated into the next BNL as an update.

Match Meeting Cadence

Family Re-Housing Stabilization Program (FRSP)

Family CAHP Match Meetings for FRSP providers occur on the second and fourth Thursday of the month via Zoom. These meetings occur from 9:30 AM – 12:00 PM. FRSP CAHP Liaisons are expected to be present to provide information on the families currently in their program that may come up for a match to tenant based PSH. The time and day of match meetings are subject to change.

Short Term Family Housing (STFH)/ Transitional Housing (TH)

Family CAHP Match Meetings for STFH/TH providers occur on the third Thursday of the month via Zoom. These meetings occur from 9:30 AM – 12:00 PM. STFH/TH CAHP Liaisons are expected to be present to provide information on the families currently in their program that may come up for a match to tenant based PSH. The time and day of match meetings are subject to change.

Post-Match Meeting Process

Following the Family CAHP Match Meeting, the CAHP Coordinator will email the CAHP Liaisons and representatives from DHS a password protected Excel that contains the list of families that were matched during that meeting. This includes but is not limited to, the HoH's HMIS ID, First Name, Last Name, Current Program, Current Program's CAHP Liaison, Program Matched To, and Program Matched To's Point of Contact. In addition, this Email will contain next steps for the current program and DHS leads.

If a family was matched to PSH, then FRSP Providers must complete the following:

1. Complete the Transfer Summary Form within the next 5 business days. Once this form is filled out online, it will automatically be sent to DHS for review.
2. Review the DHS CAHP one-pager and video. The resources can be shared with the household as it goes over the PSH housing process.
3. The LRSP application must be completed by the FRSP Case Manager and given to the Permanent Housing Division case manager at the warm handoff meeting via email.

If a family was matched to PSH, then STFH/TH Providers must complete the following:

1. Complete the Transfer Summary Form within the next 5 business days. Once this form is filled out online, it will automatically be sent to DHS for review.
2. Review the DHS CAHP one-pager and video. The resources can be shared with the household as it goes over the PSH housing process.

DHS leads will complete the following:

1. Upload the Transfer Summary Form, Notice of Transfer Form, and vital documents to HTH.
2. Assign the families to Medicaid intake. An assessor will complete the Medicaid assessment with the families.

3. Assign the families to a PSH case manager (after the Medicaid assessment is complete) and send a warm handoff email requesting a meeting between the current program points of contact and the housing program points of contact.

Case Conferencing

While the By Name List remains the primary mechanism used to identify matches to housing resources, the Family CAHP Community or CAHP Liaisons may also case conference a family for possible connection to a housing resource when an individualized review is needed. The case conferencing process is person-centric and is intended to provide individual attention and conversation in the CAHP process, while at the same time maintaining a uniform and transparent process. Case Conferences can be submitted by FRSP providers only, unless it is a current non-DHS PSH provider that is seeking a transfer through case conferencing.

Case conferencing will not always result in a housing placement, but instead may involve recommendations to refer to the single adult subsystem, specialized providers serving specific populations, and/or connection to higher levels of mental health and substance use care (e.g. mental health crisis stabilization programs, detox programs). If a family has a Family Full SPDAT AND meets one or more of the criteria listed below, then a case conference referral may be submitted.

FRSP providers are allowed two active case conference submissions at a time. If the provider has two active submissions, they may not submit another referral until a family has been reviewed in a Match meeting. The provider will submit their referrals via the Family CAHP Case Conferencing Referral Form, which can be found on the Family CAHP toolbox. Referrals submitted via any other form of communication will not be accepted.

Referrals must be submitted the Wednesday before the match meeting by 12:00 PM to ensure the information can be incorporated into the agenda. Referrals may not be submitted later than this due to the CAHP Coordinator deactivating the form and needing appropriate time to prepare for the match meetings.

Case Conferencing Criteria:

1. The family is matched to or housed through a non-DHS PSH program but would benefit from a transfer to a DHS family PSH program (to ensure they have the right level of care and living environment and prevent them from re-experiencing homelessness).
2. The family has been:
    a. previously considered for a match to TAH/tenant based PSH during a match meeting in the last 60 days, but they were not matched
    b. matched to TAH/tenant based PSH but were unassigned for any reason in the last 60 days, or
    c. housed through TAH/tenant based PSH but are re-experiencing homelessness.
3. The family has been enrolled with Family Re-Housing Stabilization Program (FRSP) three or more times.
4. The family has one or more members with unmanaged Exceptionally Medical Vulnerabilities (EMV) that directly impacts daily activities and ability to maintain housing.

   a. The referral must identify one or more family members with unmanaged Exceptionally Medical Vulnerabilities (EMV). It should identify the individual(s) and **clearly list the specific EMV conditions affecting them and explain how these conditions directly impact their daily activities and ability to maintain stable housing**.
5. The family has one or more members with unmanaged Severe Mental Illness (SMI) or Substance Use Disorders (SUD) that directly impacts daily activities and ability to maintain housing.
   a. The referral must specify one or more family members with unmanaged Severe Mental Illness (SMI) or Substance Use Disorders (SUD). It should identify the individual(s) with these conditions and **describe how these conditions directly impact their daily activities and ability to maintain stable housing**.
6. The family is not on the By Name List because of:
   a. HMIS data errors,
   b. Length of time in FRSP is not accurately reflected in DHS's records,
   c. their most recent FSPDAT score is not uploaded to HMIS,
   d. the family is experiencing literal homelessness in DC and won't/can't complete intake at Virginia Williams, or
   e. the family is being served by a Domestic Violence (DV provider) who cannot utilize HMIS.

Case Conference Review Process:

1. The CAHP Coordinator will review all referrals in the order they were submitted. The CAHP Coordinator will determine if the referral is complete and meets all criteria. If the referral does not meet at least one of the criteria and does not have a Full Family SPDAT, the CAHP Coordinator will notify the referring provider that the referral is denied and the reason behind the denial. If the referral is complete and meets all criteria, it will move to the next step.
2. At the beginning of the Match Meeting, each case conference will be reviewed by the community. During each review, the referring provider will present additional information about the family and the reason for the case conference; the community will have the opportunity to ask questions to better understand the family's situation and, if appropriate, provide the referring provider with helpful resources or suggestions.