Minutes of the
Homeless Continuum of Care of Stark County's
May 10, 2017 Central Intake and Assessment Committee Meeting

Attendance. The following members of the Central Intake and Assessment Committee attended the meeting: Frank Aquino; Renee Biggums; Amy Dornack; Amanda Fletcher; Jennifer Keaton; Tracey Lane; Teresa Ponchak; Lisa Waikem; and Jean Van Ness. HCCSC Board Chair Kurt Williams also attended the meeting.

Approval of Minutes. Jean opened the meeting shortly after 10 a.m. and requested a motion to approve the minutes of the Committee's March 22, 2017, meeting. Jennifer made the motion, Amanda seconded it, and the motion passed by a unanimous vote of those present.

Reconsideration of Transfers from RRH to PSH. Pursuant to a suggestion made at its last meeting, the Committee discussed whether it should reconsider its previous decision not to allow transfers from RRH to PSH. Since that meeting, Jean had reviewed HUD's *Frequently Asked Questions*, which indicated that such transfers were allowable since, for such purposes, clients being served in RRH were still considered "homeless."

During their discussion, Committee members considered the follow facts and opinions:

- Having providers re-score RRH clients to see if they might be eligible for PSH when they are failing or have failed in RRH results in some inequities because there is no consistency in how provider staff members score clients.
- If we are going to allow transfers from RRH to PSH, we need a policy to ensure people are re-scored consistently.
- RRH clients who make no effort to increase their income while in the program return almost immediately after they exhaust their financial assistance. These clients are "gaming" the system.
- The question was raised as to whether everyone should be rescored between 30 and 60 days after registering with the Hotline. However, Amy indicated that shelter staff had some anxiety about doing this out of fear that, at that point, clients might score lower than they did originally and qualify only for emergency assistance.

Ultimately, there was consensus among Committee members that, if not successful twice in RRH, clients should be rescored. However, if, in that event, they do score for PSH, rather than go to the top of the PSH priority list, they should be placed on the list based on the same criteria used to prioritize others waiting for PSH.

After this consensus was achieved, there was additional discussion about how high rents are right now because the rental market is so tight. A question was raised about whether RRH projects should be putting clients in housing they are unlikely to be able to afford even if clients insist upon it. Although it appears providers have no choice but to accede to clients' requests if the cost of the housing is within HUD-prescribed limits, providers may be able to address this problem better in the future if they receive more training in financial counseling.

Review of Instructions for Verification of Disability Form. Before the meeting, Jean distributed to the Committee the draft of instructions for completing the Verification of Disability Form ("VOD") that had been recommended by the Committee and approved by the HCCSC Board last December. Jennifer Keaton had prepared the draft with help from Shirene and Amy.

In response to Jean's request for comments on the draft, the following comments and suggestions were made:

1. Amy indicated that two of her counselors had reviewed the draft and suggested that the following language be included at the beginning of the section providing instructions for the licensed professionals filling out the form: "Completion of this form does not render the applicant disabled for purposes of Social Security Disability. This is strictly for housing assistance. Permanent Supportive Housing (PSH) is housing with supports to assist residents to maintain housing, community linkages, etc."
2. There should also be instructions that, in order to determine a client's eligibility for PSH, licensed professionals cannot leave any question unanswered. In completing the form, they must check a "yes" or "no" box for each question.
3. The instructions should not include any indication of the consequence of answering questions one way or another because such indication could be seen as encouraging those filling out the forms to answer the questions in a particular way.
4. The instructions should be divided into three sets: one set for the section of the VOD that is to be completed by the housing provider; one for the section of the VOD that is to be completed by the client; and one for the final section of the VOD that is to be completed by a licensed professional.

Teresa indicated that housing providers should be checking each completed VOD closely before accepting it as documentation of a client's disability. She has seen many VODs in which the licensed professional has answered "no" to Questions 1.i.

Jean indicated that, before the next Committee meeting, she would amend the draft of the instructions to incorporate the suggestions made, send it to Jennifer for review, and then distribute it Committee members for an e-mail vote.

Improvements to Central Intake and Assessment that Could be Funded with CoC Funds. Jean informed the Committee that she had asked Jennifer and Teresa to consider what, if any, improvements to the Central Intake and Assessment system they would recommend in the event that some CoC funds could be made available this year to fund some improvements. She then asked Teresa and Jennifer to talk about their recommendations.

Teresa and Jennifer indicated that, if CoC funds could be made available, they would recommend hiring another full time Hotline staff member and dedicating that person to managing the prioritization list. In making this recommendation, they emphasized the following:

- HUD Notice CPD-17-01 and the Coordinated Entry Process Self-Assessment that HUD had issued along with CPD-17-01 focused on the following themes/recommendations:

    1. In the "coordinated entry process," everyone must be treated consistently; and
    2. No one should be on the prioritization list for more than 60 days.

- There are currently 143 on the prioritization list for PSH; in order to reduce wait times on the list, there needs to be intensive management of that list. Such management is a full-time job.
- The SPDAT should really be done every 30 days, and, to achieve greater consistency in results and avoid imposing increased financial burdens on providers, it should be done by a system-level employee. However, without a steady source of funding to cover the cost of a full-time staff member, the Hotline could not assume this responsibility.
- Reaching out to people on the waiting list every 30 days to re-administer the SPDAT would help purge the waiting list.

Committee members discussed this recommendation and expressed overwhelming support for it.

Thereafter, there was discussion of the continued use of Google Docs for the prioritization list. Although there appeared to be consensus that building the prioritization list within HMIS would be far preferable to maintaining it on Google Docs, there was no consensus that CoC funding should be used to support this improvement. As some Committee members argued, a one-time grant was a better source of funding for this type of expense.

Operationalizing Compliance with HUD Notice CPD-16-11. Renewing the discussion that had begun at the Committee's March meeting, Jean indicated that she had reviewed Notice CPD-16-11 again along with all the FAQs she could find on the subject of prioritization for PSH and was left with ongoing concerns about whether what our CoC is doing now complies with this most recent guidance HUD provided in CPD-16-11. Jean indicated that her main concern revolves around whether we are honoring the first priority CPD-16-11 establishes for use (1) in prioritizing chronically homeless persons for CoC-funded PSH beds not dedicated or prioritized for occupancy by the chronically homeless and (2) in prioritizing people who are not chronically homeless for CoC-funded PSH. Although she believes that we are okay when it comes to prioritizing the chronically homeless, we may fall short of what is expected in prioritizing those who are not chronically homeless due to the following:

- We give priority for PSH to those who are not chronically homeless based on their SPDAT, taking into consideration their length of time homeless only when SPDAT scores are equal.
- However, CPD-16-11 indicates we should be giving priority first to those whose "cumulative time homeless is at least 12 months" and who have been identified as having severe service needs.

During the ensuing discussion of how we should address this requirement, the following issues were raised:

- How far back in time should the HCCSC look in determining whether a person has been homeless at least 12 months?
- For these purposes, should the HCCSC be relying more on self-reports of homelessness? (There appeared to be consensus it should not rely any more on self-reports than it does in determining whether a person is chronically homeless.)
- Should the system rely only on episodes of homelessness already documented in HMIS to determine whether a person qualifies for this priority?

The Committee was unable to resolve these issues during the meeting. However, Jennifer and Teresa agreed to consider them, and Jean indicated that she would consult with them to develop policies for the Committee to review at its next meeting.

New Business. None

Adjournment. There being no further business, the meeting was adjourned around noon.