HOUSING AND URBAN DEVELOPMENT (HUD)-DEPARTMENT OF VETERANS AFFAIRS SUPPORTED HOUSING (VASH) PROGRAM

1. PURPOSE. This Veterans Health Administration (VHA) Handbook establishes the Department of Veterans Affairs (VA) portion of the procedures for the Housing and Urban Development (HUD)-Veterans Affairs Supported Housing (VASH) Program and sets forth the national authority for the administration, monitoring, and evaluation of HUD-VASH services.

2. SUMMARY OF CHANGES. This revised Handbook:

a. Clarifies the admission process and procedure for homeless Veterans in the HUD-VASH Program and the duties of those assigned responsibilities under the program,

b. Addresses staffing changes associated with implementing and monitoring HUD-VASH-funded programs nationally, and

c. Addresses program enhancements as a result of recent program expansion.

3. RELATED ISSUES. VHA Directive 1162.

4. FOLLOW-UP RESPONSIBILITY. The Deputy Under Secretary for Health for Operations and Management (10N) is responsible for the contents of this Handbook. Questions may be directed to the Director, VHA Homeless Services, 215-823-4035.

5. RESCISSIONS. VHA Handbook 1162.05 dated June 23, 2009, is rescinded.

6. RECERTIFICATION. This VHA Handbook is scheduled for re-certification on or before the last working day of September 2016.

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Under Secretary for Health

DISTRIBUTION: E-mailed to the VHA Publications Distribution List 9/15/2011

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HOUSING AND URBAN DEVELOPMENT (HUD)-DEPARTMENT OF VETERANS AFFAIRS SUPPORTED HOUSING (VASH) PROGRAM

1. PURPOSE

This Veterans Health Administration (VHA) Handbook establishes procedures for the United States (U.S.) Department of Housing and Urban Development (HUD) and the U.S. Department of Veterans Affairs Supported Housing (VASH) Program and sets forth the national authority and responsibilities for the Department of Veterans Affairs (VA) portion of administration, monitoring, and oversight of these services.

2. BACKGROUND

Homelessness, a significant national problem, has many causes. Individuals suffering homelessness are usually unemployed, unable to work, or have such a low income that they cannot access safe affordable housing. Some individuals who are homeless have disabling mental health, substance abuse, or physical conditions that lead to, or compound, their homeless situation. Families undergoing homelessness are seen more frequently than in the past when single individuals were the primary users of homeless services.

b. In 1992, HUD and VA established the HUD-VASH Program. The primary goal of HUD-VASH is to move Veterans and their families out of homelessness. A key component of the program is VA's case management services. These services are designed to facilitate the attainment of the Veteran's recovery goals by supporting stability in safe, decent, affordable, and permanent housing of the Veteran's choice. While VA provides case management services, HUD provides permanent housing stability to Veteran participants and their immediate families by allocating rental subsidies from its Housing Choice Voucher (HCV) Program. Additionally, provisions are included to allow for some limited Project-based Vouchers (PBV) for populations that are harder to house.

c. The 2008 Consolidated Appropriations Act, Public Law (Pub. L.) 110-161 enacted December 26, 2007, provided $75 million of funding for the HUD-VASH voucher program as authorized under the United States Housing Act (USHA) of 1937 section 8(o)(19). Additional funding was appropriated for fiscal years 2009 and 2010 for a total of approximately 30,000 HUD-VASH vouchers available for use by eligible, targeted Veteran families that are homeless. VA funding was used to hire case managers to provide support services. Some sites have recently added Peer Support Specialists, as well as Housing Specialists and Substance Use Disorder (SUD) Specialists, to provide additional support and assistance to HUD-VASH Veteran participants.

d. VA and HUD worked collaboratively in determining which medical centers would participate in the program, taking into account the diverse population of Veterans suffering homelessness, the areas needing services, the number of Veterans served by the homeless programs at each VA medical facility, geographic distribution, and VA case management resources. With program expansion, additional VA medical facilities and Community-Based Outpatient Clinics (CBOC) were added to provide this resource to smaller cities and rural areas.

NOTE: *There is at least one site in each of the 50 states, the District of Columbia, Puerto Rico, and Guam.*

e. HCV are allocated by HUD to local Public Housing Agencies (PHAs) based on a needs assessment formula established jointly by VA and HUD. This formula includes the Continuum of Care data, such as the Homeless Management Information System (HMIS) statistics. Once allocated, VA medical facility staff follows procedures described in this Handbook to provide case management and other supportive services to eligible and vulnerable Veterans who are homeless.

f. A Veteran's suitability for the program needs to be addressed on a case-by-case basis and may include consultation from mental health primary care services. Veterans who are homeless and have active SUDs are at higher risk for vulnerability and thus may be strong candidates for program participation. However, HUD-VASH does not require a period of sobriety in order for a Veteran to be considered eligible for the program. ***NOTE:*** *The HUD-VASH case manager is strongly encouraged to coordinate treatment services with VA and or community-based substance abuse treatment programs. A number of SUD Specialists are allocated to specific HUD-VASH locations to provide case management services and to promote integration with SUD care providers.*

3. AUTHORITY

a. The HUD component of the program is authorized by the USHA of 1937, as amended. VA's mandate to provide HUD-VASH Section 8 HCV Program voucher recipients with case management services is found in title 38 United States Code (U.S.C.)§ 2003(b).

b. The 2008 Appropriation required HUD to "make such funding available to PHAs that partner with eligible VA medical facilities or other entities as designated by the Secretary of VA, based on geographical need for such assistance as identified by the Secretary of VA, PHA administrative performance, and other factors as specified by the Secretary, HUD, in consultation with the Secretary of VA."

4. DEFINITIONS

a. **Community Homelessness Assessment, Local Education, and Networking Groups (CHALENG).** CHALENG is a VA program designed to enhance the continuum of care for Veterans experiencing homelessness. Each VA medical facility is required to participate in CHALENG on an annual basis. Through CHALENG, medical facilities are required to collaborate with the community, other state and Federal partners and stakeholders, and Veteran Service Organizations (VSO) to identify needs of local Veterans who are homeless. Homeless, and formerly homeless Veterans, also provide input regarding gaps in services. These needs are then reported through a national survey; the results are reported to Congress; and the needs and results are used to help guide future Homeless Program priorities and services.

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

c. **HUD-VASH or Veteran Family.** A "HUD-VASH family" or "Veteran family" refers to either the single Veteran or a Veteran with a household composed of two or more related persons. The term "HUD-VASH family" or "Veteran family" also includes one or more eligible persons living with the Veteran who are determined to be important to the Veteran's care or well being, or the surviving member(s) of a Veteran's family, described in this definition, that were living with the Veteran in a unit assisted under the HUD-VASH Program at the time of the Veteran's death. The composition of the household must be approved by PHA. The family must promptly inform PHA of the birth, adoption, or court-awarded custody of a child. Other persons may not be added to the household without prior written approval of the owner and PHA. ***NOTE:*** *HUD references "Family" in their regulations for HUD-VASH (Notice Public and Indian Housing (PIH) 2010-12 HA.) The partnerships with HUD and PHA require an understanding of their terminology to improve cross agency communication.*

d. **Homeless.** The HUD-VASH Program follows the definition of "homeless" as authorized in 38 U.S.C. 2002(1) and The McKinney-Vento Homeless Assistance Act, as amended by S. 896 The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009. ***NOTE:*** *See http://www.hudhre.info/hearth/.* Homeless refers to:

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

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

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

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

(5) An individual or family who:

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

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

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

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

(b) Has no subsequent residence identified.

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

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

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

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

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

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

e. **Chronically Homeless.** The HUD-VASH Program follows the Federal definition of the term "chronically homeless" from the HEARTH Act, which states, with respect to an individual or family, that the individual or family:

(1) Is homeless and lives or resides in a place not meant for human habitation, a safe haven, or in an emergency shelter;

(2) Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least 1 year or on at least four separate occasions in the last 3 years;

(3) Has an adult head of household (or a minor head of household if no adult is present in the household) with a diagnosable SUD, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002)), post-traumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical illness or disability, including the co-occurrence of two or more of those conditions; and

(4) A person who currently lives or resides in an institutional care facility, including a jail, SUD or mental health treatment facility, hospital, or other similar facility, and has resided there for fewer than 90 days must be considered chronically homeless if such person met all of the requirements described in subparagraph 4e prior to entering that facility.

f. **Public Housing Agency (PHA).** Public housing was established to provide decent and safe rental housing for eligible low-income families, the elderly, and persons with disabilities. PHA is a specific city, county, or state agency that receives Federal funds from HUD to administer the Section 8 HCV to provide housing for low-income residents at rents they can afford. Each PHA has developed independent operating procedures that must comply with HUD regulations and the law. PHA is responsible for determining eligibility for this program based on two factors:

(1) **Income Eligibility.** PHA must determine income eligibility for HUD-VASH families in accordance with 24 CFR 982.201. Income targeting requirements of Section 16(b) of the USHA of 1937, as well as 24 CFR 982.201(b)(2), do not apply for HUD-VASH families in order to allow participating PHAs to effectively serve the targeted population specified in the 2008 Appropriation Act; that is, homeless Veterans, who may be at a variety of income levels. ***NOTE:*** *PHA may, however, choose to include the admission of extremely low-income HUD-VASH families in its income-targeting numbers for the fiscal year (FY) in which these families are admitted.*

(2) **Lifetime Sex Offenders.** PHAs are required to prohibit admission if any member of the household is subject to a lifetime registration requirement under a state sex offender registration program. Within HUD-VASH, PHAs do not have the authority to screen potentially-eligible families or to deny assistance on any grounds permitted under 24 CFR 982.552 (broad denial for violations of HCV program requirements) and 982.553 (specific denial for individuals with criminal histories or SUD).

g. **State.** "State" refers to any of the several states of the United States, the District of Columbia, the Commonwealth of Puerto Rico, any territory or possession of the United States, or any agency or instrumentality of a state, exclusive of local governments. The term does not include any PIH agency under USHA of 1937.

h. **Housing Choice Voucher (HCV).** The HCV program is the Federal government's major program for assisting very low-income families, the elderly, and the disabled to afford decent, safe, and sanitary housing in the private market.

i. **Project-based Vouchers (PBV).** Project-based vouchers are a component of PHA's housing support program. Under the PBV program, a PHA enters into an assistance contract with the owner of a property for a specified number of units and for a specified term.

j. **Portability.** Portability provides Veterans the opportunity to live in the community of their choice, within certain limits.

k. **Housing First.** Housing First is a clinical approach that centers on providing homeless people with housing quickly and then providing services as needed. What differentiates a Housing First approach from other strategies is that there is an immediate and primary focus on helping individuals and families quickly access and sustain permanent housing. This approach has the following defining characteristics:

(1) A low-demand approach with fewer access barriers to accommodate people experiencing homelessness that cannot maintain sobriety and have difficulty remaining engaged in treatment;

(2) Treatment and supportive services are made available, but are not a requirement for participation or remaining in housing; and

(3) The use of assertive community outreach to engage and offer rapid placement to people with mental illness and SUD who are homeless.

l. **Critical Time Intervention (CTI).** CTI is an empirically-supported, time-limited case management model designed to resolve homelessness and minimize adverse outcomes for individuals with mental illness. CTI, a low-barrier model, engages the client through working on the client's goals. The treatment plan typically has no more than three goals at one time, with housing being the primary goal. Timeframes for CTI case management stages are approximately 3 months in duration, with the most intensive services provided during the initial phase. Additional goals can be added as previous goals are attained. CTI also utilizes a recovery-based program that emphasizes "living" goals rather than "clinical" goals (such as "getting a date" versus (vs.) "medication compliance.") CTI does not require any sobriety, but does require that the client be stable enough to live independently with case management supports. This phased treatment approach also provides clinicians with tools to balance caseload according to the Veteran's acuity level.

m. **Assertive Community Treatment (ACT).** ACT is an evidence-based service-rich team approach designed to provide comprehensive, community-based psychiatric treatment, rehabilitation, and support to individuals with serious and persistent mental illness, who have not responded well to traditional treatment program approaches.

(1) This recovery-based model provides treatment in the community by an interdisciplinary team, (i.e., a team of professionals whose backgrounds and training include social work, rehabilitation, counseling, nursing, and psychiatry).

(2) Among the services ACT teams provide are:

(a) Case management,

(b) Initial and ongoing assessments,

(c) Psychiatric services,

(d) Employment and housing assistance,

(e) Family support and education,

(f) SUD services, and

(g) Other services and supports critical to an individual's ability to live successfully in the community.

(3) ACT services are available 24 hours a day, 365 days a year. ***NOTE:*** *In VA, this approach forms the basis of the Mental Health Intensive Case Management (MHICM) Program.*

n. **Harm Reduction.** Harm Reduction is a public health model focused on decreasing adverse events by looking to alternative ways to moderate the outcome of behavior or events that cannot be controlled or prevented, while working toward overall health and well being.

(1) The use of seat belts, air bags, smoke detectors, exercise, medicines, and clean needle exchange programs are examples of Harm Reduction strategies.

(2) A low-demand model of care, Harm Reduction is utilized with identified harmful behaviors associated with legal and illegal substance use, mental health, and physical health concerns.

(3) This model affirms the Veteran as the primary change agent in reducing the risks of substance use, empowers change producing decision making, and seeks to encourage peer support to employ new strategies, provide encouragement and champion success.

NOTE: *Harm Reduction does not attempt to minimize or ignore the real and tragic adverse consequences and danger associated with legal and illegal substance use or failure to follow medical or psychiatric advice.*

o. **Linear Model.** The linear model is a staged approach that requires successful completion of one program within the continuum of care before moving to another program with a different level of care. This model often includes threshold elements such as periods of sobriety, medication compliance, or treatment completion prior to acceptance into another program. ***NOTE:*** *Research does not show this model to be more effective than the low-barrier "Housing First," community-based models for the chronically homeless, which is the target population. This approach may be useful for some individuals, but is not a model that should be applied to all program participants.*

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

q. **Substance Abuse Disorder (SUD) Specialist.** The SUD Specialist is a professional with a Masters degree and an independent license, who is responsible for providing expertise on SUD to the HUD-VASH team, to other providers within the medical facility, and in the community. The SUD Specialist also provides assessments and treatment to certain high risk, substance using homeless Veterans.

r. **Housing Specialist.** The Housing Specialist is a professional who is responsible for providing assistance to the VA homeless programs in identifying appropriate permanent housing and landlords willing to work with homeless Veterans. The goal is to develop an inventory of readily-available housing options so that Veterans who are homeless can be rapidly housed.

s. **Homeless Registry.** The Homeless Registry is a new web-based management information and evaluation system that allows VA staff to enter, update, and track information on each unique homeless Veteran as they enter and move through the VA homeless system of care. The Registry provides real time data to VA providers, program administrators, medical facilities, and Veterans Integrated Service Network (VISN) leadership to facilitate data-driven decision-making and performance monitoring on an ongoing basis. ***NOTE:*** *This Registry integrates VA and community data so that VA staff are able to gain a longitudinal view of a Veteran's housing, treatment, and benefit status.*

t. **Homeless Operations Management and Evaluation System (HOMES).** Historically, when a Veteran entered a new VA homeless program or episode of care, homeless program staff would re-enter Veteran data into a program-specific system resulting in duplicated data across separate homeless program systems. Further, these systems did not share information about the Veteran and the care received. The HOMES system allows for single entry of Veteran data and satisfies program operations, management, and evaluation requirements. Any entry into the system is available to all homeless staff across all VISNs. HOMES is designed so that critical data elements are compatible with HUD's HMIS, allowing VA and HUD to meet the goals of integrating community and VA data into a single Registry.

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

(1) The program is based on ACT principles and is designed for Veterans with a SMI diagnosis meeting MHICM criteria and living within a practical driving distance from staff offices.

(2) High use of VA psychiatric inpatient resources is a priority, but not a requirement.

(3) Piloted Enhanced RANGE, or E-RANGE, teams augment typical RANGE services with a homeless specialist.

(a) The teams, which typically consist of three clinical staff and a half time support person, combine intensive case management services with homeless outreach.

(b) When homelessness or a risk of homelessness is identified, the teams work with facility homeless staff, such as HUD-VASH teams, as well as community resources to stabilize the Veteran with the E-RANGE team providing ongoing clinical support, if such care is indicated.

(c) The teams provide community-based care with a high frequency of personal contact, often 2 or 3 times a week, to those in need of such services.

(d) With a capacity for high-frequency community-based interventions, E-RANGE teams can assist in the management of Veterans with complex needs, and thereby support Housing First efforts in the rural areas which they serve.

5. SCOPE

a. VA is working closely with other Federal partners on the U.S Interagency Council on Homelessness (USICH) and is committed to the Federal Plan to Prevent and End Homelessness. VA has developed a 5-Year Plan to Eliminate Homelessness Among Veterans, which calls for coordinated strategic cooperation within VA and with VA's community providers. This Plan requires rapidly expanding programs to help those who are homeless now, and developing programs to prevent homelessness in the future.

b. VA has developed several programs that offer assistance and choices to VA eligible Veterans who are homeless, such as: HUD-VASH, the Health Care for Homeless Veterans (HCHV) Program, Grant and Per Diem (GPD) Program, Mental Health Residential Rehabilitation and Treatment Programs (MHRRTP), Supportive Services to Veteran Families (SSVF), the Homeless Veterans Supported Employment Program (HVSEP) and the Homeless Dental Program (see: http://www.va.gov/HOMELESS/index.asp (Internet) and http://vaww1.va.gov/homeless/ (Intranet). ***NOTE:*** *This is an internal Web site and is not available to the public.*

c. HUD-VASH is the largest supported housing program in the Nation with Congress authorizing approximately 40,000 HCVs from FY 2008 through FY 2011. These vouchers are allocated to local PHA partners coupled with VA medical facilities. Approximately 1,500 clinical and administrative staff are authorized to provide supportive services to Veterans participating in the program. Continued expansion of this program is included in the VA's 5-Year Plan to Eliminate Homelessness Among Veterans.

d. HCV tenant-based vouchers provided by HUD supplies supported permanent housing for homeless Veterans and their families. Homeless Veterans must meet HUD-VASH criteria and be willing to actively participate in their program of recovery with a case manager.

e. Veterans who are homeless often require case management and supportive services in order to remain housed in the community. Many Veterans experiencing homelessness have physical, emotional, or other problems that make the goal of stabilizing and living independently challenging.

(1) Case management may include such things as:

(a) Coordinating care with the VA medical facility,

(b) Money management,

(c) Skill development,

(d) Apartment search planning, and

(e) Other functional assistance as needed by the individual Veteran and family.

(2) The case manager monitors the Veteran's progress and intervenes, if indicated, to ensure that the Veteran remains housed.

f. Veteran families that have experienced chronic homelessness, complicated by mental illness and substance use issues, may be best served through a Housing First approach described in subparagraph 4l. This intervention has been demonstrated to be highly effective in ending chronic homelessness for many Veterans.

(1) Utilizing the Housing First approach requires:

(a) Assertive community outreach;

(b) Employing a low-demand approach; and

(c) Rapid placement into housing with no requirements for a period of stabilization, sobriety, or full compliance with mental health treatment.

(2) The HUD-VASH Program supports and encourages the use of Housing First when case manager, PHA, and landlords have been educated in the implementation and utilization of the Housing First approach.

(3) To be optimally successful, there must be:

(a) Readily available housing stock,

(b) A cadre of housing providers,

(c) Cooperative PHAs, and

(d) Clinical staff who are knowledgeable and supportive of Housing First. ***NOTE:*** *Research has demonstrated that supported housing programs like HUD-VASH-and approaches such as Housing First are effective in assisting the Veteran and the Veteran's family exit homelessness.*

6. RESPONSIBILITIES OF THE HUD-VASH PROGRAM OFFICE, VHA HOMELESS SERVICES, VA CENTRAL OFFICE

HUD-VASH Programs (10NC1), VA Central Office is responsible for ensuring that:

a. Coordination with HUD Headquarters is consistent and continual for program implementation and administration.

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

c. Procedures based on relevant VA laws, rules, regulations, directives, and analysis of collected data is provided to VISN offices and VA medical facilities to ensure that HUD-VASH Programs are maintained; quality services, which are in compliance with existing laws and policies, are provided; and are operated in accordance with this VHA Handbook.

7. RESPONSIBILITIES OF THE VETERANS INTEGRATED SERVICE NETWORK (VISN) DIRECTOR

Each VISN Director is responsible for:

a. Supporting the Plan to End Homelessness Among Veterans in 5-Years.

b. Ensuring that HUD-VASH Programs within their VISNs are:

(1) Operating in compliance with relevant public law, regulations, and VHA policies and procedures; and

(2) Meeting established VHA performance measures and monitors.

c. Ensuring timely documentation of the prevalence of those who are homeless or at risk, and timely and accurate entry of the services utilized by homeless Veterans into the Homeless Registry and HUD-VASH database.

8. RESPONSIBILITIES OF THE NETWORK HOMELESS COORDINATOR (NHC)

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

a. Ensuring HUD-VASH Programs are monitored and evaluated for their adherence to this VHA HUD-VASH Handbook.

b. Consulting with and apprising the HUD-VASH Regional Managers of any issues or concerns pertaining to the operation of the HUD-VASH Programs in their VISN.

c. Providing support, guidance, and advice to HUD-VASH program staff through regular communications, including site visits, VISN calls, etc., to facilitate mentoring, problem solving, and compliance.

d. Ensuring that required data is entered in a timely manner.

e. Reviewing HOMES results, the HUD-VASH Data Base, and other evaluation data to optimize program performance, provide support to VA medical facilities to meet established thresholds, and to develop corrective actions plans when necessary.

f. Tracking usage of obligated HUD-VASH funds, and ensuring funds are used for specified purposes.

g. Working with VA medical facilities and HUD-VASH case managers, along with Quality and Performance Management staff, to include HUD-VASH Programs in risk management and reporting systems.

h. Ensuring that critical incidents, as defined in VA Directive 0321, Serious Incident Reports, are reported according to established VISN policy, following the 10N Guide to Issue Briefs. Copies of all such reports are to be sent to the HUD-VASH Director and the appropriate HUD-VASH Regional Manager. ***NOTE:*** *VA Directive 0321, may be found at the following link:* http://www.va.gov/vapubs/viewPublication.asp?Pub_ID=565&FType=2 . *This is an internal Web site and is not available to the public*

i. Reviewing HUD-VASH Programs' critical incidents and initiating appropriate investigation and follow-up activities in collaboration with the respective medical facility.

9. RESPONSIBILITIES OF THE FACILITY DIRECTOR

Each Facility Director is responsible for:

a. Timely hiring or contracting of staff. If an internal candidate is chosen for open HUD-VASH positions, staff must be released from the previous position as soon as possible.

b. Ensuring that VA medical facility staff assigned to the HUD-VASH Program have the appropriate clinical backgrounds, education, and experience necessary to provide community-based case management services to a population suffering from homelessness. This includes:

(1) Ensuring managers and clinicians are competent to address the mental health clinical needs specific to the treatment population.

(2) Ensuring clinicians have the required training through the VA Talent Management System (TMS), a part of the VA Learning University found at: https://www.tms.va.gov/plateau/user/login.jsp. This includes training related to suicide risk reduction and working safely with high-risk Veterans, such as: those with severe mental illness and SUD, those with a history of violence, and those with an involvement with the justice system. This also includes ethics training as required by state licensing boards. ***NOTE:*** *Specific emphasis to heightening awareness of, and avoiding, potential conflicts of interest is strongly encouraged.*

c. Providing appropriate administrative support and resources to ensure the HUD-VASH Program is able to accomplish its stated mission, goals, and objectives. This includes office space, Information Technology (IT) equipment, and car allocations.

d. Providing and maintaining program oversight to ensure quality clinical services and compliance with VHA policy and procedures.

e. Providing adequate clinical staff support for consultations to determine medical and psychiatric suitability of Veterans referred to HUD-VASH, and ongoing treatment when indicated.

f. Ensuring the timely completion of all mandated reporting, monitoring, evaluation, and accreditation requirements. This includes Full-time Equivalent (FTE) employee tracking and performance measurements.

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

h. Participating in local Continuum of Cares' (CoC) and HUD's Point in Time (PIT) Count of homeless individuals. This count, usually done one day in late January, provides information to HUD and CoC on homeless populations by locality. The PIT Count, along with the information from HMIS (see subpar. 4u), is used to determine the allocation of homeless resources, including HUD-VASH, and to develop the Annual Homeless Assessment Report (AHAR) (see http://www.hudhre.info/index.cfm?do=viewCocMaps for more information on Continuums of Care, the Point in Time Count, and the AHAR).

i. Verifying that staff provide timely and accurate documentation of Veteran activity in the Homeless Registry and the HOMES data base.

10. RESPONSIBILITIES OF THE HUD-VASH PROGRAM TEAM

a. **Composition of Teams.** The composition of HUD-VASH Program teams may vary from site to site.

(1) Typical program teams are made up of independently-licensed clinical staff with Master's Degrees in social work, nursing, or psychology, or appropriately-supervised Master's level clinicians who are working toward licensure.

(2) Program teams can have other professional staff including Bachelor-level social workers, SUD Specialists, Peer Support Specialists, and Housing Specialists.

(3) At those sites where there are a large number of case managers, it is strongly suggested that there is a HUD-VASH Program Manager. Although some staff positions may be procured through contracting, contracted staff must provide the same level of service or care as outlined in this Handbook.

b. **Staff Meetings.** Interdisciplinary clinical staff conferences must be scheduled on a regular basis to:

(1) Discuss the Veteran's treatment plan, compliance issues, progress, and discharge from the program.

(2) Address program planning, administration, and quality and performance initiatives or activities.

c. **Staff Trainings.** Training for the new case manager must be conducted within 90 days of initial start date. For assistance in obtaining this orientation, the NHC, or their local designee, need to be contacted. All case managers and SUD Specialists are to have training in Critical Time Intervention, Assertive Community Treatment, Motivational Interviewing, Housing First, Low-Demand Model of Care, and other clinical approaches relevant to the population. It is essential that all staff complete appropriate ethics training as required by respective professional licensure or credentialing boards, with an emphasis on dual relationships and conflict of interest circumstances.

(1) Training must be provided by a nationally-approved provider of accredited continuing education as appropriate to the attendee's independent licensing or credentialing.

(2) Training may be provided through the VA TMS or by non-VA sources, such as the National Association of Social Workers (NASW) conferences, locally-offered workshops, etc.

NOTE: *The VA TMS Learning Catalog and calendar of events provides information on accredited training, such as VA Satellite Broadcasts, web-based courses, face-to-face conferences, etc. See: also http://vaww.ees.lrn.va.gov/ (This is an internal Web site and is not available to the public) and http://www.chepinc.org/upcoming_events/ in addition to the TMS link noted in subparagraph 9b(2).*

11. HUD-VASH PROGRAM COORDINATOR RESPONSIBILITIES

The HUD-VASH Program Coordinator is responsible for:

a. Providing supervision of the program.

b. Engaging in community outreach and developing community partnerships, particularly with the local Homeless CoC.

c. Establishing a process for referral, evaluation, and admission to the HUD-VASH Program.

d. Managing and ensuring even distribution of case loads with consideration to the CTI model.

e. Establishing clinical case reviews.

f. Providing case consultation around high-risk situations.

g. Conducting appropriate program audits, such as:

(1) Chart reviews,

(2) Performance measures and monitors, and

(3) Frequency of clinical contacts, etc.

h. Coordinating accreditation activities.

12. CASE MANAGER RESPONSIBILITIES

The Case Manager is responsible for:

a. Providing outreach services to engage Veterans experiencing homelessness, especially Veterans who are in the following groups: chronically homeless, those with families, women, with disabilities, and those who served in the Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and the Operation New Dawn (OND) eras.

b. Verifying the Veteran's status, eligibility for VA medical care, and clinical need for program participation.

c. Screening and a brief assessment to ensure appropriateness of placement into the program.

d. Assessing Veterans through comprehensive psychosocial evaluations to determine case management needs and recovery goals.

e. Providing access to appropriate treatment and supportive case management services to potential HUD-VASH Program participants. ***NOTE:*** *This can be done individually or in groups.*

f. Employing Motivational Interviewing approaches to promote Veteran follow through with referral for preventive care and treatment of medical conditions, substance use and dependence, other mental health conditions, and problematic health behaviors (e.g., problematic substance use, tobacco use, unsafe sexual practices).

g. Helping the Veteran obtain the voucher from PHA.

h. Providing housing search assistance to HUD-VASH participants with rental vouchers.

i. Making regular home visits to assess Veterans' housing stability, social connection and recovery, and acting as a liaison with other VA and community resources, landlords, and PHA. Regular re-assessment and revision of treatment plans is done as needed.

j. Ensuring coverage of caseload during absences.

k. Reviewing agreements between Section 8 HCV landlords, PHAs, and VA in establishing appropriate referral sites for HUD-VASH placements.

l. Performing site visits of HUD-VASH apartments to ensure that Veterans reside in safe environments in compliance with local housing codes.

m. Meeting regularly with landlords and PHA officials to ensure the availability of Section 8 HCV eligible housing stock.

n. Collecting and submitting HUD-VASH Program evaluation data on Veteran family participants.

o. Ensuring that there is no conflict of interest in dealings with Veterans, landlords, or other entities by adhering to professional ethical guidelines. It is essential that all staff complete annual ethics training, to include conflicts of interest, provided as indicated in subparagraph 10c.

p. Participating in program specific conference calls and broadcasts such as:

(1) Monthly 1-hour conference call hosted by the HUD-VASH National Director. Program policy, trends, and resources, as well as site-specific issues and new program ideas are addressed in this forum. A reminder is sent with conference call information.

(2) Conference calls led by the VISN NHC are also strongly encouraged to promote training, discuss local issues, share information, and develop a supportive mentoring resource.

(3) Viewing of available HUD-VASH satellite broadcasts, PowerPoint presentations, and attendance at national and regional HUD-VASH and other homeless conferences are encouraged, as time and funding permits.

13. SUBSTANCE USE DISORDER (SUD) SPECIALIST RESPONSIBILITIES

The SUD Specialist is responsible for:

a. Actively participating as a HUD-VASH team member with direct interaction with SUD specialty services.

b. Providing direct, concurrent clinical care using established evidence-based practices and Motivational Interviewing approaches for Veterans with co-occurring conditions of homelessness and SUD. ***NOTE:*** *The SUD Specialist should not necessarily be assigned to provide ongoing case management services to every Veteran in HUD-VASH who presents with a SUD, but assignment of care needs to be based on the complexity of the care required, and the competencies of available staff to meet the specific needs relate to SUD.*

c. Conducting treatment groups for Veterans with significant SUD concerns.

d. Serving as the liaison between the HUD-VASH Program, specialty SUD services at the facility, and community agencies.

e. Providing education about prevention, and low-demand or high-expectation approaches such as Housing First.

f. Coordinating with existing SUD specialty services to ensure that the HUD-VASH Veteran participant receives continuing care for SUD, as appropriate and as needed, after permanent housing has been found.

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

14. PEER SUPPORT SPECIALIST RESPONSIBILITIES

The Peer Support Specialist is responsible for:

a. Providing emotional support to encourage positive motivational change during the Veterans' recovery process.

b. Providing practical assistance to Veteran participants, such as:

(1) Accompanying the Veteran to clinical appointments and self-help group meetings,

(2) Helping with the housing search and the process of moving in,

(3) Assisting the Veteran with employment issues,

(4) Encouraging appropriate recreational activities,

(5) Helping Veterans advocate for themselves with providers and ensuring effective communications with such providers,

(6) Modeling healthy living and community engagement, and

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

15. ADMINISTRATIVE SUPPORT SPECIALIST RESPONSIBILITIES

The Administrative Support Specialist is responsible for:

a. Providing administrative support to the HUD-VASH Program and clinicians, such as keeping minutes and records, and procuring needed resources.

b. Developing relationships with community partners, attending meetings, and providing basic education about HUD-VASH Program, if indicated.

c. Providing a welcoming environment for Veterans and connecting Veterans with clinicians in a timely way.

d. Completing other duties, as assigned.

16. HOUSING SPECIALIST RESPONSIBILITIES

The Housing Specialist is responsible for:

a. Educating landlords about HUD-VASH.

b. Establishing lists of landlords interested in HUD-VASH Veterans as potential tenants.

c. Developing property lists of safe, decent, and stable housing units.

d. Obtaining pre-inspections and other inspections.

e. Showing Veteran families available housing units.

f. Assisting with PHA and landlord paperwork (lease).

17. OUTREACH AND EDUCATION

Outreach and education about HUD-VASH to all internal and external stakeholders is a critical component of this program and must be part of strategic plan implementation. To effectively accomplish this, HUD-VASH Case Managers and Outreach staff must:

a. Develop strong relationships with other VA programs such as the HCHV Program, Women's Program, Suicide Prevention, OEF-OIF Program, RRTP, Compensated Work Therapy (CWT)-Transitional Resource (TR), and GPD Programs; this expands the scope of services the HUD-VASH Program can provide to homeless Veterans. Outreach activities are to be coordinated with these other homeless programs to avoid duplication of efforts, and to maximize effectiveness and efficiency. The focus must be on each Veteran's preferences and needs.

b. Actively collaborate with facility Health Promotion and Disease Prevention staff, including the Health Behavior Coordinator, Health Promotion Disease Prevention Program Manager, and the Veterans Health Education Coordinator to ensure that homeless Veterans have access to relevant preventive care interventions, resources, and educational materials. Prevention staff can serve as a local resource for training HUD-VASH clinical staff in Motivational Interviewing and other Veteran-centered communication and health coaching skills.

c. Actively network with community programs and organizations to encourage referrals and to secure alternative resources that assist in meeting the psychosocial needs of the homeless. To accomplish this, establishing close working relationships with the local Homeless CoC is critical. The relationship between HUD-VASH case managers and PHA is also key to program success as it facilitates the timely review of the Veteran's application and approval of vouchers.

d. Use a Housing First approach, which is a highly-effective intervention strategy that utilizes assertive community outreach combined with a low-demand approach that <u>does not require</u> the usual "housing readiness" conditions of sobriety or full compliance with mental health treatment as a condition of acceptance or continued stay.

e. Have the freedom and flexibility to develop innovative approaches to reach out to the community and assist homeless Veterans.

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

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

18. REFERRAL

Referral sources may include any of the following:

a. The local CoC, community partners or other community-based stakeholders,

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

c. Veteran self-referral,

d. Other VA Homeless programs, and

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

NOTE: *It is acceptable to evaluate a Veteran for participation in a HUD-VASH Program if the Veteran is a current participant in one of VA's homeless residential programs, such as MHRRTP, CWT-TR, or GPD. Veterans from these programs must meet the definition of homeless with priority for vouchers being given to those Veterans who are chronically homeless and most vulnerable. According to the HEARTH Act, individuals are no longer considered "chronically homeless" when the length of stay exceeds 90 days, however, this does not preclude admission to the HUD-VASH program if clinically indicated and substantiated. In such cases, a discussion must occur between the referring program and HUD-VASH staff.*

19. PROGRAM PARTICIPANT TARGETING

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

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

c. The HUD-VASH Case Manager is to assess each case on an individual basis. Based on clinical judgment and resource availability, it must be demonstrated that the homeless Veteran has an identified need for case management services to obtain and sustain housing. ***NOTE:*** *It is strongly recommended that in situations where the Veteran's clinical profile is unclear, consultation with mental health leadership or primary care, or their clinical designee, be utilized to ensure appropriate placements.*

d. The following populations need to be considered for admission into HUD-VASH:

(1) Chronically homeless with children in their custody.

(2) Chronically homeless potentially getting custody of their children.

(3) Chronically homeless Veterans who are either women, disabled or served in OEF, OIF, or OND.

(4) Other chronically homeless individuals not in the preceding groups.

(5) Non-chronically homeless Veterans who are either women, disabled, or served in OEF, OIF, or OND.

(6) Other non-chronically homeless individuals not in the above groups.

NOTE: *The HUD-VASH Program need to be reserved for homeless Veterans who have few resources and require long-term case management to either obtain or maintain permanent supportive housing.*

e. If there are no available case management openings or vouchers, the Veteran needs to be placed on an "interested in HUD-VASH" list. The Veteran needs to be provided with information about HUD-VASH, and when appropriate, the HUD-VASH case manager needs to invite the Veteran to participate in any existing HUD-VASH pre-groups. The HUD-VASH program staff must document the referral and note that the reason for denial was a lack of an available voucher.

20. SCREENING AND EVALUATING

a. The screening process determines a Veteran's appropriateness and need for HUD-VASH. As the target population for this program may be difficult to engage, a low-barrier, housing-focused approach is indicated.

(1) Screening must be done by a HUD-VASH clinical team member for all Veterans referred.

(2) Screening and evaluation must occur within 3 business days of receiving the referral.

(3) Seeking consultation from Mental Health and Primary Care services is strongly encouraged when there are questions regarding stability and the ability to live independently in community housing, or when a clear determination is not forthcoming.

NOTE: *Screening teams are not required. Clinical determination for admission needs to be made as quickly and safely as possible.*

b. The first step in the screening and evaluation process is to verify that the Veteran meets the following criteria:

(1) Is homeless.

(2) Is eligible for VA health care.

(3) Is in need of, and is willing and able to, engage in clinical case management. Otherwise eligible homeless Veterans receiving HUD Homeless Prevention Rapid Re-Housing Program (HPRP) or VA SSVF funds to move temporarily into housing while waiting to get into a HUD-VASH unit, retain eligibility for the HUD-VASH Program. HPRP is a temporary form of assistance and expressly touted in the HPRP notice as an eligible resource for HUD-VASH.

c. If the Veteran is new to VHA, the case manager ensures the Veteran is enrolled for VA health care.

d. If the Veteran has not been seen in primary care for 1 year or more, then the case manager seeks to encourage primary care involvement by scheduling the Veteran for the first available history and physical, as agreeable to the Veteran.

e. If a mental health evaluation is needed, it must be scheduled as soon as possible following the Veteran's consent (unless intent to harm self or others is indicated by the Veteran, which requires emergent action and does not require consent). ***NOTE:*** *Same day appointments, while the Veteran is still present at the VA medical facility, are encouraged, where available.*

f. Criteria for admission to HUD-VASH does not include any expectation of a period of sobriety, or adherence to physical health, mental health or SUD treatment. The Veteran's stability must be considered for admission to HUD-VASH, but prior treatment completion or sobriety are not consistent with Housing First or other low-barrier approaches, inherent to HUD-VASH.

g. If it becomes clear during the screening process that the Veteran needs more intensive stabilization services, such as inpatient mental health or residential rehabilitation and treatment, the HUD-VASH case manager must coordinate and facilitate that referral with the mental health consultant.

h. If the Veteran does not require HUD-VASH, appropriate referrals are made to alternative programs or services.

21. ADMISSION

a. Admission is by clinical decision of HUD-VASH staff, or, if indicated, a mutual decision with appropriate consultation in more complex situations.

b. Veterans are considered admitted into the HUD-VASH Program when accepted for case management. Admission decisions need to occur within 24 hours of a completed assessment.

22. ASSESSMENT

a. Newly-accepted Veterans are assigned to a HUD-VASH case manager.

b. The HUD-VASH case manager must ensure that there is a homeless initial assessment completed on each new Veteran through HOMES (see subpar. 4t).

23. HOUSING PLAN

a. Veterans are encouraged to work with their case manager to develop a housing plan with specific, individualized goals that focus the direction of case management.

b. Case managers are to empower and respect the Veteran's self-determination in those areas most important to the Veteran.

c. The Veterans' participation in developing the plan must be documented.

d. The housing plan is to be reviewed and updated regularly as significant changes occur, goals are accomplished, and new goals are set.

e. The housing plan is to be integrated with the Veterans' overall care plan developed by the treating medical facility.

24. VOUCHER TYPES

There are two types of vouchers, HCV and PBV. Depending on the availability of these vouchers, the Veteran assessment would include a best placement determination for the Veteran through these voucher options.

a. HCVs are the primary voucher type available to HUD-VASH and provide the Veteran participant with the ability to utilize the HUD-VASH voucher to choose housing in the location where they want to live, within the parameters of the participating PHA and VA's ability to provide case management services. With an HCV voucher:

(1) Participants may find their own housing, including single-family homes, townhouses, apartments, single room occupancy units (SRO), congregate housing, and group homes. Standard HCV requirements regarding unit size, housing quality standards (HQS), and payment standards apply. The participant is free to choose any housing that meets the requirements of the

program and is not limited to units located in subsidized housing projects. The PHA and case manager can assist with determining the appropriate unit approved for use with the HCV.

(2) Veterans and their families are permitted to live on the grounds of a VA medical facility in units owned by VA, where and when available.

(3) HUD-VASH participant Veterans and families, eligible for HCVs, must reside in those jurisdictional areas that are accessible to case management services, as determined by the partnering VA medical facility.

(4) Since HUD-VASH participants may face challenges with their housing search, HUD-VASH HCVs have an initial search term of at least 120 days. Under certain circumstances, extensions may be granted by PHA.

NOTE: *Operating requirements may be found on HUD's HUD-VASH Web site at: http://www.hud.gov/offices/pih/programs/hcv/vash/ under "Related Notices and Guidance" HUD-VASH Operating Requirements – Complete Version.*

b. PBVs are another voucher type that allows for a housing option that provides additional on-site supports for participants, but does not include the participant choice. PBVs provide a low threshold for renting to those who are harder to place due to their credit or criminal histories.

(1) A PHA may request to have up to 50 percent of their allocation of HUD-VASH vouchers converted for use as PBV. HUD and VA Central Office must approve the conversion of the HCV to PBV.

(2) All PBV requests to HUD Headquarters and VA Central Office from the PHA must have documented support from the participating VA medical facility's leadership. ***NOTE:*** *HUD published PIH2010-23 on this subject effective June 23, 2010, and may be located on HUD's HUD-VASH Web page in the following file: http://www.hud.gov/offices/pih/publications/notices/10/pih2010-23.pdf* .

25. HOUSING PLACEMENT

a. **Case Manager.** The case manager is responsible for assisting the Veteran with the process of obtaining a HUD-VASH voucher from PHA. This includes developing a collaborative relationship with PHA, as:

(1) Working with PHA to streamline the voucher application process;

(2) Assisting the Veteran to obtain the needed documentation;

(3) Helping the Veteran complete the PHA application;

(4) Supporting the Veteran during appointment(s) at PHA; and

(5) Obtaining the Veterans' signed Release of Information indicating permission for

information exchange with PHAs and other community agencies. ***NOTE:*** *Examples of this kind of exchange would be notification of appointments, notification of additional needed documentation, or resolving concerns or issues.*

b. **PHA.** PHA is responsible for:

(1) Verifying income eligibility.

(2) Completing a background check only to ensure that the Veteran is not on a state requirement for lifetime registration for sex offenses.

(3) Issuing one of the program-designated housing vouchers after the Veteran has successfully completed this process.

(4) Assisting with porting vouchers to another PHA.

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

(6) Inspecting housing units in a timely fashion to ensure safe and decent housing. ***NOTE:*** *HUD has legislative and regulatory authority for the vouchers and PHAs. Generally, the HUD-VASH HCV is administered in accordance with regular HCV program requirements (24 CFR Section 982). However, the 2008 Consolidated Appropriations Act allows HUD to waive or specify alternative requirements for any provision of any statute or regulation that HUD administers in connection with this program in order to effectively deliver and administer HUD-VASH voucher assistance. The HUD-VASH Operating Requirements (including the waivers and alternative requirements from HCV program rules) were published in the Federal Register on May 6, 2008. Refer to subparagraph 24a(5) for the HUD link for their "Related Notices and Guidance" HUD-VASH Operating Requirements – Complete Version.*

c. **Veteran.** The Veteran, with the help of the HUD-VASH case manager, is responsible for finding a suitable apartment. The procedure sequence is as follows:

(1) Upon locating a suitable apartment, the Veteran or case manager requests the local PHA to inspect and approve the dwelling;

(2) After passing the unit inspection, PHA and the unit owner or landlord sign the Housing Assistance Payment (HAP) contract;

(3) The Veteran contacts the landlord and, if all parties agree, a standard lease is executed; and

(4) The Veteran, assisted by the case manager, moves into the housing unit on the agreed upon date. ***NOTE:*** *The Veteran may need the case manager's assistance to plan the steps involved in the move including obtaining furniture, cleaning supplies, dishes, as well as how the Veteran will physically move those items. Case managers are encouraged to work with their local Voluntary Service Program, community programs, and other appropriate resources to*

assist the Veteran with this step and the physical move. Case managers are not authorized to physically move the Veteran into the apartment.

(5) The Veteran and case manager utilize the housing plan and other strategies to sustain the Veteran in housing.

26. PHA DENIAL OF ASSISTANCE

a. **Denial of Assistance on Referral.** As in the regular voucher program, PHA must determine whether a family is income eligible prior to the provision of HUD-VASH assistance. If the family is over income (based on the most recently published area specific income limits for the family size, found on the HUD Web site: http://www.huduser.org/portal/datasets/il/il11/index_il2011.html,) the family is ineligible for HUD-VASH. If PHA denies assistance to a family under the HUD-VASH Program, it must provide:

(1) The Veteran, the VA case manager, and HUD with prompt notice of the decision denying assistance to the family;

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

(3) The family an opportunity for an informal review in accordance with 24 CFR § 982.554(a) and (b). A copy of this denial of assistance notice must be sent to the VA case manager and the Housing Program Specialist at HUD Headquarters, Office of Public and Indian Housing, Housing Voucher Management and Operations Division, Room 4210, Washington, DC, 20410-1000.

NOTE: *The only reasons for denial of assistance by PHA are failure to meet the income eligibility requirements or if any member of the Veteran's household is subject to a lifetime registration requirement under a state sex-offender registration program, according to HUD's regulations.*

b. **Violation of PHA Rules.** Once a Veteran participant has been issued a voucher, they must follow the usual PHA rules or face possible loss of their voucher assistance. PHA must follow their usual procedure in terminating assistance, to include an appeal process.

27. DEATH OF THE VETERAN

When a Veteran participant, who is under lease using the HUD-VASH voucher dies, then the family members who are also registered on the voucher and lease are able to continue to utilize the HUD-VASH voucher until another voucher from PHA is available for their use, as long as they remain otherwise eligible. Case management is not available through this program without the Veteran, but it can be arranged for the family if needed through referral to community or other programs. ***NOTE:*** *Additional information on HUD Operating requirements can be viewed at: http://www.hud.gov/offices/pih/programs/hcv/vash/index.cfm Also, see the "Questions and Answers:" http://portal.hud.gov/hudportal/documents/huddoc?id=DOC_9175.pdf.*

28. PROTECTION FOR VICTIM

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

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

b. Upon termination of a perpetrator's HUD-VASH voucher due to the perpetrator's acts of domestic violence, the victim receiving protection is to be given a regular HCV by PHA, if one is available. If a regular HCV is not available for the victim, the victim continues to utilize the HUD-VASH voucher.

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

29. CASE MANAGEMENT

a. The frequency of contacts and the intensity of involvement that HUD-VASH case managers have with the Veteran are dependent on the needs of the Veteran and can vary based on individual circumstances. HUD-VASH case managers must continuously assess the needs of the Veteran and match the intensity of services to the Veteran's need and situation.

(1) Typically, in the early stages (0-3 months), there is more frequent, intense involvement.

(2) However, as the Veteran stabilizes and transitions (3-9 months), fewer interventions are required.

(3) Veterans with more confidence, more support in the community, and who are functioning at an independent level would require the fewest interventions. At that time, involvement would most likely consist of monitoring, unless a new crisis develops requiring re-engagement at a more intense level.

(4) At some point, it may be mutually agreed that case management is no longer needed and discharge is planned.

(5) In other cases, the Veteran may decide they are no longer willing to engage in case management, despite the evident need for it, which may also result in discharge.

b. There are three levels of case management which are related to the CTI Model, but modified to meet the unique needs of the HUD-VASH Program. The Active level is the most intensive, the Stabilization level is moderately intensive and the Maintenance level is the least

intensive. The Veterans progress may not be linear. In fact, it is more likely that progress will vacillate between these levels.

(1) **Intensive.** The HUD-VASH case manager works with the Veterans to obtain clinical stability while helping with the PHA eligibility portion of the referral, such as completing required applications or obtaining documentation. At a minimum, there should be weekly visits, but even more frequent interactions than may be needed.

(2) **Stabilization.** At this stage, the Veterans are seeking, moving into, and establishing housing. This requires linkage to community resources, and planning assistance from the case manager. At least twice a month visits would be expected.

(3) **Maintenance.** Case management is provided to the Veterans in the community. Case management services ensure that needed treatment, support, and mentoring assistance continue after placement in housing. Linkages to VA programs other than HUD-VASH and community agencies need to be firmly in place and reinforcing the Veteran's ongoing recovery. Contacts need to occur at least every month.

30. RURAL CASE MANAGEMENT

For rural HUD-VASH Programs, consideration must be given to embedding the HUD-VASH-HCHV team in the E-RANGE Program and sharing case management duties with the E-RANGE Social Workers.

a. The E- RANGE Program has a mix of regular outreach services that include physician assistant or nurse practitioners psychiatry, psychology, nursing, supported employment, and peer support specialist.

b. In the initial phase of the program, the Veteran can enter the HUD-VASH Program with intensive case management provided by the MHICM Range team social worker and the HUD-VASH case manager. In this phase, the MHICM social worker might be the primary clinician with other supportive services provided by the subject matter experts on the team as needed.

c. The housing services are provided by the HUD-VASH case manager.

d. As the Veterans move into less intense phases of the program, primary case management can be transitioned to the HUD-VASH case manager.

e. Veterans can also participate in other programs, such as Care Coordination, Home Telehealth, and Tele-mental health depending on their medical and psychosocial needs.

f. Monitoring and case management throughout all phases is shared by the team, with ongoing consultation.

31. PORTABILITY

a. The HUD-VASH HCVs are portable. Portability allows Veterans to live in the community of their choice with some limitations. HUD-VASH participants may only reside in those jurisdictional areas that are accessible to case management services as determined by VA.

b. Rules pertaining to portability are dependent on whether the family moves within or outside of the referring VA facility's catchment area. ***NOTE:*** *For more information on Portability, see "Portability Attachment" on HUD's HUD-VASH Web page at: http://www.hud.gov/offices/pih/programs/hcv/vash/.*

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

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

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

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

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

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

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

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

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

(3) In all instances, HUD-VASH staff at the receiving VA must be consulted prior to the move and agree that they can and will provide case management services.

(4) When a receiving HUD-VASH Program accepts a Veteran from outside their catchment area, the treatment team needs to utilize clinical judgment in determining that Veteran's priority for receiving one of their vouchers. Decisions are to be based on whether the Veteran has a compelling reason for the request, the necessary resources, and a plan.

32. ENDING CASE MANAGEMENT SERVICES

Graduation from case management is a goal of the program in order to help the Veteran achieve optimal functioning and the ability to live independently in the community. Some Veterans are able to achieve this goal more quickly than others. Case managers, in consultation with the Veteran, determine if the Veteran achieves this milestone. Follow up after graduation may consist of periodic check-in, and participation in alumni groups and social activities.

a. A Veteran family that no longer needs case management, as determined by the VA case manager, may still be eligible for rental assistance under the voucher program. In cases where case management is no longer needed and the Veteran family remains below the income limits, PHA may use one of its own vouchers, if available, to continue assisting this family and free up a voucher for another HUD-VASH eligible family. If a regular voucher is not available, the Veteran family continues utilizing the HUD-VASH voucher. If a HUD-VASH voucher is switched to a regular voucher, the family is not subject to PHA's waiting list because the family is already a participant in PHA's HCV Program.

b. Veterans who do not meet the goals and objectives outlined in their housing case management plan must be re-assessed to determine any barriers to compliance. It is the responsibility of the case manager to work with the Veteran to eliminate the barriers, which may involve engagement issues, continued active use of substances, SMI, or a history of violence. The case manager is expected to continue efforts to engage the Veteran, unless there is a risk to the safety of the case manager. It may require using Motivational Interviewing techniques to assist the Veteran in redefining goals and making needed changes to the housing and case management plan. It is also advised that consultation with facility Mental Health leadership, Police Service, other VA programs staff, such as SUD programs, MHICM, or other homeless programs be utilized for assistance in determining alternative clinical treatment approaches.

c. In some instances, discharge from the HUD-VASH Program may be required if the Veteran refuses, despite all efforts, to engage in case management or is lost to contact. Veterans who choose to participate in behaviors that are adverse enough to result in eviction from the unit, or arrest may be terminated from case management and have the voucher revoked by PHA following the applicable laws and processes. It is highly recommended that the case manager always seek appropriate consultation with NHC on adverse events to determine the next course of action.

NOTE: *Non-compliance with HUD-VASH does not necessarily lead to loss of the Section 8 HCV voucher. PHA rescinds the HCV if the Veteran no longer meets, or is non-compliant, with PHA requirements. The Veteran receives written notification from PHA of this action.*

d. Case managers must document with a progress note and in HOMES when a Veteran leaves the program.

e. The number of Veterans discharged from the program, and the reason, must also be entered into the HUD-VASH data base each month. This is closely monitored and analyzed for the presence of any trends requiring further discussion with individual sites.

33. WORKLOAD, CREDIT STOPS, AND DOCUMENTATION

a. The HUD-VASH Program intends to incorporate the CTI Model into the assignment and management of caseloads.

(1) Veterans are grouped by the acuity of their needs and the intensity of the interventions required which are broken down into three distinct phases, each of which lasts about 3 months.

(2) All clinicians need to have a mix of Veterans in the low, medium, and high-intensity phases on their caseloads.

(3) The case management ratio may vary depending on the number of Veterans in the program at each level of acuity at any given time.

(4) HUD-VASH Program Coordinators continually evaluate case mixes for balanced distribution of staff caseloads.

b. Acuity of Veterans in the HUD-VASH Program can be determined by reviewing:

(1) The indices from the Vulnerability Index.

(2) Global Assessment Functioning (GAF) scores.

(3) The number and type of diagnoses of the Veteran, using all five axes.

(4) The number and length of times spent in mental health and homeless programs.

(5) How chronic the Veteran's homelessness has been.

(6) How recently the Veteran has been discharged from an institutional setting.

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

d. HUD-VASH SUD Specialists are to use 522 as the primary stop code and 514 as the secondary code to document their workload, if services are provided to an individual or group in the community. If the services are provided to an individual at the medical facility, 513 is to be

the secondary stop code. If services are provided to a group at the medical facility, 560 is to be the secondary stop code.

e. Telephone contacts made by HUD-VASH Program case managers with homeless Veterans with mental health or SUD, or with members of homeless Veterans' families, are entered into the 530 stop code.

f. Specific local note titles for the HUD-VASH Program must be established at each site and the titles must be tied to the HUD-VASH 522 or 530 stop codes. Workload credit must be claimed by the HUD-VASH case manager for all clinical contacts with the Veteran before and after the date of formal admission, with appropriate documentation.

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

34. INTERNAL ADMINISTRATION

a. **Local Written Policies and Procedures.** Local policies and standard operating procedures may be developed by HUD-VASH Program sites. These local documents may pertain to such things as: position descriptions and duties, staff competency assessments, staff transportation and education policies, regulations and procedures for psychiatric and medical emergencies and routine care, documentation policies, program rules and regulations, Patient Advocate Services and grievance procedures, and Quality and Performance Initiative reports.

NOTE: *It is encouraged to integrate these operating procedures with the other facility homeless programs, such as HCHV, GPD, CWT-TR and Domiciliary or MHRRTP Programs, as HUD-VASH is a significant component in the homeless continuum of care and in meeting the intent of the VHA Handbook 1160.01.*

b. **Medical Records.** Medical record documentation must comply with applicable TJC and CARF requirements, as well as local medical facility policy and procedures. Documentation must reflect planning with the Veteran that is individualized, developed with the input of the Veteran and information gathered from an assessment. Plans are to be reviewed for relevance and modified as needed. Documentation is to note progress toward achievement of goals and objectives in the plan, significant events in the person's life, the delivery of services and specific interventions, referrals, and discharges or transitions to other levels of care.

c. **Confidentiality.** VA may disclose relevant health care information to health and welfare agencies, housing resources, and utility companies, possibly to be combined with disclosures to other agencies, in situations where VA needs to act quickly in order to provide basic and/or emergency needs for the patient and patient's family where the family resides with the patient or serves as a caregiver as outlined in the Federal Register/Vol.74, No. 222/Thursday, November 19, 2009/Notices Department of Veterans Affairs, Privacy Act of 1974, System of Records #40

found on http://www.gpo.gov/fdsys/pkg/FR-2009-11-19/pdf/E9-27786.pdf. In instances of uncertainty, consult with the facility Privacy Officer.

d. **Conflicts of Interest.** In networking with not-for-profit agencies or other community-based providers, HUD-VASH Program teams must be aware of the possibility of situations that could be perceived as, or lead to, conflicts of interest.

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

(2) HUD-VASH staff must comply with all applicable laws, including the Government-wide "Standards of Ethical Conduct for Employees of the Executive Branch," found at 5 CFR Part 2635 http://www.usoge.gov/DisplayTemplates/StatutesRegulationsDetail.aspx?id=293 .

(a) In the field, any questions in this area need to be directed to the Regional Counsel.

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

35. PROGRAM MONITORING AND EVALUATION

a. **Goals.** The goals of the program evaluation are to describe the status and clinical needs of homeless Veterans, monitor services delivered to Veterans in the program, determine treatment outcomes and program effectiveness, ensure program accountability, and identify ways of refining the clinical program.

b. **Program Evaluation.** The monitoring component of the HUD-VASH Program evaluation provides on-going information about program operation. This monitoring effort includes:

(1) Collection of information about staffing and staff vacancies;

(2) Measurement of the workload of HUD-VASH Program clinicians (i.e., number of Veterans served and number of contacts with each Veteran);

(3) Analysis of information concerning the Veterans served in the program;

(4) Documentation of the referral, assessment, and housing placement process; and

(5) Longitudinal assessment of case management services and Veteran outcomes.

c. **Critical Monitors.** Various indicators, called critical monitors, are used to ensure that each program site conforms to the goals of the overall program. Some of the more important indicators are:

(1) The number of Veterans screened for the HUD-VASH Program,

(2) The number of Veterans entering and the number of Veterans being refused HUD-VASH Case Management,

(3) The length of time Veterans served by the program have been homeless, and the percentage who meet the definition of being chronically homeless,

(4) The presence of psychiatric illness and SUD among Veterans served, the number of Veterans who have families, the number of Veterans who are women, or the number of Veterans who have served in OEF, OIF, and OND theaters of combat.

(5) The number of HUD-VASH Veterans referred to the local PHAs.

(6) The number of Veterans issued vouchers from PHAs.

(7) The number of Veterans housed or "having a lease in hand" through HUD-VASH.

(8) The length of time each step of the process took.

(9) The number of vouchers returned as Veterans either successfully complete the program or drop out for some adverse reason.

(10) Veteran satisfaction.

d. **Data Collection.** This data is captured in HOMES, through the electronic HUD-VASH Database, and the Mental Health Initiatives Reporting System maintained by VA Central Office. HUD-VASH case managers must submit data that is accurate and on time.

e. **Assessment of Performance.** Performance of the HUD-VASH Program at each medical facility is assessed through comparison with other sites, especially with respect to these critical monitors. Those sites, which differ significantly from the others on any particular indicator, are identified as outliers. The identification of a site as an outlier may help the HUD-VASH Program Coordinator to align the site more closely with the national program. However, sometimes there are reasons for the difference, which are related to situations peculiar to a site, and which do not warrant correction. HUD-VASH Program Coordinators discuss the local program environment and the possible need for changes in the operation with their respective HUD-VASH Regional Managers, and where indicated, with the National Director of the HUD-VASH Program.

f. **Feedback to Local HUD-VASH Programs.** The National Center for Homelessness Among Veterans issues an annual progress report to Congress, which details the HUD-VASH Program on a national basis and the work of each HUD-VASH Program site. Programs are also continuously given information about their performance through the national and regional HUD-VASH conference calls, discussions between the HUD-VASH Regional Managers and the NHCs, and by emails. Preliminary tables for the progress report and electronic HUD-VASH data base are distributed to all sites and posted on the HUD-VASH SharePoint. ***NOTE:** The*

SharePoint can be accessed by all HUD-VASH staff registered with the HUD-VASH e-mail group at: http://vaww.national.cmop.va.gov/MentalHealth/HUDVASH/Forms/AllItems.aspx. This is an internal link and is not available to the public.

g. **Use of Evaluation Data at Local HUD-VASH Program.** Local HUD-VASH Programs often find the information captured by National Center for Homelessness Among Veterans and the national HUD-VASH Program Office in VA Central Office to be useful for clinical and administrative purposes. Evaluation data are sometimes used in support of quality assurance efforts, staff and student education, and public relations within, and outside of, the medical facility. ***NOTE:*** *The HUD-VASH Database and Mental Health Initiatives Reporting System link is: http://vssc.med.va.gov/mhinitiatives/.*

h. **Quality and Performance Processes.** Quality assurance and improvement processes are to be carried out in conjunction with, and according to, medical facility Quality and Performance Initiatives.

i. **Accreditation**

(1) HUD-VASH Programs may be required to obtain TJC or CARF certification. This independent third-party review is crucial to the quality of VA programs and their perception in both the medical care industry and the community.

(2) With regard to CARF, the following standards are most applicable:

(a) Under 2010 Behavioral Health, Section 3B, Behavioral Health Core Program Standards, Case Management (CM) or Services Coordination

(b) Under 2010 Employment and Community Services:

1. Section 5E, Psychosocial Rehabilitation Programs, CM; and

2. Section 4B Community Services Coordination (CSC).

NOTE: *Complete details about CARF accreditation are located in VHA Handbook 1170.01. For further guidance, staff needs to consult with their local Quality Management.*