Housing for Health Partnership Policy Board
Policy Review – Notes for System of Care Standards
Updated October 29, 2026

1. What existing policies, standards and procedures are being replaced or superseded by today's System of Care Standards?

None. The System of Care Standards represents a new document for the CoC that consolidates information into a system wide standards document. The performance benchmarks listed in the document represent standards established by prior CoC Board action and updated based on feedback received related to federal benefit eligibility changes. The standards were based on an analysis of state and federal articulated goals released through funding notices and a review of historical performance by providers.

2. What are the most significant substantive changes from those existing policies?

There are no significant substantive changes. The document is primarily a summary of existing federal and state expectations of CoC-partnered programs and services.

3. Could staff distinguish the major provisions that are (a) federal/state requirements, (b) existing H4HP policies or practices being consolidated, and (c) new or materially changed local policy decisions requiring Board approval?

The document outlines and references specific federal and state requirements when they apply. It incorporates information from previously adopted standards for HMIS and coordinated entry. Staff do not believe the document presents new or materially changed local policy decisions. The document has been reviewed and commented on by members of the CoC and the CoC operations workgroup.

4. Where did the numerical performance standards come from? Which are existing requirements or benchmarks, which are new, and what consequence follows when they are not achieved?

The performance standards were developed based on federal and state performance expectations issued through notices of funding opportunities as well as a review of local HMIS participating program performance over time. These standards are currently utilized in Housing for Health executed contract agreements with providers. The CoC standards do not prescribe required actions if performance standards are not met. Performance on these benchmarks is one of several areas that can be utilized to evaluate the performance of a particular program/service type within the CoC. Based on feedback received through the public comment process, the System of Care standards includes updates to the income and benefits metrics.

5. Which providers or programs, if any, will become subject to requirements through today's action that they are not currently required to meet?

Section 4.5 – Informing Materials, Client Consent, and Grievance Procedures and Section 4.8 – Participant Engagement and Discharge Expectations represent more clearly articulated expectations of providers and programs in these specific areas. They do not represent new expectations. Staff anticipate it will take time to ensure current programs and providers appropriately follow these standards.

6. Were operational, staffing or fiscal impacts on providers evaluated as part of developing these standards? If so, what did that analysis show?

Yes. The standards generally reflect minimum standards from federal and state funding sources. Many of the federal and state-required standards are challenging to adhere to given inconsistent and unstable funding. Funding sources frequently limit the availability of dollars for staff training and development as well as indirect and administrative costs. The standards were developed in partnership with current operators of programs and services. CoC staff will be working with programs and providers in the community to adhere to these standards. Adjustments to the standards can be made as funding levels and federal and state regulations change over time.

7. What written comments were received from providers, people with lived experience and the public during development of these standards, and what substantive changes were made in response?

Public Comment 1 - "The topic of racial equity appears underdeveloped when compared to the ESG Policies and Procedures."

Response 1: The final section of the standards contains less information than in earlier versions given new guidance from the federal government on issues related to race and equity.

Public Comment 2 - "Based on the standards, I think they do a good job of describing how people experiencing homelessness should be treated in Santa Cruz County. I especially like the focus on treating people with dignity and respect, helping people get into housing as quickly as possible, keeping barriers to services low, giving people choices, and making services voluntary. I also think it is important that the standards recognize that homelessness is, at its core, a housing problem.

The standards do a good job of laying out what should happen for people once they are receiving services. Where I think they could be stronger is in setting expectations for how quickly staff and service providers should respond. Someone experiencing homelessness

should not have to wonder whether their message was received, who is going to get back to them, or how long they will have to wait for a response. The standards should make it clear that people deserve timely responses and clear communication throughout the process."

Response 2 – the standards articulate the importance of documenting communications and specific time frames for responses.

Public Comment 3 - "I've had good experiences this far. My disability has been recognized and prioritized thus far. "

Response 3 - appreciate the feedback that the commentor felt their disability was recognized and prioritized.

Public Comment 4 – ""The percentage of people who will exit to housing listed under each type of shelter, etc., seems ambitious. I think as a goal it is fine, but what are the repercussions, if any, if those percentages are not met?"

Response 4 - the targets included in the standards reflect a review of federal and state performance benchmarks released in prior funding notices as well as a review of historical performance among local programs. Based on changes to public benefits eligibility related to CalFresh and Medi-Cal, the standards propose some adjustments to the targets for income growth and benefits acquisition and retention. If programs do not meet the articulated standards, there are no prescribed or required actions. CoC staff use the standards to monitor project performance and to provide feedback to agencies and program staff. Organizations and programs that consistently underperform and refuse to engage in efforts to improve their outcomes may be considered for contract changes or terminations.

Public Comment 5 - "I worry that these standards exclude the majority of individuals experiencing homelessness because of the long wait to access coordinated entry. The system itself does not appear to be readily accessible except via street outreach, which may create unequal access-that is to say, a person submitting a connection request form may wait months longer for connection services than a person contacted by street outreach, resulting in different experiences of access."

Response 5 - The standards do not directly address questions related to system capacity and priorities. The annual CoC gaps and needs analysis does include information on the gaps that exist between request for connection services and connector capacity. Street outreach programs do prioritize services to unsheltered individuals in specific geographic areas or from specific target populations. These outreach programs can conduct outreach and provide services to individuals that contact United Way/2-1-1 for connection services.

Public Comment 6 - "Overall, I think the standards are headed in the right direction. The biggest thing for me is making sure that what we're asking providers to do actually matches what the system has the resources and housing available to do.

I also see a gap when outreach workers are doing everything they're supposed to do, but there still isn't a shelter bed or housing option available. We have to be careful not to put too much of that responsibility on the outreach worker or the person experiencing homelessness. If someone is staying engaged, has done what they've been asked to do, has their documents together, and is ready for housing, but there just isn't a housing option available, that's not necessarily a failure on their part. Sometimes we simply don't have enough housing or shelter to meet the need."

Response 6 - This comment highlights the gap between need and resource availability. The standards do not directly address this issue. The annual needs and gaps analysis provides an opportunity to gather information in this area. The performance metrics are based on an analysis of historical performance and may need to be adjusted if need versus resource gaps grow.

Public Comment 7 - "I see no gaps in my personal experiences."

Response 7 - *appreciate the feedback*.

Public Comment 8 – " I don't believe our current programs are readily accessible to the majority of people experiencing homelessness partly for the reason stated above. It is increasingly difficult to access shelter through direct outreach by individuals experiencing homelessness and many shelters only serve subsets of the population. I believe greater, regular transparency with respect to number of people being served by coordinated entry and current wait times to access coordinated entry is critical to understanding access. I believe standards for the system itself need to be included in this document. "

Response 8 - *see prior comments on needs and gaps analysis*.

Public Comment 9 - "I think the performance measures cover a lot of important things, especially whether people are getting housed, staying housed, increasing their income or benefits, and whether programs are keeping up with case management and documentation. Those are all important measures of whether a program is doing its job.

One additional measure I think we should consider is the participant's experience with the services they receive and the people they interact with along the way. When someone completes a program or is discharged, is there a final exit survey or follow-up to find out how their experience was?

I think we should be asking people questions like: Did you feel respected? Did you understand what was happening? Did you feel like you were getting the help you needed? Did someone follow up with you when you needed help? Did you know who to contact when you had a question or problem?

I think that feedback would give us a better picture of how well our programs are actually serving people, beyond just looking at the numbers."

Response 9 - *appreciate the feedback regarding the importance of gathering qualitative information as part of the CoC evaluation process. This is something the CoC can consider as a factor in developing its plans for conducting the annual needs and gaps analysis*.

Public Comment 10 - "I think the performance measures may be greatly impacted by changes at the federal level, and how they will trickle down to our CoC. Based on that, at least 40% of households increasing their benefits, income, and 90% of households having health insurance could be a bit high.

For example, is it 40% of people entering the program will increase their benefits, or is it 40% of all people in the program will increase their benefits? I think instead of increasing, by 40%, etc,, it could also be that at lease 40% maintain their benefits. It will be difficult to increase the benefits of 40% of the population each year."

Response 10 - *the updated DRAFT performance metrics include proposed changes and reductions to the income and benefits targets given current and upcoming changes to benefits eligibility*.

Public Comment 11 - "I think testing various components of the system could help identify barriers. I think soliciting feedback from service providers and participants via online polls would be helpful. I think having a simple, easy-to use, system-wide grievance procedure would help."

Public Comment 12 - "I know we already have the Connector Meetings and Case Management Discussions, but I wonder if it would also be helpful to have a separate opportunity to hear directly from people who have received services. Their experience can tell us a lot about whether the standards are actually being followed and what the experience is like from the client's perspective.

I also think we should be clear about what happens when a provider or program isn't meeting the standards, but also what happens when a client isn't able to meet an expectation. What is the process in those situations, and is there an opportunity to understand why before moving toward a discharge or other decision?"

Response 11 and 12 – *this feedback is consistent with other feedback to create opportunities for the CoC to receive qualitative information as part of its evaluation process, including the incorporation of grievance data and patterns*.

SANTA CRUZ COUNTY
Housing for Health
PARTNERSHIP

Housing for Health Partnership System of Care Standards

Table of Contents

1. Introduction to Housing for Health Partnership System of Care Standards 5

1.1 Purpose of Standards 5

1.2 Standards Development 6

1.3 Process for Updating the Standards 6

2. Housing for Health Partnership System of Care Overview 7

2.1 Description of Santa Cruz Housing for Health Partnership System of Care 7

2.2 Governance & Oversight 8

2.3 Homeless Definitions 11

2.4 System-Wide Performance Goals 12

2.5 Federally Funded Program Requirements 12

3. Crosswalk of Applicability of Standards by Program Type 14

4. Standards Applicable to All Program Types 15

4.1 Core System Principles and Approaches 15

4.2 Non-Discrimination 18

4.3 Confidentiality 21

4.4 Reasonable Accommodations and Modifications 23

4.5 Informing Materials, Client Consent, and Grievance Procedures 25

4.6 Serving Overrepresented and Special Populations 26

4.7 Participation of People with Lived Experience of Homelessness 27

4.8 Participant Engagement and Discharge Expectations 28

4.9 Housing Problem Solving 29

4.10 Use of HMIS 30

4.11 Referral, Enrollment, and Coordinated Entry 30

4.12 Housing for Health Partnership System of Care Coordination & Collaboration 31

4.13 CalAIM and Medi-Cal Managed Care Services 32

4.14 Safety Transfer Policy in accordance with the Violence Against Women Act 33

4.15 Federally Required Record Keeping 33

5. Standards for Coordinated Entry Connector Services 35

5.1 Purpose of Coordinated Entry Connector Services 35
5.2 Referral Process and Enrollment 35
5.3 Minimum Standards and Required Services 36
5.4 Program Discharge 37
5.5 Performance Measures 37
6. Standards Applicable to Housing-focused Street Outreach 39
6.1 Purpose of Housing-focused Street Outreach 39
6.2 Referral Process and Enrollment 39
6.3 Minimum Standards and Required Services 40
6.4 Program Discharge 41
6.5 Performance Measures 41
7. Standards Applicable to Emergency Shelter 42
7.1 Purpose and Types of Year-Round Emergency Shelter 42
7.2 Other Temporary Accommodations 43
7.3 Referral Process and Enrollment 44
7.4 Minimum Standards and Required Services 46
7.5 Program Discharge 47
7.6 Performance Measures 48
8. Standards Applicable to Homelessness Prevention 49
8.1 Eligibility and Prioritization 49
8.2 Amount and Duration of Assistance 50
8.3 Required Services 50
8.4 Program Discharge 50
8.5 Performance Measures 51
9. Standards Applicable to All Housing Programs 52
9.1 Purpose and Types of Programs 52
9.2 Referral Process 52
9.3 Enrollment 52
9.4 Housing Standards 52
9.5 Documentation and HMIS requirements 53
10. Standards Applicable to Transitional Housing 54

DRAFT

10.1 Eligibility 54
10.2 Required Services 55
10.3 Duration of Assistance 55
10.4 Program Discharge 56
10.5 Performance Measures 56
11. Standards Applicable to Rapid Rehousing 58
11.1 Eligibility 59
11.2 Amount and Duration of Rental Assistance 59
11.3 Required Services 60
11.4 Program Discharge 61
11.5 Performance Measures 62
12. Standards Applicable to Permanent Supportive Housing 63
12.1 Eligibility 64
12.2 Required Services 64
12.3 Program Discharge 65
12.4 Performance Measures 65
13. Cross References, Resources, and Appendices 67
13.1 Cross References 67
13.2 Resources 69
Appendix A - Glossary 70
Appendix B – Homeless Definitions 77

DRAFT

Document Properties

Document Name	Housing for Health Partnership System of Care Standards
Effective Date	MM/YY
Next Review Required By	MM/YY
Approving Entity	Housing for Health Partnership Policy Board
Contact Person	Sheryl Norteye, Housing for Health Division, Senior Human Services Analyst, Sheryl.Norteye@santacruzcountyca.gov

DRAFT

1. Introduction to Housing for Health Partnership System of Care Standards

1.1 Purpose of Standards

The Housing for Health Partnership (H4HP) System of Care Standards provide an overview of expectations regarding the network of housing and services programs, known as the Housing for Health Partnership System of Care ("H4HP System"), that help people experiencing or at imminent risk of homelessness obtain and maintain healthy, safe, and stable housing. The standards include both Universal Standards, which apply to all components of the H4HP System, and Project Type Standards, which apply only to specific types of programs.

The H4HP System includes programs, contractors, and community partners in Santa Cruz County who:

1. Receive federal, state, or local funding requiring participation in or collaboration with the Housing for Health Partnership (H4HP), the Watsonville/Santa Cruz City and County Continuum of Care (CoC), including participation in Coordinated Entry or the Homeless Management Information System (HMIS); and/or
2. Hold a contract with the County of Santa Cruz Human Services Department's Housing for Health Division ("H4H Division"); and/or
3. Have a formal partnership agreement to participate in the H4HP System.

Any organization or program in one or more of these three groups is considered part of the H4HP System, referred to in this document as "System Providers." H4HP strongly encourages other organizations operating within Santa Cruz County and serving people experiencing or at risk of homelessness to become part of the H4HP System. If entities cannot or choose not to participate in the H4HP System formally, they should consider adopting these standards whenever appropriate to promote communitywide consistency.

Local agencies that receive U.S. Department of Housing and Urban Development (HUD) grants through the Continuum of Care (CoC) and Emergency Solutions Grant (ESG) programs are required to participate in the H4HP System. Certain state and local grants also require recipient agencies' participation in the H4HP System, including but not limited to:

- California Department of Social Services Housing and Homelessness programs
- California Department of Housing and Community Development (HCD) programs such as:
  - Homeless Housing, Assistance and Prevention (HHAP)
  - No Place Like Home (NPLH)
  - Homekey / Homekey+
  - Encampment Resolution Funding (ERF)
- California Department of Health Care Services (DHCS) programs such as:
  - Behavioral Health Bridge Housing
  - Medi-Cal Transitional Rent
  - Behavioral Health Services Act (BHSA).

Commented [RR1]: IMPORTANT: When these standards apply.

Commented [RR2]: IMPORTANT: Current list of known funding sources that require partnering with the CoC and using CoC standards.

DRAFT

The H4H System standards serve several purposes:

1. Ensure System Providers design and operate programs in alignment with applicable laws, funder requirements, and best practices.
2. Create a consistent and fair experience for all participants accessing housing and services through H4HP partner agencies.
3. Establish written policies and procedures that meet federal and state funding requirements, including HUD CoC and ESG regulations.
4. Outline required standards for locally funded programs not receiving federal funding but required to participate in the H4HP System.
5. Provide guidance to funding partners on recommended standards to include in contracts.

1.2 Standards Development

The H4H Division developed these standards in collaboration with the H4HP Policy Board, the governing body for the CoC, following an inclusive community engagement process.

The following groups reviewed and provided input to refine the draft standards:

- Representatives from System Provider agencies participating in the CoC Operations workgroup
- People with lived experience (PWLE) of homelessness involved in CoC action boards

Additionally, the draft standards were shared for community input during a July 2026 comment period:

- Date posted for public comment: July 15-29, 2026
- Location: H4HP website

Community input was received through written comments during the public review period.

In addition to public comments, these standards were reviewed and input was provided ~~from~~by the Operations Working Group. The H4H Division reviewed and considered all input received during this period prior to finalizing the document. The H4HP Policy Board formally adopted the standards on [Insert final adoption date].

1.3 Process for Updating the Standards

H4H will review and update these standards a minimum of every three years in accordance with the H4HP Policy Practices document, which establishes a process for creating, reviewing, approving, and maintaining policies.

Standards will be updated as needed to reflect significant program changes, new laws, regulations, and funding sources, and/or the introduction of new program models or best practices.

DRAFT

2. Housing for Health Partnership System of Care Overview

2.1 Description of Santa Cruz Housing for Health Partnership System of Care

The H4HP System is committed to work to ensure all County residents have stable, safe, and healthy places to live. The H4HP System includes a range of programs operated directly by the County or other local jurisdictions, nonprofits, health care providers, faith-based organizations, housing providers, and others. It includes structures for governance and oversight, planning, day-to-day administration and operations, and data systems for tracking resources, housing and service utilization, and outcomes.

The H4HP System offers a continuum of program types and activities designed to prevent homelessness, quickly resolve housing crises, and support long-term housing stability including:

Commented [RR3]: IMPORTANT: List of program types with developed standards.

- **Homelessness Prevention:** Activities include emergency assistance for people at-risk of homelessness. These activities may include Housing Problem Solving, light-touch supportive services, financial or legal assistance to avoid eviction, and relocation support.

- **Housing-focused Outreach and Coordinated Entry Connector Services:** Activities include engaging people experiencing homelessness, addressing their basic needs, and connecting them to resources and services available within the H4HP System and the broader community. These activities may include providing Housing Problem Solving support, conducting Housing Needs Assessments, developing Housing Action Plans, and coordinating and managing referrals to the H4HP System's housing and service resources. Connectors offer strengths-based, housing-focused assistance to help participants access housing solutions.

- **Emergency Shelter:** Activities include providing short-term, safe, temporary shelter for individuals and families who have no other safe place to stay. These programs offer a safe place to stabilize, meet basic needs, and provide housing-focused support to help participants resolve their housing crisis and transition to permanent housing as quickly as possible.

- **Transitional Housing:** Activities include providing safe, temporary housing for individuals and families who have no other safe place to stay; allowable transitional housing stays are typically between six to twenty-four months. These program sites meet housing rather than shelter facility standards. They provide a safe place to stabilize, meet basic needs, and provide housing-focused support to help participants resolve their housing crisis and transition to permanent housing as quickly as possible. Transitional Housing programs typically serve specific populations and offer support related to their needs, including families, transition age youth, veterans, those re-

DRAFT

entering from jail or prison, and individuals struggling with mental health or substance use challenges.

- **Permanent Housing programs:** Activities include helping individuals and families obtain and sustain safe, affordable homes that meet their needs. Permanent Housing programs vary in duration and service intensity but share a focus on supporting long-term housing stability. Permanent Housing programs include:
  - **Rapid Rehousing** provides a time-limited housing subsidy typically for less than 24 months coupled with intensive supportive services; and
  - **Permanent Supportive Housing** provides an ongoing housing subsidy and intensive supportive services to keep housing affordable and sustainable over the long term.

2.2 Governance & Oversight

Commented [RR4]: Summary of CoC Board Approved Governance Charter.

The H4HP System operates within a defined governance and oversight structure that establishes roles, responsibilities, and decision-making processes to ensure effective coordination of housing and services resources across Santa Cruz County.

2.2.1 Continuum of Care – Housing for Health Partnership (H4HP)

- **Continuum of Care Overview:** For communities to receive some federal homeless assistance funding, the federal Department of Housing and Urban Development (HUD) requires communities to establish a Continuum of Care (CoC) planning body. The overarching CoC responsibility is to ensure community-wide implementation of efforts to prevent and end homelessness. This role includes ensuring programmatic and systemic effectiveness of local CoC housing and service programs. The CoC membership should be representative of community members interested and involved in local efforts to prevent and end homelessness.

  H4HP is the federally designated CoC planning body for the Watsonville/Santa Cruz City and County CoC. H4HP represents a collaboration of nonprofit service providers, people with lived experience of homelessness, other concerned community members, and advocates, and five public jurisdictions, including the County of Santa Cruz and the cities of Santa Cruz, Watsonville, Capitola, and Scotts Valley. H4HP is made up of a Policy Board, an Operations Workgroup, Lived Expertise Action workgroups, other *ad hoc* working groups, and a general membership open to all. Additional information about these groups can be found in the H4HP Governance Charter. The H4H Division provides staffing and operational support for the H4HP.

- **Geographic coverage of the CoC:** The H4HP CoC covers the entirety of Santa Cruz County, California.

DRAFT

- **General membership of CoC:** The CoC general membership is made up of a wide range of community members committed to ending and preventing homelessness in Santa Cruz County, representing approximately 60 different organizations and 1,812 individual members. CoC membership is open to all interested parties in Santa Cruz County, and includes representatives from nonprofit service and housing providers, victim services providers, faith-based organizations, local government, advocates, and people with lived experience of homelessness.

  Interested individuals and organizations can sign up to become members of the CoC by completing a form on the H4HP webpage and a membership participation agreement. General CoC membership meetings are held at least twice a year.

- **Policy Board:** The H4HP Policy Board oversees high-level planning and decision-making for the Continuum of Care (CoC). This board is made up of community leaders who represent multiple groups and constituencies involved in preventing and ending homelessness. Members of the Policy Board include representatives from local jurisdictions, System Providers, partner organizations, law enforcement, and the business community. At least two members must have lived experience with homelessness.

  The Policy Board delegates implementation, operational, and planning responsibilities to specific working groups. These working groups provide recommendations and guidance on key operational and system improvement issues.

- **Operations Workgroup**: The Operations Workgroup supports system operations, implementation of CoC policies, and identifies needed updates to procedures and practices. The Workgroup consists of key housing and service providers, including CoC and ESG recipients, HMIS-participating organizations, and partners directly involved in delivering programs and services. Members represent a cross-section of program types, subpopulations, and geographic areas, including individuals with lived experience of homelessness.

  The Operations Workgroup is responsible for reviewing operational issues, developing recommendations for system improvement and new or updated policies and procedures for Policy Board consideration.

2.2.2 Overview of Responsibilities of a Continuum of Care

The H4HP carries out the responsibilities required under HUD regulations, as set forth in 24 CFR Part 578 – Continuum of Care Program. These responsibilities include:

Commented [RR5]: Summary of HUD regulations regarding CoC responsibilities.

- **Operate the CoC**: Hold meetings, invite new members, develop a governance charter, set performance targets for the system, establish a Coordinated Entry System, and develop and adopt systemwide standards.

- **Design and Operate the Homeless Management Information System (HMIS):** Appoint an HMIS Lead, establish privacy, security, and data quality plans, and ensure compliance with HUD requirements.

- **Conduct CoC Planning:** Coordinate the implementation of a housing and service system that meets the needs of homeless individuals and families, plan and conduct a biennial point-in-time count of persons experiencing homelessness and conduct an annual gaps analysis of local housing and service needs.

- **Lead Processes for Responding to Notices of Funding Opportunity (NOFOs) for CoC and ESG funds:** Conduct the periodic community planning and application processes by which the CoC develops and submits applications for HUD CoC and Emergency Solutions Grant (ESG) funding.

- **Designate Key Roles**: Determine which organizations will fill specific roles, such as the Collaborative Applicant for HUD CoC funding (Collaborative Applicant), the HMIS Lead, and the Coordinated Entry Management Entity.

2.2.3 Designated CoC Roles

The H4H Division and other key partners perform specific functions necessary for the governance and implementation of the H4HP System on behalf of the CoC. These roles are described in detail in the CoC Governance Charter and include:

- **Collaborative Applicant/Lead Agency:** The H4HP Policy Board designated the H4H Division as the CoC's Collaborative Applicant and Lead Agency. As the Collaborative Applicant, the H4H Division works with H4HP and System Providers to develop project proposals and submit the annual application to HUD for CoC program funds. As the Collaborative Applicant, the H4H Division is the recipient of CoC Planning Grant funds on behalf of the CoC. In addition, the H4H Division manages the application process for state Homeless Housing, Assistance and Prevention (HHAP) funding and oversees the local competition to recommend grantees for State-administered ESG funds.

- **HMIS Lead Agency:** The H4HP Policy Board also designated the H4H Division to serve as the HMIS Lead Agency. As the HMIS Lead Agency, the H4H Division is responsible for the implementation and administration of the data system, which includes developing and maintaining policies and procedures, and monitoring end-user licenses, data quality, and progress towards identified performance

metrics. The H4H Division provides training to providers on utilizing the HMIS and ensures that training offered by the HMIS Administrator is locally relevant.

- **HMIS Administrator:** Bitfocus is the company that provides and administers the Clarity database system that H4HP uses for HMIS. The H4H Policy Board designated Bitfocus to operate HMIS, ensuring that the local system has access to HMIS software and functionality for the collection, management, and analysis of data on people served by local programs. Bitfocus assists the H4H Division with other HMIS-related tasks, including HMIS system training and aggregate data reporting and extraction.

- **Coordinated Entry Management Entity:** The CoC Board designated the H4H Division as the Coordinated Entry Management Entity. As the Management Entity, the H4H Division is responsible for the day-to-day operations of the Coordinated Entry System, including maintaining standardized screening and assessment processes, training users, and monitoring usage of the system. HMIS is used for all Coordinated Entry activities, including enrollment, documenting Housing Needs Assessments and Housing Action Plans, housing program prioritization, queue management, and matching eligible participants to available resources.

- **Governing Body:** The H4HP Policy Board serves as the CoC Board. The Policy Board sets overall policy direction and provides system oversight to the H4HP, as described above.

2.3 Homeless Definitions

Commented [RR6]: From HUD regulations.

HUD's definition of homelessness for program eligibility is organized into four distinct categories. Appendix B and HUD's Homeless Eligibility Overview provide complete definitions for each category.

- Category 1: Literal Homeless
- Category 2: Imminent Risk of Homelessness
- Category 3: Homeless Under Other Federal Statues
- Category 4: Fleeing/Attempting to Flee Domestic Violence

Most programs in the H4H System limit eligibility to households that qualify under categories 1 and 4. Category 1 refers to people who lack a fixed, regular, and adequate night-time residence. Category 4 refers to people who are fleeing or attempting to flee domestic or dating violence and other forms of violence or threats. These categories are prioritized for housing resources as they represent the populations with the most urgent and/or life-threatening housing needs.

Category 2 describes households that are at imminent risk of losing their housing within 14 days. Category 3, Homeless Under Other Federal Statutes, pertains to unaccompanied youth (under age 25) or families with children and youth. Category 3 households are not currently eligible for CoC funding; however, they may be served with ESG funding.

Certain programs require that participating households fit the definition of "chronically homeless." Chronic homelessness is defined based on the length or frequency of homelessness and the presence of a disabling condition. For more details on the specific requirements, please refer to Appendix B.

HUD also provides a separate definition for individuals and families who are "at risk of homelessness," which applies to ESG grant recipients engaged in homelessness prevention activities. This definition is also available in Appendix B.

2.4 System-Wide Performance Goals

The Housing for a Healthy Santa Cruz strategic framework for addressing homelessness outlines action steps for H4HP and system partners to reduce homelessness. It details H4HP's goals and strategies for reducing both sheltered and unsheltered homelessness and aligns local performance outcomes with those HUD sets for "High Performing Communities."

Specifically, the strategic framework describes four system-level goals developed in collaboration with system and community partners:

1. Reduce the length of time people experience homelessness;
2. Reduce the percentage of people returning to homelessness;
3. Ensure local data captures information on program outcomes and community needs; and
4. Coordinate outreach and access to services across the region.

Commented [RR7]: This reflects the priorities in the current strategic framework. These metrics can be updated in the new framework.

The H4H Division provides leadership and administrative support for the implementation of framework goals, including regular reviews of progress reports available through HMIS and updates to H4HP and system partners on progress towards goal attainment.

System Providers are expected to support these goals through high-quality services and accurate HMIS documentation.

HUD requires CoCs to report data on federally defined, community-wide performance measures as part of the annual CoC Program Competition. All System Providers are responsible for developing and implementing agency-level policies and procedures that promote strong performance on these System Performance Measures and high data quality standards to support H4HP's ability to track and report on these measures.

2.5 Federally Funded Program Requirements

The HUD CoC and ESG programs represent the H4HP System's primary federal investments in services and housing options. System Providers receiving federal HUD CoC and ESG funds to address homelessness, whether directly or through a contract with the State or County, must adhere to specific laws and regulations as defined in the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 and related regulations put

DRAFT

forward by HUD, including the Continuum of Care (CoC) Interim Rule (24 CFR 578) and the Emergency Solutions Grants (ESG) Interim Rule (24 CFR 576). ESG funds granted by the State are also subject to State ESG standards specified by the California Department of Housing and Community Development (HCD).

The system standards outlined in this document are not intended to supersede federal or state laws, rules, or standards.

An overview of CoC and ESG funding is provided below.

- **Continuum of Care (CoC):** Funds support programs that assist households experiencing homelessness to regain and retain housing, including Permanent Housing (Permanent Supportive Housing and Rapid Rehousing), Transitional Housing, and Supportive Services Only programs, as well as data collection through HMIS and planning activities. CoC funding is awarded through a national competition. Historically most CoC funding has been reserved for renewing existing projects with only a small portion available to fund expansion or new programs.

- **Emergency Solutions Grants (ESG):** Funds can support a wide range of program activities, including Street Outreach, Emergency Shelter, Homelessness Prevention, Rapid Rehousing assistance, and data collection through HMIS. While the federal funding formula provides ESG directly to some local governments, the local jurisdictions in Santa Cruz County only receive ESG funds through the state. The California Department of Housing and Community Development (HCD) receives ESG funds from HUD and allocates them to the State's CoC service areas using a single, direct-allocation method. H4HP administers a local Request for Proposals process to determine which local applicants to recommend for available ESG funding through HCD. Selected local applicants submit their application to and receive funding directly from HCD.

DRAFT

3. Crosswalk of Applicability of Standards by Program Type

The remainder of this document is organized into sections defining standards for different program types. Each of these sections apply to one or more specific program types operating within the H4HP System as described below:

Program Types	***Applicable Sections***
Coordinated Entry Connector Services	Section 4 and Section 5
Outreach	Section 4 and Section 6
Emergency Shelter	Section 4 and Section 7
Homeless Prevention	Section 4 and Section 8
Transitional Housing	Section 4, Section 9, and Section 10
Rapid Rehousing	Section 4, Section 9., and Section 11
Permanent Supportive Housing	Section 4, Section 9, and Section 12

DRAFT

4. Standards Applicable to All Program Types

The following standards apply to all H4HP System Providers, regardless of program model or funding source. These requirements establish a consistent foundation for service delivery, program operations, and participant experience across the entire H4H System.

4.1 Core System Principles and Approaches

4.1.1 Housing First Requirements

Unless specifically exempted or restricted by contract, H4HP System Providers must meet the Housing First expectations outlined in these standards. Housing First, as a philosophy of practice, prioritizes connecting participants experiencing homelessness to permanent housing:

- As quickly and with as few barriers as possible; and
- With the treatment and support necessary to obtain and maintain housing.

Housing First recognizes safe, stable housing as a foundation from which individuals can begin addressing their needs and personal goals, such as attaining employment or connecting with physical or behavioral health care. With Housing First, housing is not seen as a reward for complying with a services plan, but rather as a foundational building block of change. This approach is client-centered and recognizes the value of participant choice in housing and supportive services. Housing First programs that combine subsidized housing with ongoing, team-based, intensive supportive services are considered an evidence-based practice for addressing homelessness among individuals with disabilities.

California law requires that programs funded through the Welfare and Institutions Code (WIC 8255-8257) operate according to a Housing First model. Previous federal guidance for CoC (24 CFR 578) and ESG (24 CFR 576) programs directed communities to implement Housing First practices. Current federal guidance is promoting "Treatment First" policies. Individuals struggling with serious substance use disorders may benefit from access to substance use treatment prior to moving into housing if the substance use challenges prevent them from being able to follow the terms of their rental or lease agreement. The sequencing of support and treatment should remain individualized to meet the goals and needs of each participant.

Commented [RR8]: Official federal and state guidance still references Housing First.

Under California's Housing First Requirements, programs must ensure:

- Minimal program entry requirements and eligibility barriers;
- Rapid connection to permanent housing;
- Participant choice in housing, services, and goals; and
- Voluntary supportive services.

DRAFT

In a Housing First model, voluntary supportive services are services participants may choose to engage in; programs may set participation expectations, but service participation cannot be used as a requirement of tenancy, nor to determine whether a participant can access housing. Participants must comply with the terms of their lease and housing subsidy agreement and maintain regular home-visit contact with their service provider as needed for tenancy support. Services are voluntary for the participant but not for the provider. Providers are expected to deliver the full scope of required services to all participants including regular contact, offering meaningful opportunities for engagement, and adjusting service approaches when participants decline or limit involvement.

Commented [RR9]: Important local interpretation language of "Housing First" regulations.

Formatted: Highlight

Formatted: Highlight

Formatted: Highlight

Formatted: Highlight

Formatted: Highlight

Formatted: Highlight

4.1.2 Person-Centered Care

Services within the H4HP System should be provided using a person-centered or individualized care approach. Person-centered care places participants at the center of planning and decision-making and provides services in a way that respects participant choice and autonomy. It recognizes each participant as a unique individual and supports staff in working collaboratively with participants to tailor services to their goals, strengths, needs, and circumstances.

Programs applying a person-centered approach should:

- Collaborate with participants in developing housing and service plans;
- Recognize and build on participant interests, goals, supportive connections, and strengths; and
- Adapt service delivery to meet participants based on their priorities and readiness for ~~change.~~ change.

Flexibility is an essential feature of person-centered care, as participant needs and circumstances change over time. Programs should adjust the intensity, frequency, and approach of services in response to each household's needs and circumstances while maintaining applicable program and funding requirements.

4.1.3 Trauma-Informed Care

Trauma-informed care recognizes that people accessing homelessness response services may have experienced significant trauma, including homelessness, systemic oppression, and interpersonal violence. The federal Substance Abuse and Mental Health Services Administration (SAMHSA) defines trauma as "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being." A trauma-informed approach ensures that services are delivered with an awareness of the ~~widespread~~ impact of trauma on a person's experiences and behavior and prioritizes physical and emotional safety, trust, choice, and collaboration.

Programs applying trauma-informed care should:

- Understand the prevalence of trauma and how trauma can impact behavior (e.g., providing staff training on trauma-informed care);
- Promote participants' physical and emotional safety (e.g., providing private spaces for meetings, maintaining safe and welcoming environments, and using calm and respectful communication during conflicts);
- Provide culturally responsive services (e.g., providing interpretation and translation services and adapting service approaches to reflect participants' cultural values and preferences);
- Provide services in a trustworthy and transparent manner (e.g., clearly explaining program expectations, participant rights, and service limitations; following through on commitments; and communicating consistently);
- Provide meaningful opportunities for participant choice and input (e.g., offering choices about services, referrals, or where meetings take place when possible);
- Create opportunities for collaboration and peer support where appropriate (e.g., participant councils, advisory groups, peer mentors, or group activities); and
- Minimize practices that may cause further trauma (e.g., avoiding unnecessary retelling of traumatic experiences and responding to crises with de-escalation and problem-solving approaches rather than punitive measures).

4.1.4 ~~Harm Reduction~~ Stage-Based Change and Motivational Interviewing

~~Harm reduction is an evidence-based public health approach that seeks to reduce the negative impacts associated with behaviors that may pose risks to a person's health, safety, or well-being. Harm reduction recognizes~~ "Motivational Interviewing" is a person-centered, goal-directed counseling approach that enhances intrinsic motivation for change by helping individuals explore and resolve ambivalence, using principles such as expressing empathy, developing discrepancy, rolling with resistance, and supporting self-efficacy. The motivational interviewing approach acknowledges that individuals make personal changes based on their readiness or stage of change level in a particular area. This approach acknowledges individuals ~~that people~~ may not be willing or able to completely stop engaging in higher-risk behaviors at a given time and that positive change can occur incrementally.

Within the H4HP System, ~~harm reduction~~this approach emphasizes non-judgmental, participant-centered engagement that respects participant choice, autonomy, and readiness for change. ~~Programs~~ Service providers applying ~~harm reduction~~these principles should:

- Provide non-judgmental, non-coercive support regardless of current substance use or other higher-risk behaviors;

- Offer practical strategies and connections to resources that can reduce harm and support wellness and recovery;
- Support participants in identifying their own goals related to health, safety, housing, and well-being, including incremental goals;
- Maintain engagement when higher-risk behaviors are ongoing;
- Respond to crises using de-escalation and problem-solving approaches rather than exclusive reliance on punitive measures;
- Coordinate with behavioral health, medical, and other providers as appropriate; and
- Work collaboratively with participants to address behaviors or circumstances that may create barriers to housing stability or successful program participation.

4.1.5 Assertive Engagement

Assertive engagement is characterized by proactive, persistent, respectful, and relationship-based efforts to engage participants, particularly those who may be hesitant, ambivalent, or have difficulty engaging consistently with services. Assertive engagement recognizes that building trust may take time and that disengagement or inconsistent participation should not automatically result in services ending.

Programs applying assertive engagement should:

- Use empathy, creativity, consistency, and relationship-building to establish and maintain trust;
- Recognize that behaviors developed in response to homelessness, trauma, or other experiences may take time to change;
- View the relationship between staff and participants as an important tool for supporting progress toward participant-identified goals;
- Make reasonable, repeated efforts to reconnect with participants when engagement decreases; and
- Support incremental progress while respecting participant choice and autonomy.

4.2 Non-Discrimination

Commented [RR10]: Federal and state requirements

All programs must follow applicable laws designed to prevent discrimination based on race, color, national origin, religion, sex, age, familial status, disability, actual or perceived sexual identity, or gender identity. All programs must have nondiscrimination policies. When state and federal rules conflict, the more protective standard generally applies unless federal law preempts.

4.2.1 Federal Requirements

Recipients and subrecipients of CoC and ESG program-funded projects must comply with federal nondiscrimination and equal opportunity law, including:

- **Fair Housing Act (42 U.S.C. §§3601–3619):** Prohibits discriminatory housing practices based on race, color, religion, sex, national origin, disability, or familial status. HUD has codified specific Fair Housing and Equal Access requirements for federally funded homeless assistance programs in program regulations, including:
    - 24 CFR 578.93 (CoC nondiscrimination and equal access requirements);
    - 24 CFR 576.407(a) and (b) (ESG nondiscrimination, equal access, and fair housing obligations); and
    - 24 CFR 574.603 (HOPWA fair housing and nondiscrimination requirements).

- **Section 504 of the Rehabilitation Act (29 U.S.C. §794):** Prohibits discrimination based on disability under any program or activity receiving federal financial assistance.

- **Americans with Disabilities Act (ADA)**
    - Title II of the Americans with Disabilities Act prohibits public entities, including state and local governments, and special purpose districts, from discriminating against individuals with disabilities in their services, programs, and activities; and
    - Title III of the Americans with Disabilities Act prohibits private entities that own, lease, and operate places of public accommodation from discriminating on the basis of disability, including shelters, social service establishments, and other public accommodations providing housing.

- **Title VI of the Civil Rights Act (42 U.S.C. §2000d):** Prohibits discrimination based on race, color, or national origin in federally assisted programs**.**

4.2.2 California Requirements

Local programs must follow all relevant California laws, including:

- **California Fair Employment and Housing Act (FEHA) – Government Code §12920:** Prohibits housing and employment discrimination based on certain characteristics, including race, color, religion, sex, gender, gender identity, gender expression, sexual orientation, marital status, national origin, ancestry, familial status, source of income, disability, veteran or military status, or genetic information.

- **The Unruh Civil Rights Act –Civil Code §51:** Requires all business establishments in California to provide full and equal services and prohibits discrimination based on protected characteristics.

- **The Transitional Housing Participant Misconduct Act – Civil Code §§1954.10–1954.14:** Requires Transitional Housing programs to address

participant misconduct through written rules, due-process notices, and time-limited exclusions while still protecting participants' rights and access to services.

- **Housing First Law – Welfare & Institutions Code §§8255-8257:** requires all state-funded homelessness programs to operate using a Housing First approach.

- **Homeless Housing, Assistance, and Prevention (HHAP) Program – Health & Safety Code §50216:** Requires compliance with Housing First, Coordinated Entry, and participation in the Homeless Data Integration System.

- **Homeless Shelter Inspection Standards (AB 362, as amended by AB 130) – Health & Safety Code §§17974-17974.6:** Requires cities and counties to investigate complaints of substandard conditions in homeless shelters funded by the State, use standardized complaint-resolution processes, ensure safe shelter conditions, and cooperate with inspections. As amended in 2025, jurisdictions must now perform annual inspections of every homeless shelter in their jurisdiction, submit annual compliance reports, and prominently display occupant rights information at shelters. Non-compliant jurisdictions may have state funding withheld.

- **Homeless Data Integration System (HDIS) – Health & Safety Code §50220.6:** Requires regional action planning, including system performance measures, racial equity analysis, and jurisdictional commitments.

- **Tenant Protection Act (TPA) of 2019 – Civil Code §§1946.2 & 1947.12:** Establishes statewide rent increase caps, just cause eviction requirements, and relocation support for no-fault evictions.

- **Shared Housing Provisions – Government Code §12927(c)(2)(B); Roommates.com Decision:** Allows sex-specific roommate advertisements in shared living situations.

- **Emergency Housing and Assistance Program (EHAP) Regulations – Health & Safety Code §§50800-50806.5; 25 CCR Ch. 7, Subch. 12:** Establishes minimum safety, sanitation, and privacy standards for State-funded Emergency Shelters and Transitional Housing.

4.2.3 HUD's Equal Access Rule

HUD's Equal Access Rule requires that all housing and services funded by the Continuum of Care (CoC) and Emergency Solutions Grants (ESG) programs be made

available without discrimination based on actual or perceived sexual orientation, gender identity, or marital status.

The Equal Access Rule also operates in the context of 24 CFR 5.403, which defines "family" broadly, including but not limited to any group of persons presenting for assistance together with or without children, regardless of marital status, age, actual or perceived sexual orientation, or gender identity, and irrespective of disability status. A child temporarily placed in foster care is considered a member of the family. Programs must treat any group presenting as a family as a family and must not involuntarily separate household members based on the age or gender of minor children.

4.3 Confidentiality

Programs must respect participants' right to confidential treatment of personal, social, financial, and health records. Programs must develop and follow written policies and procedures regarding the confidentiality of client information.

HMIS participating agencies must comply with all confidentiality, privacy, and security standards in the Housing for Health Partnership Santa Cruz County HMIS Policies and Procedures.

Programs must ensure that their procedures comply with all applicable laws and regulations, including those governing:

- Health care records and information
- Behavioral health consumer information
- Domestic violence victims
- Drug and alcohol confidentiality (42 C.F.R. Part 2)
- HIV-related information

Programs should consult legal counsel to understand confidentiality requirements and the general conditions under which records may be subpoenaed. Programs should also seek legal counsel when courts, public officials, investigative units, or law enforcement bodies request client information.

Programs must ensure that staff are trained on confidentiality standards, including when and how information may be disclosed to protect participant safety or comply with legal requirements.

4.3.1 Confidentiality and Mandatory Reporting

System Providers must ensure that staff understand and follow confidentiality requirements. Confidentiality may only be broken in special circumstances, including when a participant poses a danger to self or others, or when there is reasonable suspicion of abuse or neglect.

Mandated reporters are individuals who, by virtue of their professional role or occupational position, are legally required to report known or reasonably suspected

child abuse, elder abuse, or dependent adult abuse to designated authorities – obligations that go beyond the general duty any person has to report such concerns. These reporting requirements exist to protect vulnerable program participants, including children, elders, and dependent adults who may be unable to report abuse or neglect on their own behalf, and to prevent ongoing harm to those individuals. Mandated reporters are required to make such reports regardless of whether the information was obtained in a confidential communication. The complete list of roles and occupational categories that qualify a person as a mandated reporter under California law is set forth in California Penal Code § 11165.7. Some staff may be subject to additional mandatory reporting obligations based on their professional licensure or certification; those staff must comply with both the requirements of California Penal Code § 11165.7 and any applicable reporting standards established by their licensing or credentialing body.

System Providers are expected to establish and maintain written policies for all staff and volunteers governing: (1) the mandatory reporting of known or reasonably suspected abuse, neglect, or exploitation of children, elders, or dependent adults to the appropriate protective services agency (Adult Protective Services or Child Protective Services, as applicable); (2) the disclosure of sensitive participant information in circumstances where confidentiality may be lawfully broken; and (3) the steps staff and volunteers should take if a program participant experiences a behavioral health crisis. These policies must also address the responsibilities of staff and volunteers who are not themselves designated mandated reporters, but who may observe or become aware of potential abuse or neglect.

4.3.2 Release of Information

The H4H System's universal Information Sharing Authorization (ISA) provides a single, consistent consent process for sharing participant information across the H4H System; the ISA aligns with standard forms developed by the California Department of Health Care Services (DHCS) under the Authorization to Share Confidential Member Information (ASCMI) and California Advancing and Innovating Medi-Cal (CalAIM). Once signed, the ISA authorizes participant information to be shared among System Providers for service coordination, care management, and performance reporting. Sharing participant information outside the H4H System, or for purposes not covered by the HMIS Privacy Practices Notice, requires a separate authorization, such as the ASCMI form.

Commented [RR11]: IMPORTANT: H4HP aligning with statewide effort related to more universal release form for sharing information across service provider categories.

A copy of the signed ISA and other information-sharing authorizations should be made available to the participant and placed in the participant's file.

Authorizations used with non-System Providers must include:

- The signature of the person whose information will be released, or the legal guardian if the participant cannot provide informed consent;
- The specific information to be released;

DRAFT

- The purpose for which information is sought;
- The date the consent commences;
- The date the consent expires;
- The identity of the person or organization that will receive the information; and
- A statement that the participant may withdraw consent at any time.

To ensure all required provisions are included, the H4HP recommends the ASCMI form be used for authorizations with non-System Providers and/or uses not covered by the ISA.

4.3.3 Promotional Activities

Programs must ensure consent is obtained before including participants in promotional activities, including all types of media, publications, events, fundraising materials, and use of a participant's story, images, or creative work.

Programs must not coerce participants to provide testimonials or public gratitude.

4.4 Reasonable Accommodations and Modifications

Commented [RR12]: Legal requirements for housing programs.

Federal disability protections include the Americans with Disabilities Act (ADA) of 1990, Section 504 of the Rehabilitation Act of 1973, and the Fair Housing Act. California law offers additional protections under the Fair Employment and Housing Act (FEHA) and the Disabled Persons Act. Under federal law, a disability is a physical or mental impairment that *substantially limits* one or more major life activities. California law applies to a broader disability definition—requiring only that an impairment *limits* a major life activity, without the "substantial" threshold.

Participants with disabilities who seek or receive housing or services through the H4HP System have the right under federal and California law to request reasonable accommodations and modifications. These protections ensure equal access to housing and services and require providers to adjust policies or physical environments, when necessary to afford a person with disabilities equal opportunity to use and enjoy the provider's programming, unless doing so would cause an undue burden or fundamentally alter the program. California law requires a timely interactive process—a good-faith dialogue between the person requesting an accommodation and the housing provider to identify effective solutions—and ensures full and equal access across most forms of housing.

Reasonable accommodations and modifications serve similar purposes but differ in important ways:

1. Accommodations require changes to policies, rules, procedures, or practices to ensure equal access.
2. Modifications require physical or structural changes to units, common areas, or facilities where services are provided to ensure full use and enjoyment (Fair Housing Act for residential settings; ADA and Section 504 for service settings).

DRAFT

All H4HP-funded programs must maintain written policies on reasonable accommodations and modifications, engage in an interactive process with participants to identify appropriate accommodations or modifications, and evaluate each request to confirm the disability-related need and the reasonableness of the requested change.

4.4.1 Reasonable Accommodations

A reasonable accommodation is a change, exception, or adjustment to a policy, rule, service, or procedure that allows a person with a disability to access or participate in a housing or service program on equal terms.

Programs must consider and support reasonable accommodation requests, including:

- **Application Process:** When an applicant presents disability-related mitigating circumstances that affect screening criteria, the provider must treat this as a reasonable accommodation request. Verification may be sought only as needed to confirm the disability-related connection. *For example, if an applicant's credit history shows unpaid medical bills or employment gaps that the applicant asserts are related to their disability, this should be viewed as a reasonable accommodation request, and the provider must consider waiving or adjusting credit or income requirements and may request only limited verification confirming that these financial issues stem from the disability. Specifically, a provider may ask for a written statement from a qualified professional—such as a physician, licensed social worker, or case manager—confirming that the applicant has a disability and that the cited financial issues are related to it. Providers may not require disclosure of a specific diagnosis or medical records, nor demand detailed financial documentation beyond what is necessary to establish that connection.*
- **Policy or Rule Exceptions:** These accommodations involve making exceptions to policies and standard program rules when those rules create barriers for people with disabilities. Accommodation *examples include: allowing an assistance animal in a building with a no-pets rule; adjusting curfews or visitor policies when disability-related needs require tenants to have visitors or stay outside of the building past typical timelines; or adjusting meeting formats or service schedules when disability-related needs require it.*
- **Communication or Service Delivery Adjustments:** These accommodations modify how information is provided or how services are delivered to ensure effective communication and participation for people with sensory, cognitive, or mental health-related needs. *Examples include: providing documents in large print, offering interpretation services, or altering communication approaches to meet a sensory, cognitive, or mental health-related need.*

DRAFT

Additional information is provided in HUD's Reasonable Accommodation guidance. The Disability Rights California's website offers additional materials and information on effective accommodation practices and provider responsibilities.

4.4.2 Reasonable Modifications

A reasonable modification is a structural or physical change to a unit or common area that enables a person with a disability to fully use and enjoy their home. Modifications differ from accommodations because they alter physical space rather than change a procedure or policy.

Examples of reasonable modifications include:

- Installing grab bars or handrails;
- Widening doorways or installing ramps;
- Adjusting countertops or fixtures to wheelchair height; or
- Installing visual or tactile alert systems.

When a reasonable modification request is made, providers should consider the disability-related need, engage in an interactive review with the participant, and assess whether the request would impose an undue financial or administrative burden.

Based on the funding source and ownership structure, the owner or provider of a participant's housing may be obligated to make or allow reasonable modifications. While tenants may be responsible for costs associated with implementing a reasonable modification, providers must permit the modification unless it poses a fundamental alteration or undue financial or administrative burden.

HUD's Reasonable Modification webpage and resources from the California Civil Rights Department provide detailed information about modification requirements and housing provider obligations under federal and California law. HUD's webpage provides guidance for CoC and ESG recipients and subrecipients on evaluating when a structural change may need to be treated as a reasonable accommodation to ensure equal access. This detailed guidance instructs providers to consider the disability-related need, engage in an interactive review, and assess whether the request would impose an undue financial or administrative burden.

4.5 Informing Materials, Client Consent, and Grievance Procedures

Commented [RR13]: IMPORTANT: Area that will need focused improvement throughout the CoC.

H4H System Providers must inform participants about the services available to them and obtain participants' signed acknowledgment that they understand program expectations and available resources.

This policy aligns with applicable requirements of the HUD Continuum of Care (24 CFR 578) and HUD ESG (24 CFR 576) programs and the State of California, including Welfare and Institutions Code (§10618.9) for programs funded through the California Department of Social Services. System Providers must:

DRAFT

- Provide potential participants with written informational materials about the program or services before services begin (typically at enrollment);
- Review materials with participants in a manner they understand, including offering language assistance or reasonable accommodations when needed; and
- Obtain signed written consent from participants acknowledging understanding of the information provided.

Informational and consent materials should include the following:

- Services that may be provided or offered;
- Participant rights, rules, responsibilities, and program expectations;
- Expectations of service delivery; and
- Information about program termination and appeal processes, as outlined in the H4HP Complaint and Grievance Policy.

Sample Client Consent and Informing Materials by program type are currently under development and, once completed, will be included in specific program manuals. Additional information about the grievance process can be found in the Housing for Health System of Care Complaint and Grievance Policy.

4.6 Serving Overrepresented and Special Populations

H4HP aims to support all individuals experiencing homelessness in Santa Cruz County with particular attention to households with the highest service and housing needs. In Santa Cruz County, homelessness disproportionately impacts specific groups of individuals, including youth exiting foster care, seniors and people with disabilities, single-parent households, veterans, and certain racial and ethnic groups.

Effectively serving these and other sub-populations requires ensuring not only that the H4HP System and its programs do not illegally discriminate, but that the system and programs are designed and operated to address the unique needs of special populations experiencing homelessness.

System Providers must actively track data on their service provision by demographic group within HMIS. The H4H Division will review and analyze HMIS data to understand the demographics of system participants and assess system performance. Areas of analysis include differences across populations in the length of time spent experiencing homeless, rates at which individuals become or return to homelessness, rates of referrals and enrollments in programming, and rates of exits to permanent housing. Other areas of consideration include whether specific groups encounter issues with access, system use, or housing outcomes at different rates.

H4HP may develop new programs, initiatives, or tracking requirements to address different outcomes among different population groups.

4.7 Participation of People with Lived Experience of Homelessness

H4HP utilizes the perspectives of people currently experiencing or who have previously experienced homelessness to ensure that the System and its programs appropriately and respectfully address participant needs and experiences. Engagement efforts should strive to reflect the diversity of people experiencing homelessness in Santa Cruz County across demographic groups, geographic regions, household compositions, and experiences within the H4HP System.

The H4HP includes people with lived experience (PWLE) at all levels of governance, including on the H4HP Policy Board and the Operations Workgroup. H4HP has two lived experience action boards. Each board has a minimum of 5 members who currently live in Santa Cruz County. Members are compensated for costs, including travel and internet associated with their Board participation. Board members are recruited, among other efforts, through direct outreach to people with lived experience of homelessness.

- **Lived Expertise Action Board (LEAB):** The LEAB is an established working group in the H4HP Governance Charter. LEAB members make recommendations for system improvements, participate in community decision-making processes, and drive impactful changes from first-hand knowledge and experience. LEAB members have current or past lived experience with homelessness and must be 18 years or older. A representative from the LEAB serves as a fully participating member of both the H4HP Policy Board and the Operations Workgroup. The representative roles may be filled by a single LEAB member for both groups or by separate members for each group. The liaison(s) are chosen through a vote of the LEAB membership.

- **Youth Lived Expertise Action Board (YLEAB):** The YLEAB is an established working group in the H4HP Governance Charter. YLEAB members share insights, make recommendations to the H4HP and the H4H Division for system improvements, and participate in community decision-making processes. Two-thirds of the board members must be between the ages of 18-24. Liaisons from the YLEAB serve as fully participating members of the Policy Board, the Operations Workgroup, and the Youth Homelessness Demonstration Project (YHDP) Collaborative—a group focused on co-creating youth-specific programs and system design recommendations. The YLEAB selects its liaison(s) through a membership vote, with either one individual serving as representative to all three groups or different members serving as a liaison to a single group.

H4H System-level policy documents (such as these standards) are made available for review and input by the public including PWLE before being finalized. Efforts to secure and support PWLE participation in System activities should reflect the subpopulations that experience homelessness in Santa Cruz County.

System Providers are encouraged to create their own plans and strategies for incorporating the perspectives of PWLE into their efforts, such as to:

DRAFT

- Recruit, hire, and actively support PWLE to work at all levels within the organization, including providing appropriate training and opportunities for advancement;
- Include PWLE on their Board of Directors, program-level advisory boards, and/or agency-level advisory boards composed of PWLE, for example including current or past clients of the agency;
- Survey program participants regularly for feedback on the programs they have participated in.

4.8 Participant Engagement and Discharge Expectations

Commented [RR14]: IMPORTANT: An area of the CoC that will need focused efforts at improvement.

The effectiveness of the H4HP System is rooted in its ability to meaningfully and consistently engage and maintain helpful, hopeful, empathetic relationships with participants. The H4HP System has established participant engagement expectations from initial referral through program discharge. All engagement activities and program discharge actions must be documented in HMIS, when allowable, in accordance with the H4HP CoC HMIS Policies and Procedures Manual.

4.8.1 Participant Engagement

Participant engagement is critical to supporting individuals referred to the H4HP System. System Providers should follow the guidelines below for engaging participants prior to program enrollment. System Providers must attempt to contact participants within three (3) business days of receiving a referral and make at least three (3) contact attempts, using different types of communication methods, within the first five (5) days. After the initial five-day period, the agency is expected to continue outreach routinely for 10 additional days or until contact is made. For specific guidance and requirements on contact attempts and strategies, see Housing for Health Partnership Santa Cruz County Coordinated Entry Policies, section 7.4.

If the System Provider cannot reach the participant within fifteen (15) days of receiving a referral, the provider must notify the H4H Division that contact cannot be made, consult with the assigned Connector, if applicable, to review outreach strategies, and request a new referral when appropriate. Please see the Housing for Health Partnership Santa Cruz County Coordinated Entry Policies for more information.

4.8.2 Program Discharge

H4HP System Providers are expected to make every reasonable effort to engage participants and address concerns to prevent involuntary discharge. Providers should work collaboratively with participants to resolve issues related to safety, engagement, or participation in services.

A written notice of discharge must be provided for all planned (non-emergency) terminations and must include the reason for discharge and the effective date. Ideally this notice would be provided at least thirty days prior to the effective date. Immediate discharge without prior written notice is permitted only when an imminent safety

DRAFT

threat exists (e.g., acts of violence, credible threats to safety, or significant property damage). In such cases, Providers must document the safety concerns and provide written notice and information about next steps as soon as it is safe and appropriate to do so.

Participants retain the right to request a review or appeal of a discharge decision. Information about appeal rights, timelines, and procedures can be found in the Informing Materials, Client Consent, and Grievance Procedures Section and in the Housing for Health Partnership System of Care Complaint and Grievance Policy. All discharge decisions and related engagement activities must be documented in HMIS in accordance with the Santa Cruz Continuum of Care HMIS Policies and Procedures manual.

4.9 Housing Problem Solving

Commented [RR15]: Referenced in previously adopted coordinated entry standards.

All System Providers are expected to engage in Housing Problem Solving as a core strategy to prevent and end a participant's homelessness. Housing Problem Solving is a conversation-based approach that helps households quickly identify safe, realistic alternatives to entering shelter or waiting for limited H4HP System resources to become available to attain permanent housing. The use of Housing Problem Solving ensures that shelter and permanent housing resources are preserved for those with the highest needs. Resources on how to conduct Housing Problem Solving conversations can be found in the H4HP Housing Problem Solving Practice & Process Guide.

Housing Problem Solving is offered at all entry points into the System, including upon requesting Homelessness Prevention Services, through Coordinated Entry Connector Services, Street Outreach, Emergency Shelter, and Transitional Housing programs. Rapid Rehousing and Permanent Supportive Housing programs should use Housing Problem Solving to explore housing options that meet a participant's needs or preferences.

All Housing Problem Solving services within the H4H System must include:

- A focused conversation centered on identifying immediate and realistic housing options;
- Creation of a written plan or next steps that outline how the participant will pursue identified solutions, which is shared with the participant when possible; and
- Provision of service options or referrals to assist in resolving the housing crisis, such as mediation, financial assistance, or connection to community resources.

When available, Housing Assistance Funds may be used to help participants obtain or retain housing when no other resources are identified. For more details, refer to the Housing for Health Partnership Santa Cruz County Housing Assistance Fund Policies.

4.10 Use of HMIS

HUD requires that all CoCs utilize the Homeless Management Information System (HMIS) as the centralized, system-wide database for collecting information about households experiencing or at risk of homelessness within the region. H4HP uses the Clarity HMIS software product developed by Bitfocus, Inc.

Programs funded through federal CoC and ESG programs, except those operated by victim service providers, must participate in HMIS. Victim service providers are prohibited from entering client-identifying data into HMIS under the Violence Against Women Act (VAWA) and related federal confidentiality requirements. Agencies receiving federal funds must instead use a comparable database that meets HUD's data collection and reporting standards while maintaining survivor confidentiality.

System Providers receiving specific state or local funding may be required to participate in HMIS, as specified in their program MOU or funding contract.

Program types that participate in HMIS include Emergency Shelters, Transitional Housing, Permanent Supportive Housing, Homelessness Prevention, Rapid Rehousing, Outreach, and Coordinated Entry Connector Services.

Locally, organizations must execute an Organizational Partnership and Data Sharing Agreement with the HMIS Lead Agency, the H4H Division, to participate in HMIS. Participating agency staff must sign an HMIS User agreement and Code of Ethics, and complete initial and ongoing training to attain and retain an HMIS license.

Please see the Santa Cruz Continuum of Care HMIS Policies and Procedures manual for more information.

Commented [RR16]: Overview of adopted HMIS policies and procedures.

4.11 Referral, Enrollment, and Coordinated Entry

The H4HP System defines Coordinated Entry as the approach to coordinate and manage the system's resources for housing, participating shelters, and supportive services. This approach helps providers make equitable decisions to connect people to interventions to end their homelessness as quickly as possible based on available information and resources.

The Coordinated Entry process aims to ensure that individuals experiencing homelessness have fair and equitable access to the resources and services for which they are eligible, regardless of where they present for assistance. Households with the highest service and housing needs are targeted to those who need them most. The process also acknowledges that housing resources and services are limited.

Housing for Health Partnership (H4HP) Connectors are designated providers specially trained in this process and work to provide as many people as possible with support, connection to services, and problem-solving partnership with the goal of resolving homelessness.

To serve all of Santa Cruz County, H4HP provides geographically dispersed CE access points, and is available online and by phone through United Way 2-1-1.

Commented [RR17]: Summary of adopted coordinated entry policies and procedures.

DRAFT

Households participate in the Coordinated Entry System (CES) by enrolling in H4HP Connector Services, which includes completing a standardized Housing Needs Assessment (HNA) to prioritize households for limited H4HP housing resources. The HNA evaluates participants' needs and strengths, identifies potential eligibility for mainstream resources, and is utilized to prioritize eligible households for limited H4HP System resources. CE utilizes an inventory-based referral model based on anticipated future housing program opportunities. Persons get assigned to a "Housing Queue," a prioritized list of households to connect with available housing resources, based on a designated threshold score on the HNA. This threshold is determined by the current inventory of housing programs, the household type seeking assistance, and the likelihood of referral to a housing program within the next six months.

When making referrals from the Housing Queue to available Transitional Housing, Rapid Rehousing, and Permanent Supportive Housing resources, H4H Division staff apply the following prioritization sequence:

1. Household has been placed on the Housing Queue, meets eligibility criteria, and indicates interest in participating in the program
2. Household meets project preferences, such as geographic targeting, as stated in program memoranda of understanding or funding contracts
3. Household has all documents required for enrollment in the housing program ("document-ready status")
4. Date of enrollment in CE (oldest first)
5. HNA score (used as a tiebreaker if needed)

HUD requires CoCs to develop and maintain policies and procedures for their CE systems, including assessment use and resource prioritization processes, and how participants are matched and referred to available resources. The H4HP System's Coordinated Entry process is governed by policies detailed in the Housing for Health Partnership Santa Cruz County Coordinated Entry Policies and described on the Coordinated Entry webpage.

4.12 Housing for Health Partnership System of Care Coordination & Collaboration

Commented [RR18]: Federal and state requirement to help individuals access mainstream resources and to support cross-system coordination

System Providers are expected to connect participants to mainstream benefits and community resources that increase income, reduce participant and System costs, and support participant wellbeing. These connections help participants stabilize in housing, improve health, and strengthen long-term economic stability. Providers must actively identify participant needs, assist with benefit applications, and collaborate with community partners to ensure participants can access available benefits and supports.

Mainstream benefits and service types that programs must coordinate with, as applicable, include:

- Educational services for children and youth;
- Public benefits;
- Behavioral and physical health services;
- Veteran benefits;

- Affordable housing opportunities;
- Post-secondary education, training, and employment supports; and
- Aging and disability services.

Please consult 2-1-1 for up-to-date information about available programs and services and refer to the Housing Problem Solving Practice and Process Guide for additional guidance.

4.13 CalAIM and Medi-Cal Managed Care Services

Commented [RR19]: Changing / evolving area at federal and state level

California Advancing and Innovating Medi-Cal (CalAIM) provides Medi-Cal–funded housing and health-related services that support participants across the H4HP System. CalAIM services are available to Medi-Cal members who are experiencing or at risk of homelessness, including individuals with physical and behavioral health, or social needs that affect their housing stability. These services may operate alongside any project type. Participants must be enrolled in Medi-Cal to access CalAIM resources. Participants must be authorized to receive CalAIM services by their Managed Care Plan, the Medi-Cal health plan responsible for coordinating benefits and approving services. CalAIM policy and service details are available at DHCS CalAIM Community Supports and Enhanced Care Management guidance. CalAIM services include:

- **Enhanced Care Management (ECM):** Intensive, field-based care coordination for Medi-Cal members with complex medical and social needs. ECM is a comprehensive, whole-person approach to care that addresses the clinical and non-clinical needs of Medi-Cal members with the most complex medical and social needs through intensive coordination of health and health-related services. ECM provides systematic coordination across physical, behavioral, developmental, oral health, long-term services and supports, and coordination with community and social services.

- **Community Supports (CS):** Flexible, health-related services that address participants' social needs—including homelessness and housing instability—by assisting with obtaining and maintaining housing, supporting recovery, and stabilizing health conditions in safe, appropriate environments. Community Supports are optional Medi-Cal benefits approved by DHCS and delivered by the participant's Managed Care Plan. Under Community Supports, DHCS authorizes the following service types used in the H4HP System:
    - **Housing Transition Navigation Services** support participants in obtaining housing by assisting with housing search activities, documentation preparation and collection, communication with landlords or property managers, and completion of housing applications.
    - **Housing Deposits** cover essential move-in costs such as security and utility deposits, and other fees necessary to establish a residence.
    - **Housing Tenancy and Sustaining Services** provide ongoing support to help participants maintain housing, including early identification of tenancy

DRAFT

concerns, landlord mediation, budgeting assistance, and coordination with property managers and service agencies.

- **Transition to Housing (Transitional Rent)** provides short-term financial assistance to help a member secure safe and stable housing when they are exiting an institution, recovering from an acute health event, or transitioning from homelessness into permanent housing. DHCS defines this Community Support as time-limited rental assistance intended to stabilize the member during the transition period while permanent housing is being secured. Managed Care Plans may authorize this support when the member lacks the financial resources to obtain or sustain housing during the transition. Transitional Rent is typically authorized for short durations based on need and is not intended to function as long-term rental assistance.
- **Recuperative Care (Medical Respite)** provides short-term residential care for individuals who no longer require inpatient hospitalization but need continued recovery support and whose condition would be exacerbated by recovering in a homeless shelter or unsheltered settings.
- **Short-Term Post-Hospitalization Housing** provides temporary housing for individuals who are ready to be discharged from a hospital or psychiatric facility but lack a safe place to recover and are at risk of homelessness. DHCS allows this service for up to six months following discharge.

Additional Community Supports may be available depending on the participant's Managed Care Plan. CalAIM services are expected to continue in some form through local Medi-Cal Managed Care Plans after the current CalAIM federal waiver ends in December 2026.

4.14 Safety Transfer Policy in accordance with the Violence Against Women Act

Commented [RR20]: Federal requirement

H4HP recognizes that survivors of domestic violence, dating violence, sexual assault, stalking, or human trafficking have specific confidentiality and safety concerns. These individuals may request a safety transfer when they believe their current placement endangers their safety. The Transfer Policy outlines procedures for responding to these requests in accordance with the Violence Against Women Act (VAWA). A Safety Transfer may include household members who are not the perpetrator. All providers of Transitional Housing, Permanent Supportive Housing, and joint Transitional Housing and Rapid Rehousing projects must follow the Transfer Policy.

4.15 Federally Required Record Keeping

Commented [RR21]: Federal requirement

As required by CFR 576.500, programs receiving federal CoC or ESG funding must have established policies and procedures that outline how the organization will collect and maintain documentation of a participant's housing status and confirmation of a participant's eligibility for a funding source and program type. Housing status documentation is required for all participants in the H4HP System who receive HUD Homeless Assistance funding. Further guidance for documenting housing status is outlined in H4HP Housing Documentation training and related resources.

DRAFT

All System Providers must document participant housing status at intake. HUD mandates the following order of priority for evidence of participant's history of homelessness.

- **Third-party documentation**: Third-party documentation is preferred by HUD whenever possible. It includes written confirmation of homelessness from a third-party outreach worker, housing or service provider, or other person such as a hospital social worker, who can verify the participant's homeless status at a point in time.
    - Records contained in a HUD-compliant Homeless Management Information System (HMIS) or a comparable database operated by victim service or legal service providers are considered acceptable evidence of third-party documentation.
    - Lack of third-party documentation must not prevent an individual or family from being immediately admitted to Emergency Shelter, receiving Outreach services, or receiving services provided by a Victim Service Provider.
- **Intake worker observation**: If third-party documentation is not available, the participant's intake worker can document their knowledge of the person's housing status or homelessness.
- **Self-certification**: If evidence is not available from a third party and the intake worker does not have direct knowledge of a participant's homeless status, the person experiencing homelessness may self-certify their homeless status.

Individuals released directly from a hospital, jail/prison, or other institution who were there less than 90 days and who were previously in an Emergency Shelter or unsheltered must provide documentation of homelessness immediately prior to entry into the institution and institutional entry and exit dates. Some programs or funding sources may have additional documentation requirements associated with verifying eligibility under a specific subpopulation, such as programs that require persons to meet the definition of chronically homeless (24 CFR 578.103(a)(4)) or at risk of homelessness (24 CFR 576.500(c)).

The remaining sections of this document present minimum standards for specific project types within the H4HP System. Some of these sections apply to a single project type, while others apply to multiple project types. Please see the crosswalk in Section 3 for more information about which standards apply to which program types.

DRAFT

5. Standards for Coordinated Entry Connector Services

Commented [RR22]: Summary of part of adopted coordinated entry policies and procedures

Staff who engage participants and deliver Coordinated Entry (CE) Connector Services as part of the H4HP are referred to as Connectors. Connectors support the H4HP System by meeting people experiencing homelessness where they are, initiating strengths-based Housing Problem Solving conversations, and completing Housing Needs Assessments (HNA). The H4H Division has internal staff that serve as Connectors and contracts with agencies in Santa Cruz County to provide Connector Services. H4H executes memoranda of understanding with all Connector agencies that define program expectations and roles.

This section offers an overview of the minimum standards for H4HP Coordinated Entry Connector Services (Connector Services). All Coordinated Entry Connectors must abide by the written standards included in this section and the Housing for Health Partnership Santa Cruz County Coordinated Entry Policies. The H4HP Coordinated Entry Connector Expectations document outlines additional Connector responsibilities.

5.1 Purpose of Coordinated Entry Connector Services

Connectors serve as the primary access point for individuals and families experiencing homelessness to engage with the H4HP System. Their role includes helping participants understand, navigate, and access available resources, complete the Housing Needs Assessment, and develop a Housing Action Plan (HAP) that identifies individualized housing goals, strengths, and steps toward stability.

Connectors support participants with Housing Problem Solving, including exploring safe and realistic housing alternatives outside of system-funded housing, such as reconnecting with family or friends, shared housing, or short-term financial or community support. See the Housing Problem Solving section of this document for more details.

Connector Services operate across multiple settings, including through street outreach, at drop-in centers, and within multi-service programs. Regardless of location, Connectors build rapport with participants, support their access to mainstream resources, and help them complete steps required to attain housing. Field-based Connectors working on outreach teams provide mobile access to CE for people experiencing unsheltered homelessness and are expected to meet the CES and the Outreach Project standards.

5.2 Referral Process and Enrollment

This section describes how participants access Connector Services and how Connectors engage and work with participants, including accepting referrals and enrolling participants in CE as applicable.

DRAFT

5.2.1 Referral Process

Participants may be referred to Connector Services by completing the Requesting Connection Services form on the 2-1-1 Santa Cruz County website, or by having a service provider or someone else submit the form on their behalf.

Connector Services prioritize households that meet the HUD definitions of homelessness under Category 1 (literally homeless) and Category 4 (fleeing or attempting to flee domestic violence).

Not all Connectors accept referrals or begin services through the referral process. For Connectors that do accept referrals, referrals are managed by United Way 2-1-1. Due to limited Connector capacity,, referrals are recorded and when necessary, placed on a waitlist in the order received.

5.2.2 Engagement, Intake, and Enrollment Process

Once referred or otherwise identified but prior to the participant being enrolled, Connectors work to engage participants and provide support on any immediate safety needs. Many Connectors engage participants through street outreach or the programs where they are embedded.

Once engaged, Connectors work with participants to complete the intake process to establish eligibility and obtain consent to participate in the system. Once intake is completed, participants are enrolled and Connectors must enter the participant into HMIS.

After intake and enrollment, Connectors assess their current housing status to confirm eligibility and gather information needed for the Coordinated Entry System to determine prioritization for services and housing resources.

5.3 Minimum Standards and Required Services

Standards and expectations for Connector Services are included in the Housing for Health Partnership Santa Cruz County Coordinated Entry Policies; the following summarizes those expectations. Connectors work with persons experiencing homelessness to build rapport and provide the full scope of Coordinated Entry services.

Connectors complete an H4HP Housing Needs Assessment (HNA) with participants to evaluate their housing needs, strengths, and resources; H4H uses information from the HNA to determine eligibility and prioritization for H4H System resources. Connectors use information from the HNA to develop a Housing Action Plan (HAP) that identifies participant's goals, action steps, and supports needed for housing stability. The HAP must be reviewed

DRAFT

and updated at least every 90 days while the participant receives Connector services; a copy of the HAP must be provided to the participant.

Connectors maintain engagement with participants generally for up to six months and meet with them an average of once per week to support progress on the HAP, including connecting participants to mainstream resources. Some Connectors work in roles that provide services for longer than six months. Connectors are expected to provide participants with housing navigation assistance, assist with obtaining necessary eligibility documents, and collaborate with housing providers to support participants prioritized for housing, including document collection.

All Connector programs must enter client and services data into HMIS in accordance with the data entry and timeliness standards outlined in the Housing for Health Partnership Santa Cruz County HMIS Policies and Procedures manual.

5.4 Program Discharge

Connectors are expected to maintain ongoing contact with participants enrolled in Connector Services. A successful exit from Connector Services occurs when a participant enrolls in a housing program through a CE referral or secures permanent housing independently. An unsuccessful exit occurs when the participant declines services, becomes unresponsive despite re-engagement attempts, or cannot be located.

Note that transitions between Connectors do not constitute a program exit, such as when a participant working with one Connection shifts to working with shelter-based Connector staff after entering shelter.

Connector programs must follow the systemwide discharge expectations described in the Participant Engagement and Discharge Expectations section and the procedures outlined in section 4.7 of the Housing for Health Partnership Santa Cruz County Coordinated Entry Policies manual. All discharges and attempts to re-engage participants must be documented in HMIS.

5.5 Performance Measures

Connectors should meet the following performance expectations:

- 100% of heads of households enrolled in the program will receive at least one Housing Problem Solving service per week, which may include updating an HNA or HAP, as recorded as an HMIS event.
- Average length of program enrollment of 6 months except for participants on the Housing Queue or Connectors in roles that involve longer-term services.
- At least 80% of households enrolled in Coordinated Entry will have status updates and assessments completed on their behalf every 90 days.
- At least 80% of households enrolled for more than one year and enrolled in Coordinated Entry will have an annual assessment completed in HMIS.

Commented [RR23]: Performance measures reflect standards discussed and established at prior CoC meetings…they represent targets based on higher than average performance among current participating programs/providers.

Commented [RR24R23]: Standards also reflect historical standards promulgated by federal and state funding announcements.

- At least 80% of households will have personal contact information listed in HMIS.
- At least 80% of households will have contact information recorded in HMIS for one or more support person, such as a primary care provider, emergency contact, or care manager.
- At least 20% of households will exit to a permanent housing situation.
- At least 25~~40~~% of households will increase their income.
- At least 60~~40~~% of households will ~~increase their public benefits~~have SNAP/CalFresh benefits as documented with status updates and at exit.
- At least 8~~9~~0% of households will have health insurance as documented with status updates and at exit.

DRAFT

6. Standards Applicable to Housing-focused Street Outreach

The H4HP System includes Housing-focused Outreach services designed to support people living in unsheltered situations achieve positive housing outcomes. This section outlines the minimum standards for all Housing-focused Outreach Providers (Outreach Providers) within the H4H System. Providers must follow these standards and the requirements in the H4H System of Care Housing-Focused Street Outreach Operations Manual, which includes additional operational guidance and expectations.

Not all outreach efforts in Santa Cruz County are conducted by System Providers. Other outreach efforts may be paired with other services, such as food shelves, soup kitchens, medical care, or services for specific populations or geographic areas. While these other outreach efforts play important roles in the broader system, these standards do not apply to non-System Providers. Outreach Providers are expected to coordinate with other outreach efforts to support participants' access to services.

6.1 Purpose of Housing-focused Street Outreach

Outreach Providers support people living in unsheltered locations to move toward safe and stable permanent housing. Outreach Providers meet participants where they are, build trust over time, and assist with steps needed to secure housing. They also provide access to lifesaving supports including shelter, health care, food, and other essential services.

Field-based CE Connectors deliver Housing-focused Outreach as part of their role in the H4HP System. Connectors complete HNAs, provide housing navigation, and serve as mobile access points to Coordinated Entry. Additional details are included in the Coordinated Entry Connector Services section.

6.2 Referral Process and Enrollment

The referral and enrollment process for Outreach Providers facilitates participants' access to services while maintaining consistent procedures for engagement, documentation, and prioritization across the H4H System.

6.2.1 Referral Process

Outreach Providers may fill their caseloads through direct engagement with participants. Referrals are assigned to Outreach Providers based on participant location and service need with an eye toward maintaining countywide coverage. This structure supports access to Outreach services for people living unsheltered. Some Outreach Providers partner with local law enforcement as potential referral partners.

6.2.2 Enrollment

Initial contacts between Outreach Providers and people experiencing homelessness focus on trust-building, safety screening, and participant interest in engaging with outreach staff. These early contacts do not require a full HMIS enrollment; limited information can be collected in HMIS. Once a participant agrees to ongoing

engagement, outreach staff must enroll the participant in HMIS and document all services and contacts in accordance with the H4HP CoC HMIS Policies and Procedures Manual.

If needed, Outreach Providers may use limited or non-identifying information during early engagement. They are encouraged to use HMIS field-based tools, including location mapping, to support accurate documentation.

6.2.3 Eligibility and Prioritization

Housing-focused Street Outreach services are available to individuals and families who are experiencing unsheltered homelessness within Santa Cruz County, recognizing that these participants face the highest barriers to accessing housing and supportive services. Individual Outreach Providers may specialize in certain populations or geographic areas. Outreach teams must coordinate with one another to support countywide access to services, consistent prioritization practices, and minimal duplication of efforts.

6.3 Minimum Standards and Required Services

Outreach Providers' engagement work should be at locations and times accessible to the participant, including evenings and weekends. They must be flexible, person-centered, and responsive to each participant's circumstances, allowing individuals to guide the pace and nature of engagement. Outreach staff continue efforts to build trust and offer support until the participant connects to shelter or housing or indicates they no longer wish to engage.

Outreach Providers complete ongoing safety assessments throughout participant engagement, including connecting participants to crisis services when needed. They help participants access essential resources such as shelter, health care, food, and other basic needs, and connect them to referrals and supports that assist in moving toward safe and stable housing. Outreach staff also help participants gather identification and documents required for housing, employment, or benefits and ensure connection to the H4HP Coordinated Entry System.

Essential services provided by Housing-focused Outreach staff include:

- Maintaining weekly contact with participants to support progress toward housing (more frequent contact may be necessary based on participant need);
- Engaging in ongoing Housing Problem Solving conversations;
- Assisting participants to collect and submit eligibility documentation;
- Helping participants navigate community and housing resources; and
- Entering client and services data into HMIS in accordance with the data entry and timeliness standards outlined in the Housing for Health Partnership Santa Cruz County HMIS Policies and Procedures manual.

DRAFT

6.4 Program Discharge

There is no specified time limit for Housing-focused Outreach work with individual participants. Participants may remain enrolled as long as they need services and continue to be engaged with outreach services as described in section 4.~~7~~8 of these standards, Participant Engagement and Discharge Expectations.

A successful exit from outreach is when participants transition into a longer-term care management or Supportive Services program, Emergency Shelter, Transitional Housing, or Permanent Housing. If an outreach participant is successfully connected to shelter services, their services are typically transferred to the Connector based in that shelter. However, there may be circumstances where, due to participant choice, the field-based Connector retains a sheltered participant on their caseload. Participant choice and autonomy should be respected in consideration of the transition of care.

An unsuccessful exit is when a participant's housing status at program exit is unsheltered.

To improve the likelihood of ongoing engagement towards securing housing, outreach staff should check in regularly with participants to update their contact information, locations where they frequent, and assess whether the participant has a plan or opportunity for shelter or housing.

6.5 Performance Measures

Housing-focused Outreach services are expected to meet the following performance expectations:

- 100% of heads of households enrolled in the program will receive at least one Housing Problem Solving service a week, which may include updating a Housing Needs Assessment or Housing Action Plan, as recorded as an HMIS event.
- Average length of program enrollment of 6 months.
- At least 80% of households enrolled in the program will have a completed status update and assessment every 90 days.
- At least 80% of households enrolled in a program for a year or more will have an annual assessment completed in HMIS.
- At least 80% of households will have personal contact information listed in HMIS.
- At least 80% of households will have contact information recorded in HMIS for one or more support person, such as a primary care provider, emergency, care manager, or other contact.
- At least 20% of households will have a successful exit (as defined above).
- At least 25~~40~~% of households will increase their income.
- At least 60% of households will have SNAP/CalFresh benefits as documented with status updates and at exit.
- ~~At least 40% of households will increase their public benefits.~~
- At least 8~~9~~0% of households will have health insurance as documented in status updates and at exit.

DRAFT

7. Standards Applicable to Emergency Shelter

This section offers an overview of the minimum standards for year-round Emergency Shelter programs operating through the H4H System. The following standards align with the Housing for Health Partnership, Santa Cruz County Continuum of Care Emergency Shelter Standards, unless otherwise noted.

7.1 Purpose and Types of Year-Round Emergency Shelter

Emergency Shelters provide safe and temporary accommodation for people experiencing homelessness. Emergency Shelters in Santa Cruz County are expected to maintain low-barrier entry requirements to reduce obstacles to access.

Under the U.S. Department of Housing and Urban Development (HUD) regulations at 24 CFR 578.3, an "Emergency Shelter" means any facility, the primary purpose of which is to provide temporary shelter for homeless persons in general or for specific populations of homeless persons and that does not require occupants to sign leases or occupancy agreements.

Under the State of California Health and Safety Code § 50801(e), an "Emergency Shelter" is defined as housing with supportive services for homeless persons that is limited to occupancy of six months or less by a homeless person, where no individual or household may be denied Emergency Shelter because of an inability to pay. California law further emphasizes low-barrier entry, nondiscrimination, and the inclusion of individuals regardless of sobriety, income, or participation in services.

Emergency Shelters must comply with the definitions established by HUD and the State of California, as applicable to their funding source and operational requirements.

The H4H system includes several types of Emergency Shelter programs and facilities, including:

- **Congregate Shelter:** facilities with shared spaces where multiple people sleep in the same room. Other facilities and services, such as food, restrooms, or hygiene facilities, are also shared.
- **Non-Congregate Shelter:** facilities that offer program participants private or semi-private accommodations, such as hotel rooms or individual units. In non-congregate shelters, hygiene facilities can be private or shared.
- **Low-Barrier Navigation Centers:** as defined in State of California Government Code §65660, as facilities with private spaces and low barrier to entry that offer program participants intensive support aimed at connecting them to income, health services, shelter, and housing.

DRAFT

7.2 Other Temporary Accommodations

The H4H System includes other types of temporary accommodations such as Medical Respite, Short-Term Post-Hospitalization, Safe Parking, Safe Sleeping, and Seasonal or Severe Weather Shelters.

These programs are not classified as Emergency Shelter but are essential resources for individuals experiencing homelessness or housing instability.

- **Medical Respite or Recuperative Care:** The California Department of Health Care Services (DHCS) defines Medical Respite (also known as Recuperative Care) as facilities that provide short-term residential care for individuals who no longer require inpatient hospitalization but need continued recovery support and whose condition would be exacerbated by recovering in homeless shelters or unsheltered settings. DHCS allows Recuperative Care for up to 90 days per stay, with extensions permitted when medically necessary and approved by the Managed Care Plan.

- **Short Term Post-Hospitalization:** A Community Support offered through DHCS CalAIM, that provides temporary housing for individuals who are ready for discharge from a hospital or psychiatric facility but lack a safe place to recover and are at risk of homelessness.

- **Safe Parking:** These programs allow participants to legally sleep in operable vehicles in designated sites and access supportive services. H4H System Safe Parking programs adhere to the following standards and definitions:
    - *Vehicle Types:* The types of vehicles allowed in Safe Parking sites may vary by site and operator. Sites may allow both passenger vehicles (cars) and Recreational Vehicles (RVs, Camper Vans, Motorhomes) or only one of the types.
    - *Vehicle Operation:* Safe Parking programs require participants to have operational vehicles. A vehicle is considered operational when it is in working condition—meaning it can start and be safely driven on public roads.
    - *Valid Documentation:* Some safe parking programs require participants to have a valid driver's license, vehicle registration, and active motor vehicle insurance coverage.
    - *Services:* Safe Parking sites can offer services to connect individuals with resources to support access to permanent housing or another stable living situation.
    - *Hygiene and Basic Need Services:* Not all Safe Parking sites in Santa Cruz County offer hygiene or basic services such as showers, laundry, or food.

DRAFT

- *Eligibility for other programs:* Individuals who access safe parking sites remain eligible for Emergency Shelter, interim housing, or Permanent Housing programs.
- *Availability of Safe Parking programs:* Safe parking programs in Santa Cruz County are available year-round. Some programs require households to move their vehicles from the site during the day.

- **Safe Sleeping:** Safe Sleeping Programs are temporary sanctioned sleeping sites for individuals experiencing homelessness, providing safe locations for overnight rest and connection to supportive services. In Santa Cruz County, Safe Sleeping sites may operate on nonprofit, city, county, or state-owned property and often include on-site staff, hygiene facilities, and basic services. United Way 2-1-1 tracks safe sleeping availability and publishes this information on its website, including the eligibility criteria, intake schedules, and contact information.

- **Seasonal or Severe Weather Shelters:** Seasonal or Severe Weather Shelters are short-term emergency facilities activated during periods of extreme weather or local emergencies.

  While not separately defined under HUD, California's Emergency Solutions Grant (ESG) program allows use of ESG funds for Temporary Emergency Shelters under 24 CFR 576.102, including severe weather activation.

  Activation of Seasonal or Severe Weather Shelters is coordinated through the County Office of Response, Recovery, and Resilience (OR3) and announced via United Way 2-1-1, the H4HP newsletter, and the OR3 website.

  Seasonal or Severe Weather Shelters provide congregate beds on a first-come, first-served basis, with preference for people with disabilities or serious health risks.

7.3 Referral Process and Enrollment

Shelter programs in Santa Cruz County are typically supported by a combination of funding sources. Shelters that are contracted by the H4H Division to provide services prioritize referrals made by Coordinated Entry Connectors.

Although outside of the scope of this document, shelter programs that are not part of the H4H System must have clearly written, consistently implemented referral standards, admission policies, and hours for admitting new guests, and are encouraged to accept new guest admissions (when the shelter is open and beds are available) Monday through Friday for at least a four-hour period daily. Where feasible, admissions should be accepted on weekends.

7.3.1 Referral Process

County-contracted Emergency Shelter beds are filled by CE Connectors. Shelter referrals are made after considering a participant's interest in shelter, participant characteristics, and community decisions regarding shelter access prioritization. Shelters in each region of the County generally prioritize beds to unsheltered individuals from that region.

Because shelter beds must be filled quickly, the participant or their representative must respond to a referral for shelter within one business day.

Shelters may accept referrals from other entities once all Connector referrals have been reviewed and processed.

United Way 2-1-1 tracks and publishes shelter bed availability on its website, including populations served, eligibility criteria, intake schedules, and contact information.

7.3.2 Enrollment

H4H System Emergency Shelters are expected to have minimal entry requirements to reduce barriers to access for eligible individuals. Some Emergency Shelters may have additional eligibility requirements based on funding requirements (e.g., programs designed for specific populations, such as youth or survivors of domestic violence).

H4H System Emergency Shelters must adhere to the following:

- Maintain clear admission policies and referral standards consistent with the Housing for Health Partnership, Santa Cruz County Continuum of Care Emergency Shelter Standards and CES policies.
- Denial of Emergency Shelter admission must be based on criteria related to eligibility and documented in HMIS. The Housing for Health Partnership, Santa Cruz County Continuum of Care Emergency Shelter Standards contains detailed information on allowable eligibility criteria, which includes restrictions on certain criminal records, restraining orders, violent or threatening behavior, disallowed conduct from past shelter stays, infectious disease, or needs related to assistance with activities of daily living (ADLs).
- Use HMIS to enroll and exit program participants.
- Use HMIS to document participant Housing Action Plans, status updates, and other assessments as appropriate.

7.3.3 Eligibility

H4HP System Emergency Shelters are required to serve only individuals or families who meet the HUD definition Category 1: Literally Homeless or Category 4: Fleeing or Attempting to Flee Domestic Violence.

DRAFT

Certain Emergency Shelter programs or specific shelter beds may utilize different eligibility guidelines including:

- **Shelters serving survivors of domestic violence**: These include accommodations restricted to individuals or families who are fleeing, or attempting to flee, domestic violence, have no other residence, and lack the resources or support networks to obtain permanent housing.
- **Alternatively-funded Emergency Shelters:** Shelters funded by cities or private donors may have specific eligibility, prioritization, or referral processes. These shelters are strongly encouraged to have clear guidelines about program eligibility and how people can access the shelters.

7.3.4 Prioritization

H4HP does not currently have a standardized process for prioritizing individuals seeking shelter beds. However, the prioritization guidelines for family shelters serving households with children under 18 years old are outlined below:

Family shelters: Eligible families with the following characteristics are prioritized for vacancies in H4H System family shelters:

- A family member is pregnant;
- The family includes children under the age of 5; and/or
- The family has five or more members (large families).

7.4 Minimum Standards and Required Services

Emergency Shelters must provide safe, decent, and supportive accommodations for people experiencing homelessness. They are expected to support participants to quickly obtain permanent housing or another stable living situation.

Emergency Shelter programs must have dedicated staff to support shelter operations and provide housing navigation services. Shelter services should support participants to exit to stable housing including through information and referrals, assistance accessing applicable services, benefits linkage and advocacy, provision of or referral to employment services, and regular check-ins about participant's progress on their permanent housing plan.

H4HP System Shelters must always have sufficient staff on duty. Shelters must have at least one staff on duty and awake during all hours of operation. When only one staff is scheduled on a shift, shelters must have on-call staff available when needed. Detail on shelter staffing structure and training can be found in the *Housing for Health Partnership, Santa Cruz County Continuum of Care Emergency Shelter.*

Emergency Shelter programs must provide essential services such as food and building maintenance. Food may be prepared on-site or delivered to the shelter program. Food must

be prepared and served in a clean and sanitary environment meeting environmental health standards. Shelter participants must have access to appropriate areas to consume food including dining tables and chairs. A meal schedule must be posted and available to participants. Additional information on food preparation and delivery (e.g., donated food, meal accommodation, etc.) can be found in the Housing for Health Partnership, Santa Cruz County Continuum of Care Emergency Shelter Standards.

Shelter facilities must comply with HUD Emergency Solutions Grants Minimum Habitability Standards for Emergency Shelters, as well as applicable state and local building and fire codes outlined below.

- California Health & Safety Code § 17920.3 (substandard building standards);
- California Building Standards Code (Title 24), including local amendments adopted by Santa Cruz County under County Code Chapter 12.10;
- California Fire Code (Title 24 Part 9) and Santa Cruz County local fire code amendments, adopted under County Code Chapter 7.92; and
- Santa Cruz County Environmental Health regulations, including sanitation, food safety, water, wastewater, and other facility-related requirements enforced by the Santa Cruz County Environmental Health Division.

Shelters must provide suitable sleeping spaces and access to private and properly functioning hygiene facilities. More detailed information on the requirements of shelter facilities and the provision of appropriate sleeping areas can be found in the Housing for Health Partnership, Santa Cruz County Continuum of Care Emergency Shelter.

7.5 Program Discharge

Before discharge, Emergency Shelter programs must make reasonable efforts to connect participants with needed resources. When appropriate, staff should coordinate with H4H Connectors or the CE to support continuity of care and expedite participant access to housing.

A successful exit from Emergency Shelter occurs when a participant secures permanent housing (including privately paid rental housing, shared housing, family reunification, Rapid Rehousing, or Permanent Supportive Housing), transitions to Transitional Housing, or relocates to another stable living situation. An unsuccessful exit occurs when a participant leaves to an unsheltered situation, vacates the shelter and cannot be relocated, or is discharged for unallowed behavior.

Emergency Shelter programs must follow discharge expectations described in Participant Engagement and Discharge Expectations, ~~section 4.7~~section 4.8 of these standards, including written notice, documentation, and participant appeal rights. Emergency Shelters

Field Code Changed

must also follow applicable requirements in the Housing for Health Partnership, Santa Cruz County Continuum of Care Emergency Shelter Standards.

7.6 Performance Measures

Performance measures for H4H System Emergency Shelter programs are:

- 90% of exits occurring within six months of enrollment in Emergency Shelter
- 100% of heads of households enrolled in program have a service recorded in HMIS
- At least 80% of households enrolled in the program will have a completed status update and assessment every 90 days.
- At least 80% of households enrolled in a program for a year or more will have an annual assessment completed in HMIS.
- At least 80% of households will have personal contact information listed in HMIS.

  At least 80% of households will have contact information recorded in HMIS for one or more support person, such as a primary care provider, emergency, care manager, or other contact.
- At least 40% of households will have a successful exit (as defined above).
- At least 25~~40~~% of households will increase their income.
- At least 60% of households will have SNAP/CalFresh benefits as documented with status updates and at exit.
- ~~At least 40% of households will increase their public benefits.~~
- At least 80~~90~~% of households will have health insurance as documented in status updates and at exit.

DRAFT

8. Standards Applicable to Homelessness Prevention

This section outlines the minimum standards for Homelessness Prevention System Providers operating in the H4HP System. These standards complement and extend applicable standards described in sections 4 (Standards Applicable to All Program Types) and 6 (Housing-Focused Outreach).

Homelessness Prevention programs are designed to reduce entries into homelessness by providing time-limited financial assistance and supportive services to households at risk of losing housing. Homelessness Prevention assistance seeks to:

- Help households retain their current housing or secure alternative housing without entering homelessness.
- Provide temporary supports to help participants remain in or obtain stable housing without the need for long-term financial assistance.

For the purposes of these standards, Homelessness Prevention does *not* include broader housing stability or eviction prevention efforts, such as the provision of a universal basic income or increased availability of affordable housing. While those activities aim to address housing instability at a community or system level and may serve households experiencing financial or tenancy challenges, they are distinct from homelessness prevention interventions targeted at households at imminent risk of homelessness.

The H4HP System includes Homelessness Prevention programs supported by multiple funding sources. Programs funded with HUD Emergency Solutions Grant (ESG) resources must comply with all applicable federal regulations, including 24 CFR 576.

8.1 Eligibility and Prioritization

Homelessness Prevention assistance is intended for individuals and families who are not yet homeless but are at imminent risk of homelessness, as defined by HUD Category 2: Imminent Risk of Homelessness. Households that meet the HUD definition of homelessness under Categories 1 or 4 are not eligible for homelessness prevention assistance.

Eligible households may access Homelessness Prevention assistance through referrals from United Way 2-1-1, school districts, courts, health and human service providers, or direct outreach to Homelessness Prevention providers.

Eligibility for H4HP System Homelessness Prevention services and programs may extend beyond HUD definitions to include:

- Households living doubled up with family or friends who must leave within 14 days and are seeking shelter.
- Households staying in hotels/motels with their own resources who must vacate within 14 days.
- Renters facing eviction for nonpayment of rent who must leave within 14 days.
- Survivors of domestic violence.

DRAFT

- Youth exiting foster care and at imminent risk of losing current housing.

Households assisted with ESG funds must have income at or below 30% of Area Median Income (AMI) at intake and be re-evaluated every three months to confirm ongoing eligibility.

8.1.1 Prioritization

Homelessness Prevention programs must use a consistent, transparent prioritization process to allocate limited resources. Priority should be given to households that:

- Are at imminent risk of homelessness within 14 days;
- Have no other safe and appropriate housing options;
- Lack financial or social supports to obtain or maintain housing; and
- Would be most likely to enter homelessness without immediate assistance.

In addition, the H4H System and specific Homelessness Prevention providers should target households for assistance that have histories of homelessness, are ~~doubled up~~doubled up or do not have a legal right to where they are living (i.e. no lease), or other criteria shown to predict future housing loss.

8.2 Amount and Duration of Assistance

HUD ESG funded programs must follow ESG requirements at 24 CFR 576.105 and 576.106, to determine allowable assistance including:

- Financial assistance may be provided for up to 24 months within any three-year period.
- Rental arrears may be provided for up to six months, including late fees.

Programs funded through other sources may have different assistance limits based on specific contract or funding requirements. All Homelessness Prevention programs must complete re-evaluations of participant eligibility at least every three months.

8.3 Required Services

Prevention services should be flexible and tailored to each household's specific needs and resources. H4HP System Homelessness Prevention Providers facilitate participants' access to services that promote housing stability, including legal assistance, landlord mediation, housing relocation support, and public health or code enforcement when housing conditions are unsafe. Services should support the household's ability to remain housed or obtain new housing.

8.4 Program Discharge

A successful Homelessness Prevention program exit occurs when a household has resolved their immediate housing crisis and secured or maintained housing that is sustainable based on their current income and resources. An unsuccessful exit occurs when the participant loses housing, disengages from the program, or ceases to meet eligibility requirements and does not maintain housing.

Homelessness Prevention providers must follow the systemwide discharge expectations in the Participant Engagement and Discharge Expectations section. ESG-funded programs must also comply with 24 CFR 576.402 regarding termination of assistance.

8.5 Performance Measures

Performance measures for Homelessness Prevention programs align with broader System goals of reducing homelessness and increasing exits to stable housing.

- 100% of heads of households enrolled in program have a service recorded in HMIS
- At least 80% of households will have personal contact information listed in HMIS.
- At least 80% of households will have contact information recorded in HMIS for one or more support person, such as a primary care provider, emergency, care manager, or other contact.
- At least 70% of households will remain stably housed for twelve months after receiving prevention services.
- At least 25% of households will increase their income.
- At least 60% of households will have SNAP/CalFresh benefits as documented with status updates and at exit.
- At least 80% of households will have health insurance as documented in status updates and at exit.
-

DRAFT

9. Standards Applicable to All Housing Programs

This section shares requirements for all Housing Programs, including Transitional Housing, Rapid Rehousing, and Permanent Supportive Housing programs. These requirements include standards for referrals, enrollment, housing, and documentation. Program-specific standards are provided in Sections 10-12.

9.1 Purpose and Types of Programs

The H4HP System operates Transitional Housing, Rapid Rehousing, and Permanent Supportive Housing programs that provide the support, financial assistance, and housing opportunities to help people experiencing homelessness obtain and maintain long-term housing stability. This section describes requirements for referrals, enrollment, housing, and documentation that apply across all three housing program types.

9.2 Referral Process

H4HP System Transitional Housing, Rapid Rehousing, and Permanent Supportive Housing Providers must take referrals from the CES.

Please see Section 7 in the Housing for Health Partnership (H4HP) Coordinated Entry Policies Manual for detailed information on the CES assessment, prioritization, and referral process.

9.3 Enrollment

H4HP System housing program enrollment begins once the Provider confirms the participant's eligibility for assistance, and reviews program expectations and completes enrollment paperwork with the participant.

During the enrollment process, System Providers go through informing materials and have participants sign a program agreement that includes:

- Required participation in regular care management appointments. See specific project type standards for additional guidance.
- Required development of a written housing search and stability plan to support long-term housing stability, which may be based on an existing Housing Action Plan, if applicable.
- A rent schedule outlining the methodology used to determine future participant rent contributions, the length of rent subsidy availability, and estimated participant rent contributions to the extent feasible at the time of enrollment.

9.4 Housing Standards

This section outlines housing standards for H4HP System Housing Programs. Public Housing Authority (PHA)-administered programs may be subject to different federal regulations and may have different requirements or flexibilities related to housing standards, rents, leases, and rental assistance.

The following standards apply to all H4HP System Housing Programs to ensure a minimum level of safety:

- Housing Programs may only support participants to move into units that meet Habitability Standards. Programs funded through the CoC for leasing or rental assistance, must ensure participant housing meets HUD National Standards for the Physical Inspection of Real Estate (~~NSPIRE) through~~NSPIRE) through initial and annual inspections.
- Participant housing in all programs must meet rent reasonableness standards. For ESG and CoC providers, HUD has provided additional guidance on how to document rent reasonableness standards. For ESG-funded programs, participant rent must also fall at or below HUD's published Fair Market Rent for Santa Cruz County, which is published by HUD and updated at least annually.
- Housing Providers are encouraged to have landlords or property owners interested in renting to participants complete a Housing Assistance Payment (HAP), or similar agreement that clarifies the relationship among the landlord, provider, and participant. Programs may only issue participant rental payments to the landlord or property owner. HUD requires ESG funded Rapid Rehousing and Permanent Supportive Housing programs to enter into a rental assistance agreement (e.g. a lease addendum or comparable written agreement) with the landlord that includes the specific regulations required by the funding source and includes the amount and duration of rental assistance, in addition to a lease.
- ESG- and CoC-funded Rapid Rehousing and Permanent Supportive Housing programs must ensure that participant leases:
    - Have a minimum of a one-year term. After the first year, the lease must be renewed or converted to a month-to-month agreement. The lease may be terminated only for cause.
    - Are legally binding, comply with California landlord-tenant law as defined by the California Tenant Protection Act, and aligns with the standard terms of other permanent housing leases. Additional information on California landlord-tenant rights and responsibilities is available in the California Department of Real Estate's California Tenants – A Guide to Residential Tenants' and Landlords' Rights and Responsibilities.
- Transitional Housing programs using participation agreements must be for a term of at least one month.
    - CoC-funded Transitional Housing programs require the agreement to automatically renew upon expiration, except upon prior written notice by either party, for a maximum term of 24 months, as noted in 24 CFR 578.51(l).

9.5 Documentation and HMIS requirements

All participant program activities, including enrollment, service transactions, recertifications, and exits, must be documented in HMIS in accordance with the CoC HMIS Policies and Procedures Manual.

10. Standards Applicable to Transitional Housing

This section offers an overview of the minimum standards for Transitional Housing programs operating through the H4HP System. These standards complement and extend applicable standards described in sections 4 and 9.

Under 24 CFR 578.3, HUD defines Transitional Housing as housing where participants may remain for up to 24 months and receive supportive services designed to help them move to and maintain permanent housing. The State of California, under California Health & Safety Code § 50801(k), defines Transitional Housing as housing with supportive services operated for no more than 24 months and designed to help individuals and families transition from homelessness or unstable housing to permanent housing.

Transitional Housing is also treated differently from Emergency Shelter under California zoning and building requirements. Under California Government Code § 65583(a)(5) and California Department of Housing and Community Development (HCD) guidance, Transitional Housing is considered a residential use and is subject only to the restrictions that apply to other residential dwellings of the same type in the same zone. Accordingly, Transitional Housing facilities are generally subject to the zoning, building, health, and safety requirements applicable to the type of residential structure in which the program operates. Providers are responsible for ensuring that facilities comply with all applicable state and local requirements.

Transitional Housing within the H4HP System provides temporary housing and supportive services to assist people experiencing homelessness to regain permanent housing. Stays in Transitional Housing are typically longer than in Emergency Shelter. Transitional Housing programs differ from other Housing Programs in that people enrolled continue to be considered homeless during their enrollment and frequently involve a single provider offering both services and housing. In addition, tenancy in Transitional Housing may depend on participation in case management, treatment, or other programming. Some H4HP System Transitional Housing programs are targeted to a specific population or geared toward specific goals around education, training, or employment. Transitional Housing programs may be especially appropriate for specific populations, including:

- Transitional Age Youth (TAY), including single or pregnant youth, and/or youth-led households,
- Individuals with a substance use disorder,
- Individuals exiting from jail or prison,
- Persons with experience of or who are fleeing domestic violence, and
- Veterans.

10.1 Eligibility

To qualify for Transitional Housing, households must meet the HUD definition of literal homelessness under Category 1 (literally homeless) or Category 4 (fleeing or attempting to

DRAFT

flee domestic violence). A participant's eligibility must be verified and documented prior to program enrollment.

Joint Transitional Housing-Rapid Rehousing (TH-RRH) programs begin with a Transitional Housing stay and then transitions households to a Rapid Rehousing (RRH) program. For TH-RRH projects, the Transitional Housing portion of the project follows the standards in this section. The requirements for the RRH portion of a TH-RRH project are the same as other RRH projects.

10.2 Required Services

Transitional Housing programs must adhere to minimum housing and services standards designed to support the households' transition to permanent housing. Transitional Housing programs must develop service plans with participants and provide services that support exits to stable housing, including information, referral, and linkage to other benefits and services, assistance accessing long-term housing programs, provision of or referral to employment or educational services, and regular check-ins about progress towards permanent housing.

Supportive services must be provided to residents throughout the duration of their program enrollment. Services should be participant-centered and tailored to each participant's needs. Transitional Housing programs dedicated to specific populations should be designed to address the needs of the target population being served.

10.3 Duration of Assistance

Transitional Housing programs are expected to support people in connecting to permanent housing or another stable living situation as quickly as possible. Transitional Housing programs can offer services for a maximum of 24 months. For Joint Transitional Housing–Rapid Rehousing (TH–RRH) projects, the combined duration of Transitional Housing and Rapid Rehousing assistance may not exceed 24 months. While Transitional Housing participants may receive assistance for the full 24 months, the average length of stay is expected to be shorter, with participants exiting the program as soon as they can sustain housing on their own.

HUD allows a household in a CoC-funded Transitional Housing program may remain in Transitional Housing for longer than 24 months if permanent housing for the individual or family has not been located or if the individual or family requires additional time before program exit. The H4HP System recommends that stays not exceed 24 months; when additional time is necessary, extensions are only offered on a month-to-month basis and limited to circumstances where there is a specific, known housing or other stable living opportunity that the participant is waiting to transition into and the participant continues to work with program staff toward a positive exit. Program average lengths of stay will be considered as part of future H4HP funding decisions, with the expectation that programs demonstrate a focus on timely transitions to permanent housing.

DRAFT

Transitional Housing programs may continue providing supportive services for up to six (6) months after a participant exits to permanent housing. These short-term post-exit services are intended to help households adjust to independent living, maintain stability, and resolve issues that may arise during the early stages of their housing transition.

10.4 Program Discharge

Before discharge, Transitional Housing programs must make reasonable efforts to connect participants to alternative housing options, including Rapid Rehousing, Permanent Supportive Housing, Emergency Shelter, or other community resources. When appropriate, staff should coordinate with H4H Connectors or the Coordinated Entry System to support continuity of care and reduce the likelihood of a return to homelessness.

A successful exit from Transitional Housing occurs when a participant moves into permanent housing or, in a TH-RRH model, transitions into the RRH component of the project. An unsuccessful exit occurs when the participant returns to homelessness, leaves without a housing plan, or is terminated due to significant program violations.

Transitional Housing providers must follow the systemwide discharge expectations outlined in the Participant Engagement and Discharge Expectations, section 4.~~7~~8 of these standards. Providers must also adhere to California's Transitional Housing Misconduct Law, which allows programs to remove a participant during the first six months of occupancy by seeking a temporary restraining order and injunction from the court when certain types of misconduct occur. If the participant has lived in a program covered by this law for more than six months, or the reason for discharge is not covered under the Misconduct Law, formal eviction proceedings may be required. The H4HP System Transitional Housing Manual provides additional guidance on discharge procedures.

10.5 Performance Measures

H4HP System Transitional Housing programs are expected to meet the following:

- 100% of heads of households enrolled in program have a service recorded in HMIS.
- At least 80% of households enrolled in the program will have completed status updates and assessments in HMIS every 90 days.
- At least 80% of households enrolled in a program for at least one year will have an annual assessment completed in HMIS.
- At least 80% of households will have personal contact information listed in HMIS.
- At least 80% of households will have contact information recorded in HMIS for one or more support person, such as a primary care provider, emergency contact, or care manager.
- At least 80% of clients will exit to a permanent housing situation.
- At least 25% of households will increase their income.
- At least 60% of households will have SNAP/CalFresh benefits as documented with status updates and at exit.

- At least 80% of households will have health insurance as documented in status updates and at exit.

- ~~At least 40% of households will increase their income.~~
- ~~At least 40% of households will increase their public benefits.~~
- ~~At least 90% of households will have health insurance as documented with status updates and at exit.~~

DRAFT

11. Standards Applicable to Rapid Rehousing

This section offers an overview of the minimum standards for Rapid Rehousing programs operated within the H4HP System. These standards complement and extend applicable standards described in sections 4 and 9.

Rapid Rehousing is a time-limited housing and supportive services intervention designed to help people experiencing homelessness quickly move into permanent housing, stabilize, and maintain the housing without ongoing rental subsidies. Rapid Rehousing programs provide housing navigation services to help households secure permanent housing, individualized housing stability care management to support long-term stability, and short- to medium-term rental assistance while households assume full responsibility for their rent over time.

In Santa Cruz County, Rapid Rehousing services are delivered through a combination of federal- and state-funded programs. The following Rapid Rehousing programs are offered in the H4H System:

- **HUD Continuum of Care–funded Rapid Rehousing:** These programs follow federal Continuum of Care regulations at 24 CFR 578. They provide time-limited rental assistance, housing navigation, and individualized services to help households experiencing homelessness obtain and maintain permanent housing. Programs must comply with federal housing quality requirements, rent reasonableness standards, and documentation rules.

- **HUD Emergency Solutions Grant–funded Rapid Rehousing:** These programs follow federal regulations 24 CFR 576. They provide short- and medium-term rental assistance, housing stability services, and financial help with move-in costs. Households must have income at or below 30 percent of Area Median Income; income eligibility must be recertified every year to confirm that the household's income does not exceed 30 percent of the Area Median Income and that the household could not retain housing without ESG assistance.

- **California Department of Social Services Rapid Rehousing Programs:** The California Department of Social Services (CDSS) funds Rapid Rehousing programs, as described in California Welfare Institutions Code §10618.9. These include:
    - **CalWORKs Housing Support Program**: Assistance to CalWORKs families who are experiencing or at risk of homelessness, includes housing navigation, time-limited rental assistance, and supports that help families secure and stabilize in permanent housing.
    - **Housing and Disability Advocacy Program (HDAP):** Includes outreach, housing navigation, time-limited rental assistance, disability benefits advocacy, and care management for households experiencing homelessness who have disabling

physical or behavioral health conditions but are not currently receiving public disability benefits.

- **Home Safe Program:** Housing stabilization services and short-term financial assistance for older adults and adults with disabilities involved with Adult Protective Services.
- **Bringing Families Home:** Includes housing navigation, time-limited financial assistance, and care management for child welfare involved families experiencing homelessness.

11.1 Eligibility

To qualify for Rapid Rehousing, households must meet the HUD definition, Category 1: Literally Homeless, or Category 4: Fleeing or Attempting to Flee Domestic Violence and have verified and documented income and housing status (see Appendix B for more detail). Households assisted with ESG funds must have verified income at or below 30% of Area Median Income (AMI).

CoC-funded Transitional Housing to Rapid Rehousing (TH-RRH) programs pair RRH with Transitional Housing. These programs start with a Transitional Housing stay and then transition households into Rapid Rehousing subsidies and services. Households do not need a separate referral for the Rapid Rehousing portion if they were already matched to the Transitional Housing program through the CE Housing Queue. (See Transitional Housing standards for requirements related to the TH portion of the TH-RRH model.)

Some Rapid Rehousing programs' funding sources limit eligibility to:

- Families with children
- Households with child welfare or foster care involvement
- Seniors and people with disabilities

11.2 Amount and Duration of Rental Assistance

H4HP System Rapid Rehousing programs must determine the amount and duration of rental assistance in a consistent, participant-centered manner that supports both immediate housing placement and long-term stability.

11.2.1 Amount of Rental Assistance

Rapid Rehousing providers evaluate each household's financial situation at program enrollment and reassess throughout program participation to determine rental assistance needed. Providers must maintain written policies describing how participant contributions are calculated and adjusted. The following provides guidance on financial assistance determinations:

- Providers must establish a progressive rent contribution schedule at enrollment, where participants assume a larger share of rent over time.

DRAFT

- Rent contribution schedules should be reevaluated regularly and no less than every 90 days; adjustments should be made if household circumstances change in ways that would jeopardize housing stability or increase the risk of returning to homelessness if the contribution schedule was followed. Adjustments to rent contributions must be made in writing and acknowledged by participants in writing. Providers are required to complete quarterly updates and annual assessments in HMIS.
- Households with income must cover a portion of their rent within two months of entering housing. For ESG-funded programs, participants without income must not be required to contribute to rent, in compliance with HUD CPD Notice 17-11.
- Households are expected to increase their rent contribution as their income increases. Households exit the program once they can sustain housing without a subsidy.

11.2.2 Duration of Rental Assistance

The duration of rental assistance in CoC and ESG-funded Rapid Rehousing programs may range from the shortest amount of time needed for the household to achieve stability, with no more than 24 months of short (0-3 months) to medium-term (4-24 months) rental assistance. Rental assistance ends once a household can afford their rent without assistance. Rental assistance may be paused and restarted if the household remains enrolled, provided the total duration does not exceed the 24-month limit.

For Joint Transitional Housing–Rapid Rehousing (TH–RRH) projects, the combined duration of Transitional Housing and Rapid Rehousing assistance may not exceed 24 months.

11.3 Required Services

Rapid Rehousing providers must offer housing identification support and housing stabilization care management to all participants. Additional program requirements and guidance are further detailed in the Housing for Health Partnership System of Care Rapid Rehousing Manual.

11.3.1 Housing identification

Rapid Rehousing programs must provide participants with support in identifying safe and affordable housing opportunities. Housing identification services should be tailored to household's individualized needs and may include:

- Support identifying available units that meet program requirements, participant needs, affordability standards, and rent reasonableness criteria;
- Initiating and maintaining relationships with property managers to support tenancy;

- Helping participants prepare and submit rental applications, including support with application fees, documentation, and communication with property managers;
- Assisting participants in obtaining documents required for housing; and
- Providing financial assistance to support move-in costs, including application fees, security and utility deposits, and payment of utility arrears.

11.3.2 Housing stability care management and other services

Rapid Rehousing programs must support participants with housing stabilization and long-term housing retention. Rapid Rehousing program participants must engage with their provider monthly at minimum and develop a housing stability plan that is updated at least every 90 days; a written copy must be shared with the household. The provision of services and housing stability plan content must be shaped by the participant's goals and preferences including:

- Employment and training assistance;
- Landlord mediation and legal support;
- Credit repair and financial coaching;
- Housing counseling and tenant education;
- Connections to and support applying for mainstream benefits, health care, and other wellness resources; and
- Ongoing check-ins to monitor progress toward housing stability and update goals as needed.

11.4 Program Discharge

Rapid Rehousing programs must make every reasonable effort to support participants in sustaining housing and resolving issues impeding a successful housing outcome before program exit. Providers must document all attempts to engage the household, offer mediation, and coordinate with H4H when facing a potential unsuccessful program exit.

A successful Rapid Rehousing program exit occurs when a household maintains or transitions to permanent housing, including market-rate housing, subsidized housing, Permanent Supportive Housing, or other long-term stable housing. An unsuccessful exit occurs when a household returns to homelessness or disengages from the program prior to stabilizing in permanent housing.

Providers must follow the H4H Participant Engagement and Discharge Standards (~~Section 4.7~~Section 4.8), which outline expectations for written notice, due process, and participant rights. Additional program-specific guidance is available in the Housing for Health Partnership System of Care Rapid Rehousing Manual.

Field Code Changed

DRAFT

11.5 Performance Measures

Rapid Rehousing Programs are expected to meet the following performance expectations:

- 100% of heads of households enrolled in program have a service recorded in HMIS
- At least 80% of households enrolled in program have completed Status Updates and assessments in HMIS every 90 days.
- At least 80% of households enrolled in a program for a minimum of one year will have an annual assessment completed in HMIS.
- At least 80% of households will have personal contact information listed in HMIS.
- At least 80% of households will have contact information recorded in HMIS for one or more support person, such as a primary care provider, emergency contact, or care manager.
- At least 80% of households will exit to a permanent housing situation.
- At least 25% of households will increase their income.
- At least 60% of households will have SNAP/CalFresh benefits as documented with status updates and at exit.
- At least 80% of households will have health insurance as documented in status updates and at exit.
- ~~At least 40% of households will increase their income.~~
- ~~At least 40% of households will increase their public benefits.~~
- ~~At least 90% of households will have health insurance (as documented in HMIS status updates and at exit).~~

DRAFT

12. Standards Applicable to Permanent Supportive Housing

This section offers an overview of the minimum standards for Permanent Supportive Housing providers in the H4HP System. These standards complement and extend applicable standards described in sections 4 and 9.

Permanent Supportive Housing provides housing assistance and supportive services to households experiencing homelessness and with a disability or other health-related vulnerability that affect housing stability. It pairs permanent housing subsidies with individualized services to promote housing retention and improve residents' quality of life and other desired outcomes.

H4HP System Permanent Supportive Housing is delivered through a combination of federal and state-funded programs. The following Permanent Supportive Housing programs operate in the H4HP System:

- **HUD COC-Funded Permanent Supportive Housing:** Permanent housing in which ongoing housing assistance (e.g., long-term leasing or rental assistance) and supportive services are provided to assist households with at least one member (adult or child) with a disability in achieving housing stability as defined in 24 CFR 578.

- **No Place Like Home (NPLH) Permanent Supportive Housing:** The State of California's Department of Housing and Community Development (HCD) No Place Like Home Program funds ongoing site-based supportive housing units and services for adults with serious mental illness who are experiencing homelessness or are at risk of chronic homelessness.

- **Housing and Disability Advocacy Program (HDAP) Permanent Supportive Housing:** The State of California's Housing and Disability Advocacy Program (HDAP) provides outreach, long-term rental assistance, housing navigation, disability benefits advocacy, and ongoing stabilization services for adults experiencing homelessness who have disabling conditions that are likely to qualify them for federal disability benefits as defined in WIC 18999-1899.6 Within the H4HP System, due to reductions in available HDAP funding, HDAP is used to fund the supportive services component of some Permanent Supportive Housing (PSH) projects, while the permanent housing subsidy must be provided through another funding source

Permanent Supportive Housing programs may operate in various configurations, including:

- **Scattered site**: Units that are integrated throughout the community and leased from private property managers. Rental assistance is tenant-based, meaning the subsidy moves with the tenant if they relocate.

- **Site-based**: Units located within a single building or development, and the subsidy is tied to the unit rather than the tenant.

- **Hybrid (Site-Based and Scattered-Site):** Units are both at a central building and in the community; participating households may move between site-based and scattered-site units based on availability, needs, or preferences. Supportive services follow the participant regardless of location.

12.1 Eligibility

To qualify for Permanent Supportive Housing, households must meet the HUD definition of literal homelessness under Category 1 (literally homeless) or Category 4 (fleeing or attempting to flee domestic violence) and have a disability of long duration. Programs must maintain a low-barrier model and may not exclude participants with barriers such as a history of substance use or a criminal background.

Some Permanent Supportive Housing programs are designed for specific populations. These programs may have funding that limit eligibility to:

- Adults with serious mental illness
- Chronically homeless individuals
- Persons with specific qualifying disabling conditions

12.2 Required Services

Permanent Supportive Housing programs must make supportive services available to help participants obtain and maintain housing stability. Further information about service expectations is available in the Housing for Health Partnership System of Care Permanent Supportive Housing Manual.

All Permanent Supportive Housing programs must conduct an initial and annual recertification of participant eligibility, including verification of disability status and income.

Permanent Supportive Housing programs tailor services to participants' unique needs and goals and deliver them using a Housing First approach that does not make housing contingent on participation in specific services or treatment. At a minimum, services must include:

- Support with housing search and ongoing property manager engagement;
- Individualized services that strengthen long-term housing sustainability, such as tenancy education, life-skills coaching, and connection to mainstream benefits and resources; and
- Regular in-person or home-based visits at a frequency that reflects each participant's needs.

DRAFT

Permanent Supportive Housing Providers must make the following services available to participants by either offering them directly or coordinating them through mainstream service partners:

- Representative-payee or money-management support,
- Health or behavioral health care focused on behaviors or symptoms that affect tenancy,
- In-Home Supportive Services (IHSS), and other services that help participants maintain stable housing.

Supportive housing providers must offer services to every supportive housing participant, even if a participant declines or would prefer not to receive services.

12.3 Program Discharge

Programs must make every effort to support participants to sustain housing and resolve issues before exiting a participant without ongoing stable housing. Providers must document all attempts to engage the participant, offer mediation, and notify the H4H Division when an unsuccessful Permanent Supportive Housing exit is being considered.

A successful exit occurs when a participant retains or transitions to a different permanent housing type. An unsuccessful exit occurs when a participant returns to homelessness or disengages prior to stabilizing.

Providers must follow the Housing for Health Participant Engagement and Discharge Standards (Section 4.7), which outline expectations for providing notices to participants, sustained efforts at engagement, and participant rights. Program-specific guidance is available in the Housing for Health Partnership System of Care Permanent Supportive Housing Manual.

12.4 Performance Measures

Permanent Supportive Housing Programs are expected to meet the following performance expectations:

- 100% of heads of households enrolled in program with service recorded in HMIS.
- At least 80% of households enrolled in program will have completed Status Updates and assessments in HMIS every 90 days.
- At least 80% of households enrolled in a program for a year or longer will have an annual assessment completed in HMIS.
- At least 80% of households will have personal contact information listed in HMIS.
- At least 80% of households will have contact information recorded in HMIS for one or more formal or informal support person, such as a primary care provider, emergency contact, care manager, or other contacts.
- At least 80% of households will exit to a permanent housing situation.
- At least 25% of households will increase their income.

- At least 60% of households will have SNAP/CalFresh benefits as documented with status updates and at exit.
- At least 80% of households will have health insurance as documented in status updates and at exit.
- ~~At least 40% of households will increase their income.~~
- ~~At least 40% of households will increase their public benefits.~~
- ~~At least 90% of households will have health insurance as documented with status updates and at exit.~~

DRAFT

13. Cross References, Resources, and Appendices

13.1 Cross References

This document references the following H4HP standards, manuals, and State and federal regulations. These references provide additional detail, requirements, or procedural guidance that support the H4HP System of Care Standards.

13.1.1 Housing for Health Partnership Cross References

Housing for Health Partnership Governance Documents

- H4HP Policy Practice
- H4HP Governance Charter
- H4HP Complaint and Grievance Policy
- H4HP Coordinated Entry (CE) Policies and Procedures Manual
- H4HP CoC Homeless Management Information System (HMIS) Policies and Procedures Manual
- Housing for Health Partnership System of Care Housing-focused Outreach Operations Manual
- Housing for Health Partnership Emergency Shelter Standards
- Housing for Health Partnership System of Care Transitional Housing Manual
- Housing for Health Partnership System of Care Rapid Rehousing Manual
- Housing for Health Partnership System of Care Permanent Supportive Housing Manual

13.1.2 Federal Requirements and Regulations

U.S. Department of Housing and Urban Development (HUD)

- Fair Housing Act (42 U.S.C. §§ 3601–3619)
- Section 504 of the Rehabilitation Act (29 U.S.C. § 794)
- Americans with Disabilities Act (ADA), Titles II & III
- HUD Equal Access Rule (24 CFR 5.403)
- Continuum of Care Program (24 CFR 578)
- Emergency Solutions Grants Program (24 CFR 576)
- Homeless Definition and Eligibility Requirements (HUD Homeless Eligibility Overview)

DRAFT

- HUD Housing Quality Standards (HQS)
- HUD Rent Reasonableness and Fair Market Rent (FMR) Standards
- HUD CPD Notice 17-11 (Rent Contribution Guidance)
- HUD Reasonable Accommodation and Reasonable Modification Guidance

California State Requirements and Regulations

- California Fair Employment and Housing Act (FEHA), Government Code § 12920
- Unruh Civil Rights Act, Civil Code § 51
- California Civil Rights Department Resources on Accommodations and Modifications
- Transitional Housing Participant Misconduct Act, Civil Code §§ 1954.10–1954.14
- Housing First Requirements, Welfare and Institutions Code §§ 8255–8257
- Homeless Housing, Assistance, and Prevention Program Requirements, Health & Safety Code § 50216
- Homeless Shelter Inspection Standards (AB 362), Health & Safety Code §§ 17974–17974.5
- Homeless Data Integration System Requirements, Health & Safety Code § 50220.6
- Tenant Protection Act of 2019, Civil Code §§ 1946.2 & 1947.12
- Shared Housing Provisions, Government Code § 12927(c)(2)(B)
- Emergency Housing and Assistance Program Regulations, Health & Safety Code §§ 50800–50806.5; 25 CCR Chapter 7
- Safe Sleeping Program Authority (AB 2553), Health & Safety Code § 8699.3
- Safe Parking Program Requirements, Health & Safety Code § 103578
- DHCS CalAIM Community Supports Guidance
- DHCS Enhanced Care Management (ECM) Guidance
- DHCS Transitional Rent (Transition to Housing) Guidance

DRAFT

13.2 Resources

- Flexible Housing Assistance Fund Policies
- Cross System Coordination and referrals
- H4HP Connector Expectations
- H4HP Connector MOU
- Housing Needs Assessment
- Housing Action Plan
- Housing Problem Solving Guide
- Housing Documentation Training
- Informing Materials and Participant Consent Template
- Template: Client Consent and Informing Materials

DRAFT

Appendix A - Glossary

Assessment: The use of one or more standardized assessment tool(s) to determine a household's current housing situation, housing and service needs, risk of harm, risk of future or continued homelessness, and other adverse outcomes.

Community Supports (CS): The California Department of Health Care Services (DHCS) defines Community Supports as flexible, health-related services that address social needs—including homelessness and housing instability—by assisting with obtaining and maintaining housing, supporting recovery, and stabilizing health conditions in safe, appropriate environments. Community Supports are optional Medi-Cal benefits approved by DHCS and delivered by the participant's Managed Care Plan.

Comparable Database: In 24 CFR 578.57(a)(3), 24 CFR 576.400(f), and associated guidance, HUD defines a comparable database as a database used by Victim Service Providers that collects client-level data over time (i.e., longitudinal data), generates unduplicated aggregate reports based on the data, and meets HUD's HMIS requirements.

Connection Point: The virtual or physical places or programs where an individual or family experiencing homelessness or at imminent risk of homelessness accesses the Housing for Health System of Care.

Connector: Individuals trained to conduct a CES Housing Needs Assessment and assist participants in accessing resources and achieving self-identified goals that will support them in accessing housing. Connectors may work as part of an outreach team, drop-in center, or multi-service program. Connectors must participate in regular connector meetings and meet the expectations outlined in the H4HP Connector Expectations.

Coordinated Entry System (CE, CES): The system of program access, needs assessment, and prioritization developed by a Continuum of Care pursuant to 24 CFR 578.7(a)(8) (CoC Program), 24 CFR 576.400(d) (ESG Program), and associated HUD requirements and guidance.

Continuum of Care (CoC): A geographically based group of representatives that carries out the planning responsibilities of the Continuum of Care program pursuant to U.S. Department of Housing and Urban Development (HUD) regulations 24 CFR 578. These representatives come from organizations that provide services to the homeless or represent the interests of those at risk of homelessness, experiencing homelessness, or formerly homeless.

Disability – Social Security Administration (SSA): The inability to engage in any substantial gainful activity due to a medically determinable physical or mental impairment expected to result in death or to last for a continuous period of not less than 12 months, as defined by 20 CFR 404.1505.

- **For Supplemental Security Income (SSI)**: SSI provides benefits to individuals with limited income and resources who meet SSA's disability requirements. For adults applying based on disability, the disability standard is defined in 20 CFR 416.905. For children under age 18 applying for SSI, disability is defined as a medically

determinable physical or mental impairment resulting in marked and severe functional limitations, per 20 CFR 416.906.

- **For Social Security Disability Insurance (SSDI):** SSDI provides benefits to individuals who meet SSA's definition of disability and have sufficient Social Security-covered work history to qualify, as described in 20 CFR 404.315.
- **For Social Security Retirement:** Social Security retirement benefits provide income to eligible individuals based on age and Social Security-covered work history, as described in 20 CFR 404.310. Unlike SSDI and disability-based SSI, receipt of Social Security retirement benefits does not require an individual to meet SSA's definition of disability.

Disabling Condition – HUD: A physical, mental, or emotional impairment—including impairments caused by substance use, Post Traumatic Stress Disorder (PTSD), or brain injury—that is long-continuing or indefinite, substantially impedes independent living, and can be improved by suitable housing, as defined by the HUD Homeless Management Information System (HMIS) Data Standards, Definition 3.08.

Disabling Condition – State of California: Any physical or mental impairment that limits a major life activity, or a history of such impairment, or being regarded as having such impairment, as defined by California Government Code §12926.

Emergency Shelter - HUD: 24 CFR 576.2 defines Emergency Shelter as any facility, the primary purpose of which is to provide temporary shelter for people experiencing homelessness or for specific populations of that group.

Emergency Shelter – State of California: The State of California defines Emergency Shelter as housing with minimal supportive services for homeless persons that is limited to occupancy of six months. No individual or household may be denied Emergency Shelter because of an inability to pay. See Government Code § 65582, subd. (d) and Health and Safety Code § 50801, subd. (e).

Emergency Solutions Grant (ESG): Per 24 CFR Part 576, a HUD federal grant program that provides funds to states, local government, and territories for the rehabilitation or conversion of buildings for use as Emergency Shelter for the homeless, for the payment of certain expenses related to operating Emergency Shelters, for essential services related to Emergency Shelters and outreach for the homeless, and for homelessness prevention and Rapid Rehousing assistance.

Enhanced Care Management (ECM): As defined by the California Department of Health Care Services, Enhanced Care Management is intensive, field-based care coordination for Medi-Cal members with complex medical and social needs. ECM is a comprehensive, whole-person approach to care that addresses the clinical and non-clinical needs of Medi-Cal members with the most complex medical and social needs through intensive coordination of health and health-related services. ECM provides systematic coordination across physical, behavioral, developmental, oral health, and long-term services and supports, as well as coordination with community and social services.

Fair Market Rent: Rent estimates established annually by HUD used to determine the maximum amount that can be paid for rent, or "payment standards," for housing subsidies such as Housing Choice Vouchers and ESG-funded housing programs, as defined by HUD at 24 CFR 888.113.

Family - HUD: One person or a group of persons residing together, including households with or without children, elderly families, and disabled families, as defined by HUD at 24 CFR 5.403.

Family - State of California: One or more individuals living together in a household, regardless of marital status, gender, or blood relationship, as interpreted under California Fair Housing law in Government Code §12955.

Habitability Standards: Minimum health and safety standards that housing must meet to be considered suitable for program participation. ESG housing assistance must meet Habitability Standards, as per 24 CFR 576.403(c). Habitability Standards focus on minimum expectations for residential settings, and so are less stringent than Housing Quality Standards (HQS) required for some HUD programs.

Homeless Management Information System (HMIS): In 24 CFR 578.3 HUD defines HMIS as a local information technology system used to collect client-level data and data on the provision of housing and services to individuals and families experiencing or at risk of homelessness in accordance with HUD requirements. Each Continuum of Care (CoC) is responsible for selecting and maintaining an HMIS software solution that complies with HUD's data collection, management, and reporting standards.

Homelessness Prevention: Homelessness Prevention refers to housing stability services and financial assistance that help people who are at risk of homelessness maintain or obtain housing to prevent them from becoming literally homeless, as defined by HUD at 24 CFR 576.103. California's ESG and HHAP programs use HUD's definitions of Homelessness Prevention.

Homeless Verification: Documentation or certification that establishes an individual's or household's homeless status for program eligibility under HUD definitions as defined in 24 CFR 576.2.

Housing for Health System of Care: The set of programs, funding, activities, and coordination specifically intended to address the needs of people experiencing or at-risk of homelessness in Santa Cruz County.

Housing First: An evidence-based model that connects people experiencing homelessness to housing as quickly as possible without preconditions such as sobriety or service engagement.

Housing-focused Outreach: An outreach model used in Santa Cruz County that prioritizes connecting people experiencing unsheltered homelessness to lifesaving, person-centered services and resources while actively working towards securing stable and permanent housing solutions.

Housing Problem Solving: An engagement approach that is versatile and utilizes empowering engagement to identify and explore options to secure housing through creative, strengths- and resources-focused interaction. The goal is to support participants to identify options and actions toward safe housing solutions outside of the formal H4HP response system quickly and without the need for ongoing support.

Housing Quality Standards (HQS): National standards established by HUD in 24 CFR 576.403(c) to ensure that subsidized housing units meet minimum health and safety requirements. HQS inspections evaluate conditions such as sanitation, structure, utilities, and security. These inspections are required by some federally funded housing programs, including those receiving CoC or Housing Choice Voucher funds. Other programs may instead require compliance with Habitability Standards, which are typically less detailed but still ensure basic safety and livability.

Housing Queue: A list of households maintained in the HMIS system that have indicated an interest in one or more types of housing resources and have been assessed and prioritized for such resources. The Housing Queue contains key information about the household that is used to match them to available and anticipated housing resources.

Low-Barrier Navigation Center (Navigation Center): Temporary living facilities that offer more intensive housing-focused services than a typical shelter and is focused on moving people into permanent housing. Case managers at Navigation Centers typically connect individuals experiencing homelessness to income supports, health services, shelter, and housing.

Medical Respite: As defined by the California Department of Health Care Services, Medical Respite (also known as Recuperative Care) provides short-term residential care for individuals who no longer require inpatient hospitalization but need continued recovery support and whose condition would be exacerbated by recovering in a homeless shelter or unsheltered setting. DHCS provides for up to 90 days per Recuperative Care stay, with extensions permitted when medically necessary and approved by the Managed Care Plan.

Outreach: As defined in 24 CFR 576.101 (Emergency Solutions Grant) and 24 CFR 578.53(e)(13) (Continuum of Care), HUD defines outreach as activities designed to meet the immediate needs of people experiencing homelessness in unsheltered locations by connecting them with Emergency Shelter, housing, or critical services, and providing urgent, non-facility-based care. For more details on Outreach in Santa Cruz County, See Housing Focused Street Outreach.

Permanent Supportive Housing - HUD: In 24 CFR 578.3, Permanent Supportive Housing is defined as permanent housing in which supportive services are provided to assist homeless persons with a disability to live independently.

Permanent Supportive Housing - State of California: As defined in California Health and Safety Codes §50490 and §50675.2, Permanent Supportive Housing means permanent housing with no limit on the length of stay that is occupied by the target population and that is linked to onsite or offsite services that assist the supportive housing residents in retaining

the housing, improving his or her health status, and maximizing his or her ability to live and, when possible, work in the community. "Permanent Supportive Housing" includes associated facilities if used to provide services to housing residents.

Person with Lived Experience: A person who is currently experiencing or has previously experienced homelessness. This term also includes individuals who have lived through challenges that often contribute to or result from homelessness, such as poverty, mental health conditions, substance use or recovery, and involvement with the criminal justice system. Their experiences provide valuable insight for shaping programs and policies.

Point in Time (PIT) Count: As defined in 24 CFR 578.3, a count of sheltered and unsheltered homeless persons carried out on one night in the last 10 calendar days of January. CoCs are required to conduct a PIT Count per 24 CFR 578.7(c)(2).

Rapid Rehousing (RRH): Provides housing search and stabilization services and time-limited financial assistance to help individuals and families experiencing literal homelessness move quickly into permanent housing and remain stably housed, as defined by HUD at 24 CFR 576.104 and 24 CFR 578.37(a)(1)(ii). California's ESG and HHAP programs use HUD's definitions of Rapid Rehousing.

Reasonable Accommodation: A modification or adjustment to a program, service, or environment that enables a person with a disability to participate fully and equally, as required under the Americans with Disabilities Act (ADA), 28 CFR 35.130(b)(7); Section 504 of the Rehabilitation Act, 24 CFR 8.4(a); and the Fair Housing Act, 24 CFR 100.204.

Recuperative Care: See Medical Respite

Rent Reasonableness: A HUD standard defined in 24 CFR 582.305(b) and 24 CFR 983.303 used to ensure that the rent for a housing unit is fair compared to similar units in the same area. Housing programs must confirm that the rent charged is "reasonable" and not more than what is typically paid for comparable, unassisted units, considering factors such as location, size, type, and condition.

Rental Subsidy: Financial assistance provided through a housing program to help a household afford rent. Programs that offer rental subsidies have specific guidelines that determine who is eligible and the amount and duration of the subsidy.

Safe Parking: Under California Government Code §65589.9, Safe Parking Programs are locally authorized programs that provide safe, legal overnight parking locations for people living in their vehicles, including bathrooms, onsite security, and rules and regulations for the program.

Scattered Site Housing: Housing programs in which units are located in various locations in the community, rather than in a single development or building.

Seasonal or Severe Weather Shelters: Short-term emergency facilities activated during periods of extreme weather or local emergencies.

Serious Mental Illness (SMI) / Serious Mental Disorder: A diagnosable mental, behavioral, or emotional disorder that substantially interferes with one or more major life activities. The Substance Abuse and Mental Health Services Administration (SAMHSA) defines SMI as a diagnosable mental, behavioral, or emotional disorder of sufficient duration meeting diagnostic criteria, resulting in functional impairment that substantially interferes with or limits one or more major life activities, as established under the ADAMHA Reorganization Act (Pub. L. 102-321) and published in the Federal Register, 58 FR 29422 (May 20, 1993). In California, Serious Mental Disorder is defined in Welfare & Institutions Code § 5600.3(b) as a mental disorder that is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time.

Short-Term Post-Hospitalization Housing: As defined by the California Department of Health Care Services, Short-Term Post-Hospitalization Housing is a CalAIM Community Support that provides temporary housing for individuals who are ready for discharge from a hospital or psychiatric facility but lack a safe place to recover and are at risk of homelessness. DHCS funds this service for up to six months following discharge.

Subpopulation: A subset of people experiencing or at risk of homelessness who share certain characteristics of household type, age or status and may be served based on their membership in the subpopulation. Subpopulation categories in Coordinated Entry include Adult Only households, Family Households with Minor Children, Transition Age Youth (TAY) ages 18-24, Chronic Homelessness, Veterans of the U.S. Military, and Survivors of Domestic Violence.

Transition Aged Youth (TAY) - Individuals between the ages of 18 and 24 who are experiencing or at risk of homelessness and may require developmentally appropriate housing and services as they move into adulthood.

Transitional Housing - HUD: In 24 CFR 578.3, HUD defines Transitional Housing as programs that provide temporary housing with supportive services to individuals and families experiencing homelessness with the goal of successfully exiting to permanent housing. Transitional Housing programs allow for longer stays than Emergency Shelters, within 24 months (or such longer period as HUD may determine), per 24 CFR 578.3.

Transitional Housing – State of California: In Health & Safety Code §50675.2, California defines Transitional Housing as rental housing operated under program requirements that call for the termination of assistance and recirculation of the assisted unit to another eligible program recipient at some predetermined future point in time, which shall be no less than six months.

Unsheltered Homelessness: As defined in 24 CFR 578.3, the condition of having 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 cars, parks, abandoned buildings, bus or train stations, and campgrounds.

Victim Services Provider: In 24 CFR 578.3, HUD defines a Victim Service Provider as a private nonprofit organization whose primary mission is to provide services to victims of domestic violence, dating violence, sexual assault, or stalking. Providers include rape crisis centers, domestic violence shelters and Transitional Housing programs, and other programs.

DRAFT

Appendix B – Homeless Definitions

HUD's definition of homelessness for program eligibility is organized into four distinct categories. The definitions of each of these categories are included below, as are the federal definitions of chronic homelessness and at-risk of homelessness. HUD guidance on acceptable evidence for documenting homeless status is available at 24 CFR 576.500.

Category 1: Literally Homeless

An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:

i. Has a primary night-time residence that is a public or private place not meant for human habitation;
ii. Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, Transitional Housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or
iii. Is exiting an institution where the individual has resided for 90 days or less and who resided in an Emergency Shelter or place not meant for human habitation immediately before entering that institution.

Category 2: Imminent Risk of Homelessness

An individual or family who will imminently lose their primary nighttime residence, provided that:

i. Residence will be lost within 14 days of the date of application for homeless assistance;
ii. No subsequent residence has been identified; and
iii. The individual or family lacks the resources or support networks needed to obtain other permanent housing.

Category 3: Homeless under other Federal statutes

Unaccompanied youth under 25 years of age, also referred to as transition age youth (TAY), or families with children and youth, who do not otherwise qualify as homeless under this definition, but who:

i. Are defined as homeless under the other listed federal statutes;
ii. Have not had a lease, ownership interest, or occupancy agreement in permanent housing during the 60 days prior to the homeless assistance application;
iii. Have experienced persistent instability as measured by two moves or more during in the preceding 60 days; and

DRAFT

iv. Can be expected to continue in such status for an extended period of time due to special needs or barriers.

Category 4: Fleeing/Attempting to Flee DV

Any individual or family who:

i. Is experiencing trauma or a lack of safety related to, or fleeing or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous, traumatic, or life-threatening conditions related to the violence against the individual or a family member in the individual's or family's current housing situation, including where the health and safety of children are jeopardized.
ii. Has no other safe residence; and
iii. Lacks the resources to obtain other safe, permanent housing.

Chronically homeless

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

i. Lives in a place not meant for human habitation, a safe haven, or in an Emergency Shelter; and
ii. Has been homeless and living as described in paragraph (1)(i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1)(i). Stays in institutional care facilities for fewer than 90 days will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a Safe Haven, or an Emergency Shelter immediately before entering the institutional care facility;

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

(3) A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Acceptable evidence of chronically homeless status is detailed in 24 CFR 578.103(a)(4)

At Risk of Homelessness

Per 24 CFR 576.2 of the ESG Program Interim Rule and 24 CFR 578.3 of the CoC Program Interim Rule.

DRAFT

(1) An individual or family who:

i. Has an annual income below 30 percent of median family income for the area, as determined by HUD;
ii. Does not have sufficient resources or support networks, *e.g.*, family, friends, faith-based or other social networks, immediately available to prevent them from moving to an Emergency Shelter or another place described in paragraph (1) of the "Homeless" definition in this section; and
iii. Meets one of the following conditions:
    A. Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
    B. Is living in the home of another because of economic hardship;
    C. Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days of the date of application for assistance;
    D. Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
    E. Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons, or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
    F. Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
    G. Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

(2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C.254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

(3) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a (2)), and the parent(s) or guardian(s) of that child or youth if living with her or him.

Acceptable evidence of at risk of homelessness status is detailed in 24 CFR 576.500(c).

DRAFT