Howard County Department of Community Resources and Services
Glossary of Commonly Used Homelessness Service Terms

By-name List:

a real-time list of all people experiencing homelessness in your community. It includes a robust set of data points that support coordinated access and prioritization at a household level and an understanding of homeless inflow and outflow at a system level. This real-time actionable data supports triage to services, system performance evaluation and advocacy (for the policies and resources necessary to end homelessness).[1]

Chronic Homelessness:

(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. [2]

Collaborative Applicant:

The eligible applicant that has been designated by the Continuum of Care to apply for a grant for Continuum of Care planning funds under this part on behalf of the Continuum.

Continuum of Care (CoC):

a regional or local planning body that coordinates housing and services funding for homeless families and individuals. A CoC should be composed of representatives of organizations including: nonprofit homeless providers, victim service providers, faith-based organizations, governments, businesses, advocates, public housing agencies, school districts, social service providers, mental health agencies, hospitals, universities, affordable housing developers, law enforcement, organizations that serve homeless and formerly homeless veterans, and homeless and formerly homeless persons.

Purpose and Activities of the CoC are to:

- Promote community-wide goals to end homelessness;
- Provide funding to quickly rehouse homeless persons;
- Promote access to mainstream resources; and
- Improve self-sufficiency among people experiencing homelessness.

Responsibilities of a CoC include operating the CoC, designating and operating an HMIS, planning for the CoC (including coordinating the implementation of a housing and service system within its geographic area that meets the needs of the individuals and families who experience homelessness there), and designing and implementing the process associated with applying for CoC Program funds.[3]

Continuum of Care Board:

The Continuum of Care must establish a board to act on behalf of the Continuum using the process established as a requirement by (the Interim Rule) and must comply with the conflict-of-interest requirements. The board must: (1) Be representative of the relevant organizations and projects serving homeless subpopulations; and (2) Include at least one homeless or formerly homeless individual. The Purpose of the CoC Board is to act as a governing body on behalf of the Continuum of Care.[4]

Coordinated Entry:

a process developed to ensure that all people experiencing a housing crisis have fair and equal access and are quickly identified, assessed for, referred, and connected to housing and assistance based on their strengths and needs.

An effective Coordinated Entry Process has the following qualities:

- Prioritization
- Low Barrier
- Housing First Orientation
- Person Centered
- Fair and Equal Access
- Emergency Services
- Standardized Access and Assessment
- Inclusive
- Referral to Projects

- Referral to Protocols
- Outreach
- Ongoing planning and stakeholder consultation
- Informing local planning
- Leverage local attributes and capacity
- Safety planning
- Using HMIS and other systems for coordinated entry
- Full Geographic Coverage [5]

Defined by HUD's the Interim Rule, at 24 CFR 578. 7(a)(8), as:

A Centralized or coordinated assessment system is <u>defined</u> to mean a centralized or coordinated process designed to coordinate program participant intake, assessment, and provision of referrals. A centralized or coordinated assessment system covers the geographic area, is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool. This definition establishes basic minimum requirements for the Continuum's centralized or coordinated assessment system.

<u>Video: Example of how Coordinated Entry works in Kent County Michigan</u>[6]

Developmental Disability:

As defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002):

I. A severe, chronic disability of an individual that
    1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
    2. Is manifested before the individual attains age 22;
    3. Is likely to continue indefinitely;
    4. Results in substantial functional limitations in three or more of the following areas of major life activity:
        a. Self-care;
        b. Receptive and expressive language;
        c. Learning;
        d. Mobility;
        e. Self-direction;
        f. Capacity for independent living;
        g. Economic self-sufficiency.
    5. Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

II. An individual from birth to age 9, inclusive, who has a substantial developmental delay or specific congenital or acquired condition, may be considered to have a developmental disability without meeting three or more of the criteria described in paragraphs (1)(i) through (v) of the definition of developmental disability in this section if the individual, without services and supports, has a high probability of meeting these criteria later in life.

Emergency Shelter

Emergency shelter is defined in 24 CFR part 576: 24 CFR § 576.2 as any facility, the primary purpose of which is to provide a temporary shelter for the homeless in general or for specific populations of the homeless and which does not require occupants to sign leases or occupancy agreements.[4]

Evidence-Based Practice:

A process involving creating an answerable question based on a client or organizational need, locating the best available evidence to answer the question, evaluating the quality of the evidence as well as its applicability, applying the evidence, and evaluating the effectiveness and efficiency of the solution. In addition to, a process in which the practitioner combines well-researched interventions with clinical experience, ethics, client preferences, and culture to guide and inform the delivery of treatments and services.[7]

Functional Zero:

Within the homelessness services realm when we speak of ending homelessness, typically what is meant is reaching functional zero. That is, when the number of individuals or families experiencing homelessness within a community is less than the average number of individuals or families being connected with housing each month. "In achieving this measure, a community has demonstrated the system and capacity to quickly and efficiently connect people with housing and ensure that homelessness within the community will be rare, brief, and non-recurring."[8]

[Video: How to Measure and Achieve Functional Zero using a By-name List](#)[9]

Harm Reduction:

Harm Reduction is a set of practical strategies that reduce the negative consequences of drug use, and other addictive behaviors. It incorporates a spectrum of strategies from safer use, to managed use, to abstinence.[10]

In the context of homelessness services, harm reduction has been embraced as an evidenced based practice to inform the low barrier shelter model and supportive housing. Since historically, addiction has been used as a factor to screen individuals out of shelter or say they are not "housing ready", the harm reduction approach helps address this barrier.

[Video: Homelessness & Harm Reduction](#)[11]

Homeless:

HUD defines Homelessness in four separate categories

1) *Literally Homeless:* People who are living in a place not meant for human habitation, in emergency shelter, in transitional housing, or are exiting an institution where they temporarily resided.

2) *At Imminent Risk of Homelessness:* People who are losing their primary nighttime residence, which may include a motel or hotel or a doubled-up situation, within 14 days and lack resources or support networks to remain in housing.

3) *Homelessness under other Federal Statues:* Families with children or unaccompanied youth who are unstably housed and likely to continue in that state. This is a new category of homelessness, and it applies to families with children or unaccompanied youth who have not had a lease or ownership interest in a housing unit in the last 60 or more days, have had two or more moves in the last 60 days, and who are likely to continue to be unstably housed because of disability or multiple barriers to employment.

4) *Fleeing or attempting to flee domestic violence:* People who are fleeing or attempting to flee domestic violence, have no other residence, and lack the resources or support networks to obtain other permanent housing.[12]

Homelessness Management Information System (HMIS):

a local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness. Each Continuum of Care is responsible for selecting an HMIS software solution that complies with HUD's data collection, management, and reporting standards. The Howard County CoC uses Servicepoint as our local HMIS softward.

An HMIS can be used to:

- Produce an unduplicated count of persons experiencing homelessness for each CoC
- Describe the extent and nature of homelessness locally, regionally, and nationally
- Identify patterns of service use
- Measure program effectiveness [13]

HMIS Lead:

The entity designated by the Continuum of Care in accordance with the Interim Rule to operate the Continuum's HMIS on its behalf.[4]

The Housing Choice Voucher Program (Formerly Section 8):

The housing choice voucher program is the federal government's major program for assisting very low-income families, the elderly, and the disabled to afford decent, safe, and sanitary housing in the private market. Since housing assistance is provided on behalf of

the family or individual, participants are able to find their own housing, including single-family homes, townhouses and apartments.

The participant is free to choose any housing that meets the requirements of the program and is not limited to units located in subsidized housing projects.

Housing choice vouchers are administered locally by public housing agencies (PHAs). The PHAs receive federal funds from the U.S. Department of Housing and Urban Development (HUD) to administer the voucher program.

A housing subsidy is paid to the landlord directly by the PHA on behalf of the participating family. The family then pays the difference between the actual rent charged by the landlord and the amount subsidized by the program. Under certain circumstances, if authorized by the PHA, a family may use its voucher to purchase a modest home.[14]

Housing First:

Housing First is a homeless assistance approach that prioritizes providing permanent housing to people experiencing homelessness, thus ending their homelessness and serving as a platform from which they can pursue personal goals and improve their quality of life. This approach is guided by the belief that people need basic necessities like food and a place to live before attending to anything less critical, such as getting a job, budgeting properly, or attending to substance use issues. Additionally, Housing First is based on the theory that client choice is valuable in housing selection and supportive service participation, and that exercising that choice is likely to make a client more successful in remaining housed and improving their life.[15]

Video: Housing First: Principles into Practice – Animated Overview [16]

Low Barrier Shelter:

A shelter model that emphasizes welcoming guests in as they are, while having clear and simple behavioral expectations that apply to anyone residing in the shelter. These expectations are narrowly focused on maintaining a safe environment for all. Staff are trained in trauma-informed care and de-escalation techniques in order to help residents understand and conform to these expectations. This model attempts to remove as many preconditions to entry to shelter as possible i.e. sobriety, employment etc.[17]

Video: Advice on Lowering Shelter Barriers – From Those Who Have Done It [18]

Outreach:

Street outreach involves moving outside the walls of the agency to engage people experiencing homelessness who may be disconnected and alienated not only from mainstream services and supports, but from the services targeting homeless persons as well.[19]

Permanent Supportive Housing:

Permanent supportive housing is an intervention that combines affordable housing assistance with voluntary support services to address the needs of chronically homeless people. The services are designed to build independent living and tenancy skills and connect people with community-based health care, treatment and employment services.[20]

PIT Count:

The Point-in-Time (PIT) count is a count of sheltered and unsheltered people experiencing homelessness that HUD requires each Continuum of Care (CoC) nationwide to conduct in the last 10 days of January each year.[21]

Progressive Engagement:

Progressive engagement refers to a strategy of providing a small amount of assistance to everyone entering the homelessness system. For most households, a small amount of assistance is enough to stabilize, but for those who need more, more assistance is provided. This flexible, individualized approach maximizes resources by only providing the most assistance to the households who truly need it. This approach is supported by research that household characteristics such as income, employment, substance use, etc., cannot predict what level of assistance a household will need.[22]

Project Based Vouchers:

Project-based vouchers (PBVs) are a component of a public housing agency's (PHA's) Housing Choice Voucher (HCV) program. PHAs are not allocated additional funding for PBV units; the PHA uses its tenant-based voucher funding to allocate project-based units to a project. Projects are typically selected for PBVs through a competitive process managed by the PHA; although in certain cases projects may be selected non-competitively.[23]

Rapid Re-Housing:

Rapid re-housing provides short-term rental assistance and services. The goals are to help people obtain housing quickly, increase self- sufficiency, and stay housed. It is offered without preconditions (such as employment, income, absence of criminal record, or sobriety) and the resources and services provided are typically tailored to the needs of the person.

Core components include:

- Housing identification
- Rent and move-in assistance
- Rapid Re-Housing Case Management and support services [24]

Video: What is Rapid Re-Housing? from the National Alliance to End Homelessness[25]

Severe Service Needs:

For persons identified as having the most *severe service needs,* at least one of the following is true:

    I.   History of high utilization of crisis services, which include but are not limited to, emergency rooms, jails, and psychiatric facilities; or

   II.   Significant health or behavioral health challenges or functional impairments which require a significant level of support in order to maintain permanent housing.

Transitional Housing:

A project that is designed to provide housing and appropriate supportive services to homeless persons to facilitate movement to independent living within 24 months, or a longer period approved by HUD. For purposes of the HOME program, there is no HUD-approved time period for moving to independent living.[4]

Vulnerability Index Service Prioritization Decision Assistance Tool (VI-SPDAT): The VI-SPDAT is an evidence-informed approach to assessing an individual's or family's acuity. The tool, across multiple components, prioritizes who to serve next and why, while concurrently identifying the areas in the person/family's life where support is most likely necessary in order to avoid housing instability.[26] Howard County CoC uses the VI-SPDAT as the standardized assessment tool at coordinated entry. The VI-PSDAT has been adopted by the majority of CoC's nationwide.

Video: Introduction to the VI-SPDAT[27]

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