

**VOLUSIA/FLAGLER COUNTY COALITION FOR THE HOMELESS  
STANDARDS OF CARE – rev. March 9, 2006**

**PURPOSE, APPLICABILITY AND REVIEW:**

These Standards of Care establish definitions, policies and standards relating to the provision of housing and services directly to homeless individuals and families located in Volusia and Flagler Counties County, Florida.

The mission of the Continuum of Care is to provide homeless individuals and families with the resources and opportunities through which they may attain residential, financial and personal stability and self-sufficiency. It is the intent of the Volusia/Flagler County Coalition for the Homeless (Coalition), serving as the Continuum of Care, that this mission is to be adopted by all Publicly-funded providers.

The purpose of these Standards is to establish the minimum scope of housing and services to be provided and the minimum quality level when providing such housing and services directly to homeless individuals and families.

These Standards apply to all publicly-funded providers who provide housing and/or services directly to homeless individuals and/or families located in Volusia and Flagler Counties. Publicly-funded providers are to establish policies and procedures that reflect and incorporate these Standards, as may apply to the type/category of care provided. It is desired that other providers who provide housing and/or services directly to homeless individuals and families, but who are not publicly-funded also adopt these Standards. The Coalition has endorsed these Standards and encourages its member providers to adopt them.

**DEFINITIONS:**

**Best Practice:**

Homeless Continuum of Care, housing and social service programs are identified as Best Practice on the US Department of Housing & Urban Development (HUD) homepage. This term may also apply to programs receiving awards and/or presenting at national, state and local conferences on homelessness.

**Client(s):**

A Client(s) means homeless individual(s) or family(ies) referred to a publicly-funded provider.

**Continuum of Care:**

Continuum of Care or Continuum means and refers to the consolidated and integrated homeless housing and services delivery system designed by the U.S. Department of Housing and Urban Development (HUD) and subsequently updated in Exhibit 1 of Volusia and Flagler Counties County's HUD Homeless Continuum of Care application and consolidated plan.

**Publicly-funded Provider(s):**

A Publicly-funded provider means a municipal or state agency, not-for-profit corporation or for-profit corporation, that provides housing and/or services directly to homeless individuals and/or families and that is under contract to receive public monies.

**Common Service Plan:**

Common Service Plan means an individualized contract that is based upon the participant's current state, capabilities and personal goals and objectives, a comprehensive assessment of Client's conditions and need, as well as case management recommendations, and that describes the participant's needs for supportive services and outlines the steps that the participant must take in order to begin the personal process towards residential and financial stability self-sufficiency and community reintegration.

**Phase:**

A segment of the Homeless Continuum of Care designed to address specific needs of homeless Clients at specific

stages of their recovery from homelessness. Phases are listed in typical chronological order below:

**Prevention Phase:**

Prevention Phase includes programs, which provide emergency financial assistance, financial, and other forms of counseling and supportive services designed to prevent individuals and families from becoming homeless.

**Outreach Phase:**

Outreach refers to any program to locate and engage homeless individuals and families, conduct preliminary assessments of immediate unmet needs, and arrange for appropriate placements in housing and/or services provided by publicly-funded providers.

Outreach usually provides the initial contact for homeless persons within the Continuum of Care. Outreach is conducted through a variety of individual and program efforts, including, but is not limited to, individuals and mobile units to locate, identify and assist the homeless on the street, feeding programs, day shelters, food pantries, clothing banks, and faith-based assistance programs.

**Safe Haven and Tiered-Incentive Programs:**

Safe Haven refers to programs defined by the Department of Housing and Urban Development (HUD) designed to provide initial shelter for homeless persons with severe persistent mental illness (and may involve co-occurring substance abuse problems). A Safe Haven is characterized by flexible rules, harm reduction, adequate personal space and persistent outreach to engage residents in mainstream mental health services and residence.

Tiered-Incentive is similar to Safe Haven programs and targets homeless chronic substance abusers. Tiered-Incentive programs may include detoxification and low-demand sobering stations, link with outreach and provide mentors and incentives for Clients to engage in mainstream substance abuse treatment and housing programs.

**Emergency Phase:**

Emergency Phase refers to shelters which provide emergency housing and care to homeless individuals and/or families and to such provider's programs. An entry point into the continuum, this is where basic and immediate needs are addressed with a range of in-house and inter-agency services (see Supportive Services) and a preliminary case plan is developed. Generally, emergency shelter is limited to a stay of less than 60-days.

**Transitional Phase:**

Transitional Phase refers to the provision of housing and supportive services to special needs homeless populations comprised of persons with a history of mental illness, substance abuse, victims of domestic violence, HIV infection or AIDS, physical and developmental disabilities, as well as other homeless individuals and families, in order to assist such persons in the transition from homelessness to independent living or to permanent supported housing, and to such provider's facilities and/or programs. Length of stay is normally limited to less than 24 months. Time is taken during the Transitional Phase to address specific underlying causes of homelessness.

**Permanent Affordable and Supportive Housing Phase:**

Permanent Affordable and Supportive Housing refers to a provider who (1) operates or provides access to supported housing for those homeless individuals and families with special needs (i.e., permanent disability, the frail or elderly) and/or (2) assists those homeless individuals and families capable of maintaining independent living with minimal initial support to secure housing in the affordable housing market. Unlike other phases of the Continuum, permanent housing is not time limited.

**Supportive Services:**

Supportive Services refers to services provided directly to homeless individuals and/or families by a provider independent of, or in affiliation with, a shelter or housing provider, intended to assist homeless individuals and/or

families in attaining residential, financial and personal stability and self-sufficiency. Such services include, but are not limited to, health care, case management, life skills training, mental health or substance abuse treatment, education or vocational training, job counseling, training and/or placement, child care, meals, clothing, therapy and legal services.

#### **After Care:**

After Care includes all supportive services, tracking and monitoring activities designed to provide ongoing support to Clients who have attained permanent housing and self-sufficiency. The goal of after care is to help prevent a recurrence of homelessness and facilitation of the ultimate success of Clients in maintaining self-sufficiency and full community reintegration.

#### **Progressive Counseling:**

Any policy and/or procedures that are implemented for the purpose of fair enforcement of shelter rules and that utilizes incremental consequences for rule infractions prior to discharge from the facility.

### **GENERAL STANDARDS**

#### **Administration**

All not-for-profit organizations (NPOs) seeking to obtain funds through the Continuum of Care, are required to adopt these Standards of Care. All providers are encouraged to become certified where there is a certifying body, to improve the overall quality and uniformity of service delivery throughout the Continuum service area. All HUD funded agencies are required to submit a copy of HUD Annual Progress Reports to the Continuum of Care, and these will be reviewed by the Continuum of Care Committee, which will provide information and support to optimize outcomes.

#### **After Care**

- All shelter providers are encouraged to develop and implement an aftercare plan. This may be done by the agency's own staff or in collaboration with other agencies/community partners. Each facility should attempt to track and provide follow-up supportive services to its program graduates for up to 90 days after discharge. In some cases, this may be impossible when a Client leaves a facility without a proper discharge interview/plan in spite of facility policies to provide discharge planning.
- In cases where a Client moves from an emergency shelter to a full service transitional shelter or permanent supported housing program, the obligation for attempting to arrange for aftercare will fall to the staff of the new Continuum facility. The emergency shelter should then merely track the Client's living situation, with the help of staff at the Client's new facility, for any required outcomes reporting.
- When a Client moves from any facility to market-rate housing or is reunited with family or friends providing domicile in the community, agency case workers should make a concerted effort to maintain contact for at least six (6) months after discharge. Face-to-face visits should be done at three (3) months and at six (6) months and monthly if possible. Supportive services should continue during this time to help prevent a recurring episode of homelessness. Clients in need of ongoing services should be linked with agencies providing such services as appropriate.

#### **Best Practices / Outcomes**

Community Standards: All providers are encouraged to develop and implement an ongoing research, review and training program designed to identify and incorporate programmatic elements of local and national agencies which are considered Best Practices by HUD and other authorities. The goal is to improve the effectiveness of service delivery to homeless Clients and to achieve the highest possible outcomes. Such programs may include, but are not limited to: staff attendance at local, state and national training conferences and workshops including HUD Best Practices Symposiums, Internet searches for Best Practice models and contemporary program literature. References to Best Practice model is required as part of all funding applications that are submitted to the

Continuum of Care.

Outcome measures, designed to demonstrate a program's success at aiding Clients to attain financial self-sufficiency and permanent housing independence, are required of all County funded providers. Programs, which target various disabled homeless sub-populations, aim at assisting Clients to maintain their highest possible level of independence and functioning.

### **Budgeting**

Community Standards: All Clients who are employed or receiving financial benefits are encouraged to establish a savings plan with their caseworker. All residential facilities are encouraged to provide a method for Client savings, proper receipting and financial accountability and budgeting training to Clients.

- A transitional shelter or permanent supported housing is encouraged to require Clients who are employed or receiving benefits to contribute towards the cost of their housing and services and/or to a client savings account, only where these arrangements are clearly defined to the Client and written policies are adhered to. And only consistent with Federal limits on the percentage of income (not exceeding 30%) that can be paid for housing that is affordable and consistent with any other applicable federal, state or local regulations. Emergency phase shelters are strongly encouraged not to charge for shelter and basic necessities.

### **Cultural Sensitivity / Diversity**

All care facilities should demonstrate sensitivity to Clients' primary languages and cultural backgrounds. Any publicly-funded provider shall arrange for ongoing translation services as required by client(s), within 24 hours of request and should consider bilingual qualifications in its hiring practices.

There shall be no discrimination on the basis of race, color, gender, sexual orientation, disability, religion, or national origin in the provision of housing and services to Clients by providers. No religious practice or affiliation requirement shall be imposed upon Clients or prospective Clients at publicly-funded facilities.

### **Common Service Plan**

Community Standards: Comprehensive assessment of current social, health (including mental health and substance abuse/use) and employment/education conditions are essential in order to establish a service plan for the individual as he or she progresses.

During an individual's stay at emergency and transitional facilities an individualized Common Service Plan should be developed, describing the Client's needs for supportive services, establishing a service/referral plan and outlining the Clients personal goals toward attaining residential, financial and personal stability and self-sufficiency. The Client must participate in both the development and implementation of his/her care or recovery plan.

### **A Common Service Plan is encouraged but not required for Safe Haven, Tiered Incentive and Outreach Phase Clients.**

- The Common Service Plan is required to be shared (with proper release of information) with other agencies and shelters the Client might access. This is to insure the continuity of care, reduce duplication of services and to increase the Client's accountability for completing agreed upon goals.

Agencies should assist by linking with/referring to internal and/or external services such as, though not limited to benefit programs, in-patient/out-patient mental health or substance abuse treatment or support groups, educational/vocational opportunities, job counseling, training and placement, child care, legal services and transportation (see Supportive Services).

- The case managers shall be responsible for producing a comprehensive or revised assessment, as the case may be, of the Client's current social, health (including mental health and substance abuse or use)

and education/employment and other needs. The case managers shall play a major role in assisting the resident in the development, or revision, and implementation of a Common Service Plan that will enable the Clients to successfully achieve his/her personal goals and objectives by addressing unmet needs.

- Clients shall be assisted in initiating an individualized Common Service Plan within twenty-four (24) hours of the completion of their comprehensive assessment of their current social, health and education/employment conditions and needs.
- The individualized Common Service Plan shall be based on the comprehensive assessment of Client's conditions and needs, as well as case manager's recommendations, and the Client's personal goals and objectives. Goals and/or services sought by the Client should be consistent with those articulated by the Client during initial engagement and assessment by outreach, assessment and placement programs or while in the care of another provider.
- Meetings with the Client's case manager to evaluate progress toward goals set fourth in the Common service plan should be conducted on a weekly basis, at least until placement in permanent affordable housing.
- In the event that a Client developed a Common service plan while in the care of another provider, the new provider shall incorporate the Client's Common service plan into the Client's service plan, subject to revision by the Client and his/her case manager.
- The Common service plan is an individualized contract based upon the participant's current state, capabilities and personal goals. The Common service plan shall describe the participant's needs for supportive services and outline the steps that the participant must take in order to begin the personal process towards residential and financial stability and self-sufficiency. The Client's signature on the Common service plan signifies his/her commitment to obtaining residential, financial and personal stability and self-sufficiency.
- The individualized Common Service Plan should address the following goals and objectives that respond to the following potential needs: health (including mental health, including substance abuse), education, vocational skills and employability, benefits, housing, child care, and legal services, as well as family/interpersonal issues and spirituality.

#### **Community Standards:**

- Unrealistic goals should be avoided to prevent discouragement with the rehabilitation process. Conversely, too simplistic goals should be discouraged to prevent loss of interest by the Client due to the existence of too few challenges. The choices made by the Client with the assistance of his/her case manager should be meaningful, realistic and within the Clients range of skills, abilities and present circumstances.
- Common Service Plans are intended to be individualized, flexible service plans facilitating steady movement toward independent living at a pace suited for each participant's circumstances and needs. The Common Service Plan must be adjusted to reflect the progress or identified areas where additional attention is needed either by the Client's own efforts or through the provision of additional services or resources.

#### **Core Case Managers Functions:**

- Assessment- a thorough evaluation detailing the Client's current potential strengths, weaknesses, service needs and appropriate resources to meet the service needs.
- Planning- the development of a holistic service plan with each Client, containing service goals and appropriate time lines.

- Linkage/Brokerage- the process of referring or transferring Clients to all required internal and external services.
- Monitoring- the continuous evaluation of the Client's progress, leading to reassessment and development of new service linkages, or other dispositions as indicated.
- Advocacy - interceding on behalf of a Client or group of Clients to assure access to needed services and/or resources.
- Collaboration with any other case managers assigned to a Client including, but not limited to, case managers for mental health and substance abuse Clients.

**Community Standards: Areas of case managers' intervention should include but are not limited to:**

- Service planning
- Assistance in obtaining food and clothing and transportation
- Referrals for in- or out-patient mental health services, substance abuse treatment, and medical services.
- Assistance in obtaining benefits
- Provision and/or referrals to self-sufficiency related programs and services such as adult education, vocational training, job counseling, training and permanent placement services, childcare and legal services and transportation.
- Assistance and referral in obtaining appropriate housing placement.
- It is recommended that all care providers develop a multi-disciplinary approach toward providing care to the Clients to ensure a holistic response to the Clients' needs. Care providers are encouraged to develop multi-disciplinary care teams, comprised of the Clients' case managers, a health care worker caring for the Client, and/or government or community providers directly serving the Client, that would meet to review Client progress, make recommendations, and ensure successful referral to additional services and resources. Such an approach ensures effective, comprehensive service provision within the Continuum or in the community.
- Clients have both privileges and responsibilities relating to their stays at the care facilities which should be set forth in a Resident/Client Agreement that each Client should sign upon admission to the facility.

**Community Reintegration**

Continuum of Care facilities/services should facilitate and promote a Client's sense of belonging within or to a community.

As part of the recovery goals of homeless Clients, all facilities and programs should include a specific community re-integration program component. This may include, but is not limited to: mentoring programs, outside recovery groups (such as AA), voluntary attendance at community-based worship services, volunteer activities in the community, field trips and guest lectures by business persons, elected officials and other prominent and active members of the local community.

- Shelters and residential facilities should develop Neighborhood Advisory Boards where issues of neighborhood impact have been raised.

**Comprehensive Assessment**

Case management services shall be preceded by a comprehensive assessment of the Client's current social,

health (including mental health and substance abuse/use) and education/employment conditions. Screening for emotional disorders and dysfunctions, including substance abuse, and for other serious mental health impediments to independence, shall be performed by, or under the supervision of, qualified mental health or substance abuse professionals. The comprehensive assessment of the Client's social, health and educational/employment needs shall commence within seventy-two (72) hours of admission of the Client to a care facilities.

- The comprehensive assessment shall include treatment and referral recommendations and will form the basis for the Client's individualized Common service plan and referral services provided to the Client. The comprehensive assessment shall be comprised of information gathered by caseworkers, at intake through Client interviews and through medical and referral information.

### **Cooperation / Continuum of Care**

Community Standards: Each care provider shall work closely and cooperatively with Volusia and Flagler County Coalition for the Homeless, as well as other community-based service providers to effectuate service provision to homeless Clients.

### **Confidentiality and Sharing of Information**

- Publicly-funded providers are required to share Client data and demographics electronically using the HMIS approved software when such HMIS is implemented Continuum-wide.
- All care facilities shall comply with all federal and local state laws and regulations governing the confidentiality of information regarding AIDS/HIV status and medical, substance abuse or mental health history, referral or treatment. Clients' privacy must be guaranteed with regard to information not otherwise protected from disclosure by federal or state laws and regulations that is shared with the transitional care facilities' staff members.
- Care facilities shall respect the privacy of a Client's personal mail and telephone calls.

Community Standards: Client information may be subject to disclosure as provided by laws including investigation by law enforcement, probation officers, and DCF protective services related to minors or the elderly, subject to any limitations on disclosure set forth in state or federal law, including those laws protecting the confidentiality of information regarding HIV/AIDS, substance abuse or mental health history, referral or treatment.

Sharing of Clients' information with other providers to whom Clients may be referred is necessary to ensure effective provision of services, attaining the Client's Common Service Plan goals, and efficient use of Continuum resources. The necessity of sharing information with other service providers shall be explained to the Client. Client information shall only be shared upon the Client's written consent.

### **Empowerment of Homeless Persons**

Community Standards: Continuum providers should train and establish formerly homeless para-professional staff at all levels: kitchen, custodial, administration, counseling, shelter operations etc. whenever possible.

- Every continuum shelter or agency should create an advisory council made up of current residents or Clients. Senior staff, preferably the shelter or agency director, should meet with the council on a monthly basis to solicit input and discuss rules and other aspects of agency operations.
- Every agency, which primarily serves homeless persons, should have homeless or formerly homeless person included in the composition of its local governing board.

### **Environment**

- All residential facilities must adhere to local zoning and fire code regulations governing maximum occupancy for all dwelling units.

- All facilities shall comply with local and state ordinances, laws or regulations governing the prevention and/or control of communicable air-borne diseases within residential facilities which may include the implementation of structural or environmental measures and quarantining, notification and health screening procedures.
- All care facilities shall maintain safe, clean, and sanitary conditions and the opportunity to keep papers, documents and valuables safe. Beds, pillows and bed coverings (e.g., sheets and blankets) shall be clean and sanitary (e.g., free of infestation).
- Donated clothing must be washed/sanitized prior to distribution to Clients.
- Personal hygiene facilities shall be made available to each Client. Such personal hygiene facilities shall be kept clean and sanitary and maintained in operable working condition at all times, subject to periodic emergency interruptions due to maintenance or repair.

Housing quarters offered to the Client shall be consistent with the Client's Common Service Plan. In the case of residential facilities that are not single gender facilities, separate sleeping quarters and personal hygiene facilities shall be provided and maintained for (1) single male adults (2) single female adults, and (3) families.

- Housing and shelter design (light, ventilation, commodiousness, color scheme, finishes, cleanliness etc.) and operations should facilitate the recovery, dignity, and overall stability and sense of well-being of its residents. Physical design should be based on Best Practice models.
- Building, yards, landscaping, outdoor patios, rooms, common areas, roofs, windows, screens, plumbing, appliances, counters, shelving, doors, locks, paint, tiles, base boards, carpeting etc. must be properly maintained, regularly cleaned, repaired, and kept in good working order. (Consult rules for Adult Living Facilities required by State of Florida Agency for Health Care Administration (AHCA)).

A regular cleaning schedule, with staff inspections, must be adopted for every facility .

Exterior building designs should be unobtrusive in neighborhood settings, should enhance area aesthetics and should avoid calling attention to any institutional aspect of a facility's function. Housing and shelter must comply with all local zoning, design review, signage and landscaping requirements consistent with fair housing regulations.

**Clients may be required to participate in the general housekeeping of care facility.**

#### **Intake**

- Written intake eligibility criteria are clear, specific, nondiscriminatory and readily available to both Clients and referring entities.

#### **Length of Stay and Options**

- Each Client must be informed as to the facility's lengths of stay requirements and options. Lengths of stay should be consistent with Continuum definitions for the type of facility. However, length of stay should be made on a case by case basis, and predicated on the Client's demonstrated commitment to the goals established by the Client with assistance of case management in his or her individualized Common Service Plan.
- Linkage with the next phases of the Continuum must always be explained to the Client as part of the process for developing the Client's plan along with a clear explanation of how Clients attain other housing options by working on and achieving their goals.
- All program services must have as their goal preparing the Client for success at the next phase of the Continuum of Care, and ultimately self-sufficiency in Permanent, Affordable & Supported Housing.

## **Licensing**

- Facilities shall comply with all local and state ordinances, zoning regulations (in accordance with Fair Housing rules), laws or regulations governing residential facilities and/or housing conditions and secure necessary licensing as may be required under such local or state law. Treatment facilities shall also comply with local and state ordinances, laws or regulations governing providers of substance abuse or mental health treatment and related services.

Chemical Dependency/ Abuse Treatment providers shall meet standards and regulations contained in Amended Rule 65D -30 and as amended from time to time and shall obtain a license to operate the program according to definitions and classifications more specifically contained in Section 65D -16.009 F.A.C. and as amended from time to time.

Providers serving the mentally ill shall comply with Rule 65E - 4.016 and shall obtain a license to operate the specific program or a level of care as classified in section 65E - 4.016 (4) F.A.C. and as amended from time to time.

Community Standards: Where the care provider aims to serve the dually diagnosed population, the disability that is the primary to be addressed shall determine whether a substance abuse or mental health treatment license is the appropriate choice. However, regardless of license, both types of treatment providers are encouraged to provide integrated, holistic treatment to the dually diagnosed.

It is recognized that certain providers rely on 12 steps and faith based recovery modules to assist persons in recovery from substance abuse and are, therefore, not required to adhere to the more stringent licensing requirements of treatment programs. Similarly, counseling is distinguished from mental health treatment in that mental health treatment necessarily involves the prescription of medications for major psychiatric disorders, whereas counseling is didactic in nature and addresses less severe emotional and behavioral issues. Certain types of counseling and therapy are also governed by state licensing requirements.

Exemptions to state licensing requirements, including those for religious organizations, are found in Florida Statutes (as amended from time to time) or can be obtained from the FL DCF ADAMH Program Office or HIP Administration.

## **Mainstream Resources**

Any homeless service provider is required to screen, or arrange for screening, of all homeless clients (or to document that the client was previously screened) for eligibility for mainstream programs, including but not limited to: Medicaid, State Children's Health Insurance Program, Temporary Assistance to Needy Families, Food Stamps, Supplemental Security Income (SSI), Workforce Investment Act, and Veteran's Health Care. If a client is deemed to be eligible for any of these programs, the contracted agency will be responsible; to the extent it is possible for the agency to do so, for obtaining the service or benefit for the client. Screening must be documented on a checklist and within a specific time range to be determined and approved by the Volusia and Flagler Counties Coalition for the Homeless Continuum of Care Committee.

## **Medication**

- All facilities must have provisions for properly storing, refrigerating, and retrieving residents' medications.

## **Nutrition**

- Clients should be provided a minimum of three meals a day, at least one of which must be a hot meal, at any residential shelter where the Client is earning no income and is dependent upon the facility for meals. Working Clients should be offered an opportunity for a cooked or bag lunch until first payroll.
- All meals served by emergency, transitional and permanent supportive housing phase facilities shall be nutritionally sound and balanced in compliance with USDA and other standards and/or regulations adopted

and/or issued by the local public authority responsible for the regulation of meals at residential facilities as they pertain to both adults and children as applicable. Special health dietary considerations or requests for vegetarian meals shall be accommodated.

- Meal preparation facilities and staff must comply with local Health Department food safety licensing requirements for public safety.

Community Standards: It is recognized that nonresidential soup kitchens and other outreach programs may rely on donated food and, therefore, are encouraged to adopt the standards outlined in this section but are not required to do so unless so stated in a funding contract.

- All residential facilities must make a reasonable effort to meet medically appropriate dietary needs of all Clients.

## **Rules**

- All care facilities shall establish and enforce house rules governing the use of alcohol, illegal use of controlled substance, fighting, violence, and/or inappropriate behavior for the purpose of protecting the health and safety of the Clients and staff.
- Violations of facility's house rules may be grounds for terminating a Client's length of stay and/or privilege of readmission, consistent with all local and state ordinances, laws or regulations governing tenancy, if and when applicable.
- Rules must be posted in a conspicuous place in the facility and must also be presented, reviewed and signed by Clients at intake. Homeless individuals and families served in facilities shall be accorded dignity and respect.
- A grievance procedure providing for fair notice and hearing shall be made known and available to Clients by which to seek redress in the event that a Client has a grievance regarding the operation of the facility, or should the Client believe that he or she has been unfairly accused of a rule infraction, or in the event of a decision by the care provider to refuse or terminate services to the Client. Facility staff must sign acknowledgment of the same grievance policies and procedures.
- All providers must implement a system of Progressive Counseling to provide a variety of consequences for rule violations and failure-to-follow-plan short of and leading up to termination of stay. Actions that endanger the health and safety of other Clients and staff remain grounds for immediate termination but which still may be appealed through the normal grievance procedure.

## **Spirituality**

Community Standards: Spirituality is recognized as an integral part of recovery for many homeless persons. Mandatory participation in religious activities is prohibited for publicly-funded providers.

- Facilitation of voluntary involvement in faith-based community activities, of the Client's choosing, and inclusive of all religious creeds, is encouraged to be a part of all programs.

## **Staff**

- Continuum facilities' administrators shall ensure that facility staffs have the qualifications, licensing, proper training, and supervision necessary and appropriate to the job function(s) with which such staff members are entrusted, and have been adequately screened for drugs and a background screening for prior criminal offenses.

Staff-to-Client ratios should be appropriate for the facilitation of Client and agency outcomes outlined in other sections.

- Staff providing care to homeless individuals and families should receive special training in order to be sensitive to the special needs of this population and to be able to demonstrate a balance of both compassion and structure often lacking in the daily lives of the homeless. Development of a rapport between the Client and his/her case managers, establishing trust and familiarity, is deemed integral to establishing an effective service plan and a realistic, Client developed Common Service Plan.

## PREVENTION PHASE

**Community Standards:** Eligibility requirements for prevention services must be clearly defined and distinguished from eligibility for shelter services. It is recommended that if a Client is seeking shelter services but is not actually totally without shelter at the time of the request, that the Client be referred for immediate prevention intervention to keep that Client from becoming homeless (sheltered) if at all possible.

- All prevention phase activities (e.g., temporary financial assistance) must include the Client's involvement in an assessment and self-sufficiency plan as described in other sections.
- Homeless prevention providers should track Client's living situation and report outcomes for a minimum of six months after the intervention with the individual or family.

## OUTREACH PHASE

**Community Standards:** Outreach provides an opportunity for many community members to personally become involved in assisting homeless people or programs that are established in efforts to help. However, Outreach needs to be more than just a handout of food or other items.

In order to truly help the homeless, efforts need to be centered on positive initial contact and, the building of a healthy relationship aimed at establishing and fostering trust, commitment, understanding, and true concern for the welfare of the homeless person.

One of the most successful first efforts in starting this relationship is through provision of essential human needs such as food, clothing, hygienic products, medical care and mental health intervention. These services are vital, but are not a solution to homelessness.

The ability to link homeless people to case management, services aimed toward a healthy, productive lifestyle, and continued support of the homeless individual through this change should serve as the guiding principals behind all Outreach efforts.

In order to assist individuals and groups towards successful Outreach and assistance to the homeless, serious consideration should be given towards participation in the Coalition. Participation seeks to assist Outreach efforts by establishing guidelines for efforts on behalf of the homeless.

It is preferred that community assistance to the homeless be accomplished through established, formal programs. Individuals who really feel drawn towards assisting the homeless can connect to such programs through the referral services of the Coalition. Handing a homeless person a sandwich or a dollar may provide a sense of gratification on the part of the giver; it does not necessarily assist the homeless person towards complete assistance, rehabilitation and a productive life. Many of the established, formal programs throughout Volusia and Flagler are in vital need of volunteer assistance, assistance that can change a homeless person's life.

Formal, established programs need to ensure they provide crucial services, meet critical needs such as transportation, and establish linkages to other support services for the benefit of the homeless. Effective knowledge of programs and efforts on behalf of the homeless can be enhanced through participation, networking and advocacy of the Coalition. At the same time, it is recognized that new providers are continually drawn to respond to the needs of homeless persons. Such informal providers provide fresh perspective and new dedication. They should be welcomed, offered assistance and training to offer quality assistance to homeless persons, and encouraged to share new approaches to old problems.

With relationship building a key component of successful Outreach, efforts should also focus on maintaining

contact throughout the homeless person's efforts to reach self-sufficiency. Outreach should help weave a successful safety net for the person as they attempt to successfully complete any rehabilitation, training, job search, etc.

It should be recognized that each homeless person's needs and life circumstances are individual and unique. What is perceived as enabling one individual to adhere to unsuccessful coping skills is merely life sustaining to another individual. Outreach will always need to be flexible and considerate of individuals whose life experiences may have resulted in their needing compassionate outreach and services aimed at something as simple as harm reduction, over a period of many years.

- Outreach efforts should make every effort to locate, identify and assist homeless people in their habitat. In creating a congregation of homeless persons, normal sensitivity should be shown to surrounding residences, businesses and other establishments. In terms of noise levels, sanitation, etc. Individuals and established, formal programs are encouraged to use commercial or religious properties for activities that would attract a number of homeless people.
- Attention to local zoning for these activities is vital for successful implementation.
- Meeting the medical and health needs and concerns of people assisting the homeless, as well as the homeless themselves, requires application of all appropriate hygienic and health codes and practices. Especially where food is involved, individuals and established, formal programs must ensure compliance for the medical safety of everyone concerned.

Although homeless people are more often the victims rather than the perpetrator of violence, attention to safety and security issues needs to be acute. Common sense dictates that youthful assistants not be placed in isolated situations, nor should individuals seek out the homeless late at night.

- Individuals and established, formal programs need to have appropriate standards of conduct that address safety and security for themselves and the homeless.

#### **EMERGENCY PHASE**

- In an effort to fulfill the role of providing a clean and safe environment, in addition to the emergency housing, emergency care facilities shall also provide clothing, meals, and a complete physical within seventy-two (72) hours of the Clients' entry into the facility.
- To reduce the risk of harm to other Clients and staff, emergency care facilities shall arrange for health screens for communicable, air-borne diseases, such as tuberculosis, within 12 to 24 hours of the Client's entry into the facility. Clients determined to pose a threat to the health of others shall be quarantined and referred for appropriate medical treatment.
- Emergency care facilities shall assist in obtaining at least two sets of appropriate clothing (both under and outerwear) and shoes. Appropriate clothing in the instance of underwear and socks shall mean new or previously unused items.

Emergency Phase programs also include Safe Havens for those suffering from severe persistent mental illness and who are not accepting of mainstream treatment and shelter and Tiered Incentive programs willing to meet the chronic inebriate where they are and encourage rather than demand change. Similar to Outreach phase programs, responding to individual needs and circumstances is paramount.

#### **TRANSITIONAL PHASE**

**Community Standards:** As distinguished from the emergency phase that focuses more on meeting basic human needs, the transitional phase program should focus on preparing Clients for self-sufficiency in permanent housing. Common Service Plans must include goals that address overcoming barriers to self-sufficiency and maintenance of permanent housing. The Client is expected to assume an increasing degree of autonomy and personal responsibility (e.g., fewer rules and restrictions, greater financial contributions to self-support where able) during

their stay in transitional housing.

- Clients being referred to Transitional or Permanent Housing must have attained a minimal level of progress towards self-sufficiency during Emergency Phase:
- Identification sufficient to be employable
- Full-time employment or enrollment in formal job training if able bodied
- Formally initiated disability application if claiming to be disabled
- Thirty days' compliance with Care Plan and any treatment plan as applicable
- In the absence of documentation that a Client has undergone a complete physical within the previous six months, transitional care facilities shall arrange for a full medical assessment and evaluation (i.e., complete physical) for each Client within seventy-two (72) hours of the Client's entry into the facility.

### **PERMANENT AFFORDABLE AND SUPPORTIVE HOUSING PHASE**

**Community Standards:** Permanent Affordable and Supported Housing for homeless persons is the primary goal of the Continuum of Care.

The purpose of Permanent, Affordable & Supported Housing is two fold: (1) to provide access to supported housing for those homeless individuals and families with special needs (e.g., permanent disabilities) and (2) to assist those homeless individuals and families capable of maintaining independent living with minimal initial support to secure housing in the affordable housing market. Permanent, Affordable & Supported Housing may be accessed by homeless individuals and families from any phase of the Continuum of Care, provided that the Client meets eligibility criteria of the facility. Eligibility should include a demonstrated ability of the Client to maintain self-sufficiency during the emergency and/or transitional phases of their placement.

- Clients must be provided with housing appropriate to their needs (e.g., assisted living, single room occupancy, tenant based rental assistance,) with supportive services necessary to maintain residential and personal stability (e.g., after care case management, mental health treatment, medical care, recovery groups, domestic violence counseling, etc.)

For those Clients seeking market rate affordable housing, assistance shall include, but is not limited to: assisting the Client in locating suitable housing, assistance with housing applications and lease negotiations, application fees, first and last month's rent, short term rental subsidies, furniture stipends, utility deposits, start-up household supplies and groceries, mortgage and first time home buyer classes as appropriate. Such assistance shall include aftercare as described above.

- Providers assisting Clients in locating and securing affordable market rate housing shall insure that housing meets comparable market rent guidelines and housing quality standards established by local, state and/or federal ordinance, law and regulation as applicable.

Violations of permanent, Affordable & Supported Housing program rules may be grounds for terminating the provision of services to a Client, including, but not limited to rent subsidies.

In the event that a Client is at risk of losing Permanent, Affordable & Supported Housing and is in need of a placement more appropriate for their needs, every effort shall be made to provide additional services within the Continuum of Care to prevent a return to homelessness. Such services may include but are not limited to contract case management recovery plans signed by both the Client and an aftercare case manager defining steps needed to be taken by the Client to avoid eviction.

Landlord/Tenant based lease agreements, and local and state ordinances, laws or regulations governing tenancy thereof, shall govern breaches.

It is recognized that in many affordable housing situations fair market rents are collected according to Federal rental affordability guidelines based on a percentage of income. At the same time, it is recognized that disabled formerly homeless individuals and families still require supportive services to maintain housing and self-sufficiency. Every effort should be made to integrate services with housing in such a way that facilities remain profitable for landlords, while at the same time, support and flexibility is extended to renters taking their disabilities into consideration.

## **SUPPORTIVE SERVICES**

**Community Standards:** Provision of supportive services should be linked to shelter and/or housing in order to maximize the effectiveness of the service. With the exception of outreach programs, providing supportive services to homeless persons living on the street diminishes the effectiveness of the service due to the instability of the Client's living situation.

- All supportive services should be provided with the same level of professionalism and standards outlined in other sections for residential services.
- Mainstream supportive service providers should identify and eliminate barriers to service access that may be encountered by homeless individuals and families. Mainstream providers should consider themselves to be as much a part of a homeless Client's inter-disciplinary care team as providers who specialize in homeless services.
- All supportive service providers should be properly licensed, as applicable, in accordance with licensing requirements found in other sections.

### **Attachment "A"**

#### **Licensing**

**All providers of substance abuse treatment and prevention services - public and private - are required under Chapter 397 of the Florida Statutes to be licensed, unless certain exemptions from licensing are met. These exemptions, listed under Chapter 397.405 are:**

1. A hospital or hospital-based component licensed under chapter 395;
2. A nursing home facility as defined in s.400.021 (11);
3. A substance abuse education program established pursuant to s.233.061;
4. A facility or institution operated by the Federal Government;
5. A physician licensed under chapter 458 or chapter 459;
6. A psychologist licensed under chapter 490;
7. A social worker, marriage and family therapist, or mental health counselor licensed under chapter 491;
8. An established and legally cognizable church or nonprofit religious organization, denomination, or sect providing substance abuse services, including prevention services, which are exclusively religious, spiritual, or ecclesiastical in nature. A church or nonprofit religious organization, denomination, or sect providing any of the licensable service components itemized under s.397.311 (19) is not exempt for purposes of its provision of such licensable service components but retains its exemption with respect to all services which are exclusively religious, spiritual, or ecclesiastical in nature;
9. Facilities licensed under s.393.063 (7) that, in addition to providing services to persons who are developmentally disabled as defined therein, also provide services to persons developmentally at risk as a consequence of exposure to alcohol or other legal or illegal drugs while in utero;
10. DUI education and screening services required to be attended pursuant to ss.316.192, 316.193, 322.095, 322.271, and 322.291 are exempt from licensure under this chapter. Treatment programs must continue to be licensed under this chapter.

**Memorandum of Agreement  
Standards of Care**

I, \_\_\_\_\_, hereby attest that I am authorized by my Agency,  
\_\_\_\_\_, to commit that my Agency  
has reviewed the Volusia/Flagler County Coalition for the Homeless' Standards of Care and that  
my Agency will comply with these Standards of Care, and that any policies and procedures  
developed, adopted and implemented by my Agency, will conform with these Standards of Care.

I also hereby attest that I understand that if my Agency fails to comply with these Standards, my  
Agency will be ineligible to apply for grant funds through the Volusia/Flagler County Coalition for  
the Homeless, which is the Continuum of Care for Volusia and Flagler Counties.

For: \_\_\_\_\_  
Printed Name of Agency

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name and Title: \_\_\_\_\_

Witnessed by: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name and Title: \_\_\_\_\_