New York City

Emergency Solutions Grant (ESG)

Written Standards February 2024

Human Resources Administration
Department of Homeless Services
Department of Social Services

Written Standard Review and Revisions

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Purpose and Overview

The goal of these standards is to clarify key elements of the U.S. Department of Housing and Urban Development's (HUD) regulations for projects funded under HUD's Emergency Solutions Grant (ESG) Program and how New York City's ESG-funded programs meet those regulatory standards. See ESG Interim Rule for detailed program regulations.

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I. Introduction

The City of New York receives McKinney Vento - Emergency Solutions Grant (ESG) funds from the U.S. Department of Housing and Urban Development (HUD) and applies those funds to help individuals and families in New York City experiencing homelessness, as well as those at risk of becoming homeless, in the areas of street outreach, emergency shelter, homelessness prevention, and a Homeless Management Information System (HMIS).

Under the umbrella of the City's Department of Social Services (DSS), the Department of Homeless Services (DHS) and Human Resources Administration (HRA) oversee and manage the provision of ESG-funded programs in New York City for single adults and adult families who are homeless, people experiencing street homelessness, and individuals and families at risk of becoming homeless. All ESG-funded programs must meet the standards below, as required by Federal regulation.

II. New York City Continuum of Care

The New York City Continuum of Care (CoC) is a broad-based coalition of homeless housing and shelter providers, people with lived experience, community members, advocates, and government representatives, working together to shape citywide planning and decision-making. The CoC, which includes DSS representatives from both DHS and HRA, is charged with the following:

- Identifying the gaps and needs of households experiencing homelessness in New York City and participate in the process of prioritizing local and state funding to meet these needs;
- Coordinating citywide applications for homeless housing and service funding including, but not limited to, the City's annual application for HUD McKinney-Vento funding;
- Tracking trends and adjusting priorities to meet the changing needs of households that are homeless; and
- Advocating together for increased federal funding to meet the needs of New Yorkers who are homeless or at risk of becoming homeless.

The New York City Continuum of Care works in concert with NYC Department of Social Services to support the goals of New York City's five-year Consolidated Plan.

DSS is the Collaborative Applicant for the NYC CoC as well as the ESG funding recipient. This role enables DSS to coordinate extensively with the CCoC and the Consolidated Plan jurisdiction (see New York City's five-year Consolidated Plan (Con Plan)). Goals of the Con Plan are made around shared goals of the CoC strategic plan, which includes: investing in proven strategies to reduce the number of individuals who are street homeless; preventing adult families and individuals at risk of homelessness from entering shelter; and ensuring that shelter is a short-

term solution to a housing crisis by rapidly re-housing people who are homeless. The Con Plan aims to end homelessness, with an emphasis on unaccompanied youth, people who are chronically homeless, and veterans who are homeless.

III. Coordinated Entry

17-01CPDN.PDF (hud.gov) HUD Notice CPD-17-01 establishes federally mandated requirements for CoC and ESG recipients and sets forth strategies for Coordinated Entry - defined as a process to ensure that all people experiencing a housing crisis have fair and equal access and are quickly identified, assessed for, referred to, and connected to - housing and assistance based on their strengths and needs, as required by HUD regulations. A core strategy in this effort is the development of the Coordinated Assessment and Placement System (CAPS).[1] CAPS streamlines and improves the assessment, prioritization, housing match, and placement system for households who are homeless or at risk of becoming homeless within the CCoC geographic region.

CAPS assesses individuals and families who are homeless or at risk of homelessness for potential housing options, provides detailed instructions on how to apply for those housing options, prioritizes referrals (based on a Standardized Vulnerability Assessment), performs a housing match for the household, and places applicants according to verified information on their eligibility, preferences, and available vacancies.

All ESG-funded projects are expected to participate with the eligibility screening processes developed for CAPS.

Currently, if CAPS indicates potential eligibility for supportive housing, the referral source should complete the Coordinated Assessment Survey (the "Survey") before starting a supportive housing application. Information from completed surveys is used to generate a list of supportive housing and rental subsidies for which the household is potentially eligible and is used to guide the applicant's housing choice. While there are no set time requirements for Survey completion, it should be completed within the first two (2) weeks of an applicant's arrival at the relevant access point. (Access points include shelters, street outreach teams[2], hospitals, jails, prisons, drop-in centers, and anyone who has access to the HRA PACT web-based supportive housing application system.) Assessors typically complete the Survey during regular business hours; however, it is a web-based system so there will be 24/7 access to the Survey at every access point.

[1] The CCoC's written standards include general eligibility requirements of CAPS and can be found on the CCoC's website: www.nychomeless.com

[2] For street outreach teams and drop-in centers, the Survey should be completed within the first two (2) weeks of an applicant willingly engaging with the service provider and providing relevant information.

IV. Relevant HUD Definitions

Federal regulation sets applicable definitions for ESG funded programs to guide localities in determining eligible projects and eligible clients. [3]

A. Literally Homeless: An individual or family experiencing homelessness meets the following criteria:

1. Lacks a fixed, regular, and adequate nighttime residence, meaning:
    - A primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation (including car, park, abandoned building, bus/train station, airport, or camping ground);
    - A publicly or privately-operated shelter or transitional housing, including a hotel or motel paid for by government or charitable organizations; or
2. If being discharged from, or exiting, an institution where the person has been a resident for 90 days or less and the person resided in a shelter or place not meant for human habitation immediately prior to entering that institution.
3. If the person will imminently lose their primary nighttime residence within 14 days, has not identified a subsequent residence, and lacks resources or supports needed to obtain other permanent housing.

B. At-Risk of Homelessness: An individual or family who meets the following three (3) criteria:

1. Has an annual income below 30% of median family income for the area; AND
2. Does not have sufficient resources or support networks immediately available to prevent them from moving to an emergency shelter or another place defined in Category 1 of the "homeless" definition; AND
3. Meets one of the following conditions:
    - Has moved because of economic reasons 2 or more times during the 60 days immediately preceding the application for assistance; OR
    - Is living in the home of another because of economic hardship; OR
    - Has been notified that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance; OR

[3] *See* 24 CFR 576.2.

- Lives in a hotel or motel and the cost is not paid for by charitable organizations or by Federal, State, or local government programs for low-income individuals; OR
- Lives in an SRO or efficiency apartment unit in which there reside more than 2 persons or lives in a larger housing unit in which there reside more than one and a half persons per room; OR
- Is exiting a publicly funded institution or system of care; OR
- Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved Con Plan

C. Fleeing/Attempting to Flee Domestic Violence**:** Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking.

- Any individual or family who:
- i. Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence;
- ii. Has no other residence; and
- iii. Lacks the resources or support networks to obtain other permanent housing.

D. <u>Chronically Homeless</u>

- HUD chronically homeless: As defined in the McKinney-Vento Act, and amended by the HEARTH Act a homeless individual with a disability. They must have been living in a place not meant for human habitation, in an emergency shelter, or in a safe haven for the last 12 months continuously or on at least four occasions in the last three *years where those occasions cumulatively total at least 12 months;*

  The updated definition of "homeless individual with a disability" requires that the condition be of *long and continuing duration*; *substantially impedes the individual's ability to live independently*; and, *is expected to improve with the provision of housing*. To be eligible for permanent supportive housing generally, an individual or family member must be considered a "homeless individual with a disability", therefore, HUD adopted this term into the definition of chronically homeless to ensure consistency;

Additional requirements of the HUD chronic homeless definition include:

- Occasions are defined by a break of at least ***seven nights*** not residing in an emergency shelter, safe haven, or residing in a place meant for human habitation (e.g., with a friend or family). Stays of fewer than seven nights residing in a place meant for human habitation, or not in an emergency shelter or safe haven do not constitute a break and count toward total time homeless; and
- Stays in institutions of fewer than 90 days where they were residing in a place not meant for human habitation, in an emergency shelter, or in a safe haven immediately prior to entering the institution, do not constitute as a break and the time in the institution counts towards the total time homeless. Where a stay in an institution is 90 days or longer, the entire time is counted as a break and none of the time in the institution can count towards a person's total time homeless.

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V. Department of Homeless Services and Human Resources Administration ESG-Funded Programs

All persons served by ESG funded program described below must meet the HUD homeless eligibility.

A. Street Outreach

- *Approach*

The DHS Division of Street Homeless Solutions manages and provides an array of services to people who are street homeless. Multidisciplinary street outreach teams work 24/7, 365 days a year to locate people living in public spaces and link them to services with the goal of bringing them indoors. These outreach teams cover each borough throughout New York City, including end of line subway outreach, and prioritize focus on the most vulnerable of those living outdoors to ensure they are safe and/or are not at risk for injury or death.

- *Eligibility*

Individuals served by outreach teams must meet the definition of "literally homeless" in order to be eligible for such services. Outreach teams will engage anyone observed to be unsheltered on the street, within the subway system, or other public place, and determines, based on engagement, whether such individual lacks a fixed, regular and adequate nighttime residence.

- *Intake and Assessment*

Outreach teams canvass extensively throughout all five boroughs. They respond to 311 calls and accept information from various community stakeholders about people who are street homeless in their respective catchment areas, as well as information from public and

governmental entities. They meet with participants – on the street as needed – to support them as they take initial steps toward obtaining permanent housing.

Outreach teams complete an initial assessment with participants, which includes a risk assessment for self-harm and harm toward others. This assessment helps the team to learn more about the persons unique needs and preferences, which allows the team to determine how best to serve the individual with the goal of bringing them indoors. Following an assessment, information is recorded within the DHS system of record and, if eligible, an individual is added to the outreach team caseload.

- *Case Management Services*

Using a harm reduction approach, outreach teams focus efforts on engagement and building relationships with people who have historically rejected services; staff meet

participants “where they are.” People who have been on the street for any period of time are brought onto caseload regardless of their willingness to engage in services. A harm reduction approach applies to substance use, as well as overall health and wellbeing. Outreach teams offer opportunities for safe use and treatment at a participant’s pace in an effort to improve their health.

Each outreach participant is assigned a case manager. Outreach staff is expected to be skilled in, and use, motivational interviewing techniques to encourage a participant’s active decision-making and goal setting.

Case managers provide or link participants to services and supports including, but not limited to, the following:

- Mental health treatment
- Substance use treatment
- Medical treatment
- Benefits (e.g., cash assistance, SSI/SSD, Medicaid, Veterans Affairs (VA) benefits)

Outreach teams work to place individuals into transitional housing or permanent housing as quickly as possible. They assist with interview preparation and apartment/room visits.

- *Housing Assistance*

Outreach staff will conduct or arrange for family mediation, counseling, and travel assistance in cases where reunification with family is possible.

Outreach teams also have the ability to place participants into other transitional housing options such as stabilization beds or safe havens.

- *Documentation Standards*

Outreach teams collect client-level information throughout their work with each participant, including aftercare once a participant is safely housed. Participant services are documented by use of initial intake assessment, monthly or quarterly service plan, bi-weekly progress notes, case conference notes, housing progress notes, discharge notes, psychosocial assessments, and psychiatric evaluations. Staff records information in case files, the Client Assistance and Rehousing Enterprise System (CARES), which is the DHS system of record, StreetSmart, and the provider’s own case management database, as applicable.

B. <u>Drop-In Center</u>

A crucial part of the DHS Division of Street Homelessness Solutions portfolio, a drop-in center is a low-barrier setting generally geared towards people who are chronically street homeless or other hard-to-reach populations experiencing street homelessness. Drop-in centers are also open to people generally without stable housing. Drop-in centers do not

have beds, but through on-site services and referrals, participants have access to respite beds.

- *Eligibility*

A drop-in center serves literally homeless individuals, specifically persons who are experiencing unsheltered homelessness, , Drop-in centers screen people who may be street homeless and refer such individuals to outreach teams.

- *Intake and Assessment*

Participants complete an initial intake questionnaire when entering a drop-in center. A more extensive evaluation process with a social worker or case manager will occur within the first few engagements following intake. Staff engages the participant in a conversation about available services and encourages participants to take an active role in decision-making. Participants will be encouraged to provide the screener with short-term goals surrounding their housing and overall health needs with the ultimate goal of placing the participant into housing. The drop-in centers will provide services for individuals who are street homeless and would be living on the streets if not for the drop-in center, or, those facing the threat of becoming homeless by refusing to enter traditional shelters.

- *Case Management Services*

Drop-in centers provide seating, hot meals, showers, laundry facilities, clothing, medical care, recreational space, employment referrals, storage for belongings, and other social services to eligible participants. Staff also can help participants connect to more appropriate systems of care, and find a safe and secure place to sleep.

- *Respite Beds*

Respite bed providers offer overnight lodging for individuals using drop-in centers. The respite bed provider is expected to deliver a fixed number of beds to the drop-in centers every night. Drop-in centers are responsible for determining the assignment of respite beds and for filling capacity. In order to ensure capacity needs are met, the drop-in and respite providers must communicate daily. All participants at a drop-in center have the option of sleeping in a respite bed. Drop-in center staff are expected to encourage participants to accept respite beds.

- *Documentation Standards*

Client-level information will be collected for each participant throughout the duration of their stay at both drop-in and safe haven facilities and includes the following:

  - Outreach referral documentation
  - Drop-in or safe haven initial intake assessment
  - Monthly or quarterly service plan

- Bi-weekly progress notes
- Case conference notes
- Housing progress notes
- Discharge notes

Staff enters all information in CARES, StreetSmart, and the provider's own case management database.

C. Safe Haven

The Street Homelessness Solutions Division provides a low threshold, easily accessible alternative to people who are experiencing homelessness but who avoid traditional shelter. Safe havens (DHS Sate Havens are not the same as HUD defined Safe Havens) follow a harm reduction model where abstinence from substances and compliance with mental health treatment, for example, are not necessary to access services, nor are they prerequisites for housing consideration. Safe haven staff promotes a safe environment that encourages participants to take steps towards permanent housing at a comfortable pace. A low barrier environment, a high staff to client ratio, and an acknowledgement of participant strengths and self-determination are some of the ways safe havens begin to introduce a safer and healthier standard of living for those who are among the hardest to engage on the street.

- *Eligibility*

The single point of access into a Safe Haven is through a referral by a DHS-contracted street outreach team. Eligibility is established by assessing whether the individual is chronically homeless and historically has not accepted other placement options. All persons served by Safe Havens meet the definition of "literally homeless."

- *Case Management Services*

Safe haven staff have a number of case management responsibilities, which include, but are not limited to, the following:

- Developing clear exit strategies for clients with realistic target dates;
- Assisting participants with securing public benefits
- Providing timely services that include the collection of documents, housing search assistance, and referrals to social services, such as medical and mental health treatment;
- Collecting health screenings, immunization documents, employment and entitlement documentation;
- Providing employment referrals and vocational training referrals if needed;
- Helping participants in their search for supportive or permanent housing

- *Documentation Standards*

Client-level information will be collected for each participant throughout the duration of their stay at both drop-in and safe haven facilities and includes the following:

- Outreach referral documentation,
- Drop-in or safe haven initial intake assessment,
- Monthly or quarterly service plan,
- Bi-weekly progress notes,
- Case conference notes
- Housing progress notes
- Discharge notes

Staff enters all information in CARES, StreetSmart, and the provider's own case management database.

D. Intake and Assessment for Single Adults

DHS provides temporary emergency shelter pursuant to NYS Social Services Law, rules, regulations, and administrative guidance provided by the DSS and DHS oversight agency, the NY State Office of Temporary and Disability Assistance (OTDA). Applicants for shelter, including single adults, are assessed for the immediate need of temporary assistance and must complete an intake application, which collects demographic and housing-related information designed to establish the need for emergency shelter, the appropriateness for shelter, and the potential for diversion. During this interview DHS also performs a housing history check. These mandatory processes are completed by both the client and a staff member and are documented in Client Application and Rehousing Enterprise System (CARES), the DHS electronic system of record.

During the application process, clients must attest to the truthfulness of their homelessness claim, their reported housing history, and their immediate need for emergency shelter. For single adults and unsheltered clients on caseload, staff must confirm homelessness through observation, engage clients to assess the viability of all other housing options, and divert clients to such housing options, whenever possible.

- *Eligibility*

  Persons presenting themselves to shelter intake must meet the definition of "literally homeless in order to be eligible for such services. Intake staffwill observe applicants and determine, based on engagement, whether such individual lacks a fixed, regular and adequate nighttime residence.

- *Intake and Diversion*

As described above, all applicants for shelter must conduct an intake application, which collects various demographic and housing-related information designed to establish the need for emergency shelter, the appropriateness for shelter, and the potential for diversion. Through CARES, DHS's system of record, the following information is collected:

- Basic demographic information to create a unique identifying CARES identification number for the participant
- The reported reasons for homelessness and any prior living arrangements, including prior shelter stays;
- Fingerprinting through the Automated Finger Imaging System to ensure there has not been a duplication of services, and to record participant information for public assistance usage;
- Health information, including information pertaining to medical appropriateness for shelter; this includes, but is not limited to, being able to complete activities of daily living independently.

The initial application for temporary housing assistance also includes a pre-screening that DHS uses to identify any immediate diversion services. All applicants are screened to ensure they consider all their housing options and resources, and explore options of assistance to prevent homelessness when possible. Diversion services are available to applicants upon intake, which include, but are not limited to, the following:

- on-site rent arrears assistance
- family reunification
- residential and non-residential substance use treatment
- room rentals
- landlord mediation

Participant identification is useful but not required. All participants applying for shelter are offered shelter services the day of their application. Participants with no immediately viable housing options are then assigned to a single adult assessment shelter, where diversion efforts are continued and an appropriate program shelter is identified.

- *Assessment*

Before being assigned to a program shelter, all single adult shelter clients must complete an assessment at an assigned assessment shelter. This 21-day assessment allows staff to appropriately assess participant strengths, needs, and barriers to housing. Staff is also expected to help participants with identifying and gathering important documents, completing a brief biopsychosocial, TB testing, and psychiatric evaluations as needed.

E. Program Shelters for Single Adults

Following intake and assessment, single adult clients are assigned to a program shelter for the duration of their shelter stay. This program shelter becomes their official shelter unless or until they are transferred . If a participant leaves shelter and remains in the community for more than one year, they must return to a single adult intake site for a new assessment and shelter placement determination.

- *Shelter Programs*

There are different types of program shelters, which are variably appropriate based on client needs, as determined through intake and assessment:

- **General Population**: Participants do not show a need to receive a specific type of service outside of housing search and placement and they also possess a high probability to find long-term housing.
- **Employment**: Participants have demonstrated that their biggest obstacle in obtaining housing is finding or maintaining employment and income.
- **Mental Health**: Participants have been assessed to have a history of Mental Health challenges and/or diagnoses and need to be provided services tailored to their mental illness.
- **Substance Use**: Participants have been assessed to have a history of substance misuse and need to be in a shelter that will provide services to address this issue.
- **Special Populations**: Within the shelter types there are a subset of shelters that offer the same services, however their population is based on other additional factors such as age, LGBTQI determination, and veteran status or based on community agreements and previous housing history (applies only to residents of specific community districts/boards). Additionally, through the reasonable accommodation process, participants that are identified as having mobility restrictions, are unable to navigate certain building types, and in some instances, are unable to return or be placed in certain communities due to legal, gang related, or domestic violence situations are granted placement within appropriate program shelters that will meet their needs.

- *Case Management Services*

Program shelters provide daytime and evening social services to all shelter clients designated to develop independent living plans (ILPs) to guide participants through the process of moving to permanent housing. Shelters also refer to community-based organizations, as needed, for housing referrals, legal services, clothing banks, job placement, medical and outpatient services, etc. Case managers, housing specialists and job developers are on site to assist participants in navigating the system and the access to city services, with a focus on available housing subsidies for those eligible.

- *Documentation Standards*

Single adult participants seeking to access NYC Department of Homeless Services shelter are not required to provide any documentation. Participant identification documents are helpful during the intake process, but not required. Staff copies and scans all documents provided by the participant into the CARES Document Management System and included in the participant's case record at the shelter. Documentation maintained in CARES consists of, but is not limited to, the following:

- Photo Identification (ID, passport, Benefits Card, Social Security Card, etc.)
- Medical documentation
- All signed DHS forms provided to participant
- Release of information forms
- Biweekly progress notes
- Case conference notes
- Housing progress notes
- Independent Living Plans (ILPs)
- Appointment notices

Staff enters all information in CARES and the provider's own case management database, if applicable.

Individuals in shelter actively participate in the process and take strides toward independent living. When the caseworker and participant develop an Independent Living Plan (ILP), the document outlining relevant goals to exit shelter and return to self-sufficiency is printed and signed by the participant. The signed ILPs are maintained in a paper record by the shelter. Program shelters must also include Public assistance application appointment notices, interviews, pay stubs/schedules, housing applications, psychiatric evaluations, documentation provided by the participant, and all relevant DHS forms part of the participant case record. Participant records are maintained in the shelters per the NYC records management policies. In addition to participant records physically located at the shelters, staff is expected to update CARES with relevant information about the participant's case, including the ILP and other meetings with the participant. Whenever possible, staff should also scan and upload documents in CARES.

F. Intake and Eligibility for Adult Families

DHS provides emergency shelter to adult families through a standalone set of shelter resources. DHS considers an adult family to be any family without minor children. In collaboration with their case manager, households develop an Independent Living Plan (ILP), a document that outlines relevant goals to exit shelter and return to self-sufficiency. Adult families in shelter must actively participate in this ILP development process including applying for Public Assistance (PA) and completing all requirements necessary for establishing and maintaining eligibility for PA benefits. If able to work, DHS encourages participants to actively seek employment and accept a suitable job offer when it is offered. Participants are expected to work closely with their case manager or housing specialist to locate and view available apartments.

- *Definition of a Family*

Adult families applying for shelter services must **verify** their household constitutes a family as described below and can demonstrate that they have resided with one another for 180 days within the year immediately prior to the date of their application.

Examples of households constituting a family:

- A legally married couple who present a valid (original) marriage certificate; or
- A domestic partners couple who present a valid, original domestic partnership certificate; or
- Adults who provide, as part of their application for Temporary Housing Assistance, proof establishing the medical dependence of one applicant upon another;
- Two or more adults who can provide birth certificates to prove a parent and child or sibling family relationship or share a "caretaking" (emotionally or physically supportive) relationship, including:
  - aunt or uncle to niece or nephew
  - grandparent to grandchild
  - parent to child or stepchild
  - siblings

- *Eligibility*

All Adult Families seeking shelter must apply at the DHS Adult Family Intake Center (AFIC). At AFIC, families complete a Temporary Housing Application, upon which families must describe their need for emergency shelter and provide a one-year housing history, and also provide demographic and health related information. Other assessments at this time include but are not limited to eligibility, psychiatric evaluations, health screenings, and domestic violence.

Following shelter application, adult families are conditionally assigned to shelter placement for up to 10 days while DHS investigated their eligibility for shelter. Eligibility for shelter is based on State regulation and guidance, including 18 N.Y.C.R.R. 352.35 and 16 ADM-11 (OTDA), and includes a determination that the family has fully cooperated in their shelter application and has no viable non-shelter housing resources. All households have a right to a legal conference at AFIC if they are found ineligible and disagree with the DHS decision. Families may request a fair hearing from New York State within 60 days of being found ineligible for shelter.

- *Diversion*

In addition to intake and assessment, all applicant Adult families are referred for a diversion interview. During this interview, the AFIC caseworker explored potential non-shelter housing options and resources, and explains emergency housing options available and shelter diversion services including family mediation, anti-eviction legal services, out-of-city relocation assistance, or a one-shot deal through HRA. Case managers will obtain information on their prior living situation, if available, to inform the selection of appropriate services.

- *Documentation Standards*

Staff documents the assessment in CARES, as well as a thorough intake case note. This includes a housing assessment.

G. Emergency Shelter for Adult Families

Either directly placed from AFIC or following a determination of eligibility and a placement at an assessment shelter, DHS places eligible adult families into an official shelter placement.

- *Case Management Services*

DHS encourages all participants who enter shelter, if possible, to obtain and maintain employment while seeking housing. All participants develop an Independent Living Plan (ILP) collaboratively with their case managers, which outlines their path towards permanency. Staff works with participants on an individual basis to tailor services to their specific needs. Staff provides assistance in the following areas:

- Applying for Public Assistance
- Applying for jobs
- Housing assistance through local, state or federal subsidies or supportive services including, but not limited to, family reunification, and vouchers

Adult families found eligible for shelter have certain responsibilities that they must meet, including obtaining and maintaining employment for all those who are able to work. With the assistance of their caseworkers, households will develop an Independent Living Plan (ILP), a document that outlines relevant goals to exit shelter and return to self-sufficiency. Now, more than ever, employment-focused programs and work supports remain a cornerstone of DHS' efforts to help participants move back to permanency. Individuals and adult families in shelter must actively participate in this process and take strides toward independent living.

As part of a continuum of services, DHS utilized the Client Application and Rehousing Enterprise System (CARES), a web based application that records and maintains the ILP and centrally records participant's progress and pertinent information to assist with housing. All eligible participants are assigned to a unit and are provided case management, and allowances for meals through Public Assistance. With the cooperation of the family and case worker, reasonable accommodations can be made for families as needed; language translation services are also available for participants that require the assistance. Adult families in shelter are expected to and encouraged to, with the assistance of social services to take all steps toward obtaining permanent housing.

- *Documentation Standards*

Documentation for adult families in emergency shelter includes, but is not limited to, the following:

- Photo Identification (ID, passport, Benefits Card, Social Security Card, etc.)
- Medical documentation

- All signed DHS forms provided to participants
- Release of information forms
- Biweekly progress notes
- Case conference notes
- Housing progress notes

H. Homelessness Prevention

DHS firmly believes that individuals and families are best served in their communities through prevention efforts and that temporary emergency shelter is a last resort when experiencing an immediate housing crisis. New York City provides prevention services through a program called Homebase, a neighborhood-based homelessness prevention network. There are 24 Homebase offices located in communities throughout the city to serve New Yorkers at risk of homelessness. Homebase staff work with each participant to review their individual situation and apply for services. Homebase staff helps participants develop a stable housing plan before their housing situation becomes an emergency. Homebase provides eviction prevention, assistance obtaining benefits, financial counseling, landlord and family mediation, employment services/referrals, and linkages to community resources.

Activities or programs designed to prevent the incidence of homelessness include, but are not limited to: (1) short-term subsidies to defray rent and utility arrears for families that have received eviction or utility termination notices; (2) security deposits or first month's rent to permit a homeless family to move into its own apartment; (3) mediation programs for landlord-tenant disputes; (4) legal services programs that enable representation of indigent tenants in eviction proceedings; (5) payments to prevent foreclosure on a home; and (6) other innovative programs and activities designed to prevent the incidence of homelessness.

- *Eligibility*

To be eligible for ESG-funded prevention assistance, prevention programs must assess and document that the household is at risk of homelessness, and that such household would become homeless but for the ESG assistance. A household at risk of losing their present housing may be eligible if it can be documented that their loss of housing is imminent and they do not have sufficient resources or support networks, e.g., family, friends, faith-based or social networks, immediately available to prevent them from becoming homeless.

Homebase determines a household's eligibility for ESG-funded services through use of a risk assessment instrument provided by the Human Resources Administration. This instrument determines whether an applicant is at imminent risk of homelessness. Providers must assess, document and verify (when possible) the household's risk of homelessness.

To be eligible for ESG-funded Homebase prevention services, the applicant must meet all of the following criteria:

- **Household Composition** - The household must be either a single adult or adult

family.

- **Risk of Homelessness** - The household must receive an assessment using a risk assessment instrument provided by HRA and determined to be at imminent risk of homelessness, scoring above the threshold set by HRA.
- **Resources & Network** - The household does not have sufficient resources or support networks, e.g., family, friends, faith-based or social network, immediately available to prevent them from becoming homeless.
- **Recertification** - *Recertification* is a re-evaluation of the program participant's eligibility and type of assistance needed is required at least once every three (3) months for households receiving assistance greater than 90 days. ESG-funded programs should determine the re-certification date based on the original ESG eligibility assessment date. The intent of the recertification rule is to ensure programs are fully evaluating households that are receiving ongoing financial assistance and/or other ESG assistance to ensure the household remains eligible and needs continued assistance to prevent homelessness. ESG-funded programs may be monitored to ensure appropriate documentation is obtained and included in ESG participants' files.

- **Documentation**

ESG Income Criteria and Definitions
To be eligible to receive ESG-funded assistance, an applicant household must have a current gross annual income of all adult household members that is at or below 30% of the Area Median Income (AMI), which is determined by the state and by the local jurisdiction in which a household resides and is dependent on the number of household members. The table providing income limits by local jurisdiction, including 30% AMI, is adjusted periodically and can be accessed through the following link: https://www.huduser.gov/portal/datasets/il.html.

Income is money that goes to, or on behalf of, the family head or spouse (even if temporarily absent) or to any other family member. Annual income includes the current gross annual income of all adult household members.

Gross Income is the amount of income earned before any deductions (such as taxes and health insurance premiums) are made. Earned income, business income, interest & dividend income, pension/retirement income, unemployment & disability income, TANF/public assistance, alimony, child support and foster care income, and armed forces income are the types of income that must be counted when calculating gross income.

Current income is the income the household is currently receiving at the time of application for assistance. Income recently terminated should not be included. Documents and information collected to verify income should be recent and dated within 30 days prior to

the time of application. However, for public assistance benefits (e.g., SSI, cash assistance), a benefits statement received any time within the 12 months prior to the time of application and reflecting current benefits received by an applicant household is allowed. A copy of a recent bank statement indicating direct deposit of benefit(s) is also acceptable.

Adult full-time students who are not the head of household are excluded from gross income calculations

- *ESG Income Documentation Standards*

Various types of documentation, ranging from third party verification to applicant self-declaration are acceptable. Documentation standards, in order of preference, are as follows:

1. **Third Party Verification**: The documents for the program staff to complete for the Third Party Verification process are Written Third-Party Verification of Income Form (WTP-2) and the Oral Third-Party Verification of Income Form (OTP-2).
2. **Source (Notices/Statements)**: Official communication on letterhead or statement template; document must be signed and dated (when appropriate). Examples include; paystub, most recent financial statement, statement of income from employer/income source.
3. **Written (Written Letters/Referrals)**: Official communication issued on agency stationary or program template; document must be signed and dated by appropriate representative of third party. Examples include; letter from employer/income source, income source.
4. **Oral (Recorded Oral Statements)**: Oral statement recorded by intake staff of 3rd party providing verification;
5. **Self-Declaration**: Written statement by the individual/head of household applying for assistance. The statement must be completed on the Self-declaration of Income form (SD1-2) and certified (i.e. signed and dated by applicant) as true and complete. Program staff must describe efforts to obtain third party information (phone logs, email correspondence, copies of certified letters etc.) and details of outcome, including obstacles. Once completed, the form must be signed and dated by intake staff as true and accurate.

I. <u>Homelessness Management Information System (HMIS)</u>

An HMIS is a computerized data collection application designed to capture participant-level information over time on the characteristics and service needs of people experiencing homelessness, while also protecting participant confidentiality. It is designed to aggregate participant-level data to generate an unduplicated count of participants served within a community's system of homeless services. An HMIS may also cover a statewide or regional

area, and include several continuums of care. The HMIS can provide data on participant characteristics and service utilization. HMIS is an eligible budget activity. All ESG-funded projects are expected to participate in the NYC CCoC HMIS date warehouse. DHS and the CCoC use HMIS for federal reporting purposes to ensure NYC is compliant with requirements and standards put forth by the Department of Housing and Urban Development (HUD).

Specifically, HMIS is used for regular reporting including the following:

- Annual Homeless Assessment Report
- Consolidated Annual Performance and Evaluation Report
- Housing Inventory Chart-Housing Inventory Count,
- System Performance Measures and the Notice of Funding Availability.
- DHS and federally funded CCoC programs also use HMIS to ensure data quality, completeness, accuracy, and consistency with the goal of improving program performance. Data collected and uploaded into HMIS, by DHS' CARES system for Emergency Shelter, and by Providers for Transitional Housing and Permanent Housing, is used to run statistical reports for up-to-date information on a host of metrics used to assess program performance and track a variety of demographics. HMIS is also used to monitor system and individual level performance for the CCoC and function in coordination with ESG funded programs. HMIS will support regular monitoring to ensure NYC's progress in meeting the goals outlined in Home Together, HUD's federal strategy to prevent and end homelessness.

J. ESG Reporting

Consolidated Annual Performance and Evaluation Report (CAPER)

The Consolidated Plan is designed to help states and local jurisdictions to assess their affordable housing and community development needs and market conditions, and to make data-driven, place-based investment decisions. The consolidated planning process serves as the framework for a community-wide dialogue to identify housing and community development priorities that align and focus funding from the CPD formula block grant programs: Community Development Block Grant (CDBG) Program, HOME Investment Partnerships (HOME) Program, **Emergency Solutions Grants (ESG) Program**, and Housing Opportunities for Persons with AIDS (HOPWA) program.

The Consolidated Plan is carried out through Annual Action Plans, which provide a concise summary of the actions, activities, and the specific federal and non-federal resources that will be used each year to address the priority needs and specific goals identified by the Consolidated Plan. Grantees report on accomplishments and progress toward Consolidated Plan goals in the Consolidated Annual Performance and Evaluation Report (CAPER). Recipients with HUD funding received through the Emergency Solutions Grants (ESG) Program are required to submit a Consolidated Annual Performance and Evaluation Report (CAPER) to HUD annually. Data collection for the ESG portion of the CAPER is aligned with

the most recent version of the Homeless Management Information System (HMIS) Data Standards.

For additional information please visit the HUD Exchange and review the *ESG CAPER Guidebook*.