PERMANENT SUPPORTIVE HOUSING (PSH)
FIDELITY REPORT

Date: March 25, 2021

To: Kevin Green, CEO

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Annette Robertson, LMSW
AHCCCS Fidelity Reviewers

Method

On February 16 – 18, 2021, Karen Voyer-Caravona and Annette Robertson completed a review of the Arizona Health Care Contract Management Services, Inc. (AHCCMS) Permanent Supportive Housing Program (PSH). This review is intended to provide specific feedback in the development of your agency's PSH services, in an effort to improve the overall quality of behavioral health services in Maricopa County.

AHCCMS provides services to individuals with serious mental illness. The agency is contracted with the Regional Behavioral Health Authority (RBHA) for the Central Region of Arizona to provide residential treatment, community living placement houses and apartments, and permanent supportive housing. The PSH program, which at the time of the review served 26 members, is the focus of this review. The PSH program assists members in finding and maintaining safe and affordable independent housing in integrated settings and offers a range of supportive services focused on transportation to search for housing, problem solving, communication skills, living skills, identification of resources, and coping skills to manage behavioral health symptoms.

Due to the system structure with separate treatment providers, information gathered at the Lifewell Windsor and Southwest Network San Tan clinics were included in the review as sample referral sources. However, records reviewed, and members interviewed during the review at AHCCMS were not exclusively served at those clinics.

March 11, 2020 the Governor of Arizona made a Declaration of Emergency and an Executive Order in response to the pandemic, Coronavirus 2019 (COVID-19). Among others, recommendations were made to practice social distancing of six feet to avoid spreading the disease as well as limiting gathering of groups of more than ten people. This review was conducted during the pandemic and adjustments were made to the review process to observe the Governor's requests and to reduce burden on providers, including reducing the sample size of member records reviewed, conducting staff and member interviews telephonically or videoconferencing, remote access to provider electronic health records when available, and other adjustments as needed to follow public health guidance.

The individuals served through the agency are referred to as "members" and "tenants", and for the purpose of this report, the term "tenant" or "member" will be used.

During the site visit, reviewers participated in the following activities via telephonic and videoconferencing platforms:

- Orientation to the agency with the Clinical Director;
- Group interview with the Clinical Director and the Clinical Supervisor;
- Group interview with the two PSH Coordinators;
- Group interviews with two Case Managers from one partner clinic and one Case Manager and one Housing Specialist from another partner clinic;
- Individual interviews with two members who are participating in the PSH program;
- Review of agency documents including organizational chart; PSH program flier with eligibility criteria; agency policies and procedures including admissions, discharges, and crisis and emergency response protocol; *AHCCMS PSH Member Survey*; leases, copies of Housing Quality Standards reports; and
- Review of ten randomly selected records, including charts of interviewed member/tenants.

The review was conducted using the Substance Abuse and Mental Health Services Administration (SAMHSA) PSH Fidelity Scale. This scale assesses how close in implementation a program is to the Permanent Supportive Housing (PSH) model using specific observational criteria. It is a 23-item scale that assesses the degree of fidelity to the PSH model along 7 dimensions: Choice of Housing; Functional Separation of Housing and Services; Decent, Safe and Affordable Housing; Housing Integration; Right of Tenants, Access of Housing; and Flexible, Voluntary Services. The PSH Fidelity Scale has 23 program-specific items. Most items are rated on a 4-point scale, ranging from 1 (meaning *not implemented*) to 4 (meaning *fully implemented*). Seven items (1.1a, 1.2a, 2.1a, 2.1b, 3.2a, 5.1b, and 6.1b) rate on a 4-point scale with 2.5 indicating partial implementation. Four items (1.1b,5.1a, 7.1a, and 7.1b) allow only a score of 4 or 1, indicating that the dimension has either been implemented or not implemented.

The PSH Fidelity Scale was completed following the visit. A copy of the completed scale with comments is attached as part of this report.

Summary & Key Recommendations

The agency demonstrated strengths in the following program areas:

- Per interviews with clinic and AHCCMS staff, and tenants participating in the PSH program, system partners support member choice of housing type and unit. Members are provided information about options available respecting housing types prior to submitting applications for housing assistance and support. At the agency level, members are supported in finding independent housing that meets their identified needs and preferences.
- Most tenants participating the PSH program reside in independent housing that is integrated in the community, either scattered site units funded through various subsidy voucher programs or available at market rate.
- Access to housing is supported through the lack of readiness standards, prioritization of members with significant barriers to housing stability, and a shared respect for tenants' right to privacy within their home environments.

- The agency PSH Coordinators provide on-call emergency service 24 hours a day, seven days a week, both over the phone and on-site.

The following are some areas that will benefit from focused quality improvement:

- It was reported that tenants using vouchers affiliated with the RBHA do not have control of household composition and must obtain approval from their clinical team to add tenants to their leases. Remove restrictions to household composition that are beyond those commonly required by private landlords.
- The agency appears to struggle to maintain copies of current leases and Housing Quality Standards reports. The agency should develop a reliable practice for collecting and maintaining copies of tenants' current leases and HQS documentation that they can readily access to effectively support and advocate for safe and affordable housing.
- The PSH program lacks an obvious mechanism for people with the lived experience of psychiatric disability and recovery to shape program design and service provision. The agency, program, and system partners should collaborate on options such as peer representation on boards, a tenant advisory committee, or peer facilitated tenant focus groups supporting the peer perspective and recovery-oriented services. Technical assistance in this area is advised.
- Optimally, all behavioral health services should be provided through an integrated team. Integration is difficult to achieve with separate providers of PSH and clinic services, including separate offices, record systems, etc. System partners should improve coordination of care through means such as adult recovery teams where the roles and responsibilities of PSH service providers are clearly identified on clinic service plans; virtual platforms may facilitate this process. Likewise, if an integrated health record and team cannot be implemented, share updated service plans, and ensure that documentation such as monthly summaries of PSH service participation and outcomes are incorporated in electronic records.

PSH FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
Dimension 1 Choice of Housing				
1.1 Housing Options				
1.1.a	Extent to which tenants choose among types of housing (e.g., clean and sober cooperative living, private landlord apartment)	1, 2.5 or 4 4	Clinic staff interviewed reported that members decide the type of housing they pursue. Clinic staff said that they present members with available housing options and discuss the pros and cons of each. One Case Manager reported making referrals for PSH regardless of the clinical team assessing for a higher level of care. Members interviewed reported preferring and receiving independent housing. PSH staff interviewed reported that they will support members in pursuing the type of housing they prefer, including when members decide they want to move to a program offering a higher level of care.	
1.1.b	Extent to which tenants have choice of unit within the housing model. For example, within apartment programs, tenants are offered a choice of units	1 or 4 4	PSH staff reported supporting member choice of unit by helping them rank and prioritize their needs and preferences, such as proximity to services, public transportation, and natural supports; layout and accessibility requirements; pet policies; and desired amenities. PSH staff interviewed described the use of decisional balancing techniques to prioritize needs and preferences. PSH staff identified structural barriers to choice in unit such as low income, reduced availability of affordable housing, and unwillingness of landlords to accept some subsidy vouchers. PSH staff noted that many previously	• Collaborate with housing advocates and stakeholders outside the behavioral health system to increase the availability of affordable housing options for members who do not receive subsidy vouchers. Work to maintain agreements with complexes undergoing improvements to prevent turn out of tenants with vouchers. • Continue to educate property owners about the benefits of involvement with the PSH program. Advocate for income qualifications based on the tenant's

			affordable complexes have been redeveloped and charge rent that exceeds fair market value covered by vouchers. Staff interviewed acknowledged the barriers are not unique to people with disabilities due to pervasive rise in rents in recent years and migration to the geographic area. All clinic and PSH staff interviewed repeatedly described the lack of affordable housing as a significant barrier to housing stability and choice. PSH staff will advocate with landlords to accept vouchers, and one record reviewed showed a PSH Coordinator successfully helping a member to obtain a unit this way. Staff reported, and records showed, staff encouraging a member to rent a unit in a desired complex and to then transfer to a preferred unit when one next becomes available.	portion of the rent and seek to ensure members are treated fairly during the application process.
1.1.c	Extent to which tenants can wait for the unit of their choice without losing their place on eligibility lists	1 – 4 4	All staff interviewed reported that wait times for scattered site vouchers can be lengthy, from several months to several years. Wait lists of public housing authority vouchers, project-based units, and low-income housing tax credit housing can also be quite lengthy due to the demand. Staff said that once awarded a voucher, members have a predetermined period to locate housing but can obtain several extensions with evidence that they are actively engaged in housing search. Members can turn down housing until they find a unit that meets their needs and preferences. PSH staff interviewed said that some members seeking housing are not referred to the program until their voucher is near expiration. PSH staff reported this is less of a problem for clinical teams that have a Housing Specialist because they usually have the most current knowledge and information about housing and better prepare members for	• When suggesting or supporting members considering moving to another complex upon lease expiration, ensure they are clearly informed that financial assistance through the RBHA for move-in assistance, i.e., deposit fees, etc., are a once in a lifetime benefit.

			the housing search process. Staff said that when members enter their program with an expiring voucher, they sometimes encourage members to accept a less than ideal unit, with the plan to wait for a more preferred unit in the complex, and seek to transfer units, or begin a new search at the end of the term of lease.	
1.2 Choice of Living Arrangements				
1.2.a	Extent to which tenants control the composition of their household	1, 2.5, or 4 2.5	When members first apply to the RBHA for housing assistance, they identify household members. PSH and clinic staff reported that one voucher administrator requires approval from the clinical team when tenants seek to add roommates not listed on the original housing application, resulting in limited ability to control household composition. However, PSH documentation in member records showed staff supporting tenants in getting a family member added to a subsidy voucher.	• Ensure that all system partners have an accurate understanding of policies regarding composition of household that is communicated consistently to tenants and members seeking housing assistance. With the evidence-based practice of PSH, tenants decide who they live with and the only restrictions are those usually applied by property managers of market rate units to all tenants regardless of disability status.
Dimension 2 Functional Separation of Housing and Services				
2.1 Functional Separation				
2.1.a	Extent to which housing management providers do not have any authority or formal role in providing social services	1, 2.5, or 4 4	Per interviews and records reviewed, landlords and property managers have no role in providing support services. Some records showed Case Managers and PSH staff interacting with RBHA and public housing authority affiliated housing staff about matters related to housing assistance processes such as employment verification and income eligibility. PSH staff said that other property management interactions with social services are at tenant discretion and focused on eviction prevention or maintenance.	
2.1.b	Extent to which service providers do not	1, 2.5, or 4	Per interviews and records reviewed, service providers do not have a role in property management functions such as enforcing	

	have any responsibility for housing management functions	4	provisions of leases or collecting rent. PSH staff provide psychoeducation and motivational interventions such as: eviction prevention activities, as well as skill-building and support in self-advocacy in communicating with landlords when issues arise that threaten tenancy. Records reviewed showed numerous instances of PSH staff offering to or supporting tenants in talking to the landlords on their own behalf. One record showed a PSH staff engaging a tenant in role play for the purpose self-advocating with a landlord.	
2.1.c	Extent to which social and clinical service providers are based off site (not at the housing units)	1 – 4 4	The PSH program does not maintain office space at member residences, nor does it own or manage properties where members reside. Services to members may be provided at individual homes as appropriate, elsewhere in the community, or at the agency's central office location.	
Dimension 3 Decent, Safe and Affordable Housing				
3.1 Housing Affordability				
3.1.a	Extent to which tenants pay a reasonable amount of their income for housing	1 – 4 3	The agency provided rent to income data on 23 of 26 tenants, showing an average of 18% income paid in rent. Tenants using subsidy vouchers pay 30% or less of income in rent. Many, but not all, of those voucher subsidized units include utilities. Eight tenants showed paying zero income toward rent. Two members in market rate housing, including one who is renting a room in a private home, pay more than 60% of their income in rent. No rent to income data was provided for three tenants in market rate housing. The missing data and extreme income burden are reflected in the score.	• To the extent possible, with consideration for market factors, continue to work with tenants who are paying over 30% of income toward housing to find more affordable units, assistance programs, or employment to help mitigate their rental costs. • Seek to maintain documentation of rent to income data to better support members in budgeting to maintain housing. • System partners should take an active role in efforts to encourage the maintenance of existing and creation of new affordable housing.

			Both reviews of clinic and PSH records show staff assisting members in obtaining resources to ease rent burden and other affordability barriers resulting from low income, including food boxes and housing startup kits. It was reported that the RBHA offers one time assistance, upon application, for move in expenses such as movers and deposits. All clinic and PSH staff interviewed repeatedly described lack of affordable housing as a significant barrier to housing stability and choice.	
3.2 Safety and Quality				
3.2.a	Whether housing meets HUD's Housing Quality Standards	1, 2.5, or 4 1	Of 26 housed tenants in the PSH program, Housing Quality Standards (HQS) reports were provided for 13 units. However, eight of those reports were expired. It was not clear to the reviewers what process the program uses for maintaining verification of HQS. Staff interviewed reported HQS inspections have been on hold or delayed due to the public health emergency. Other staff reported overall there have not been delays in units getting an HQS inspection currently. Staff reported that they will support members in advocating for maintenance and safety issues and must rely on this process for those members who live in units rented at market rate or from friends or family and not subject to HQS inspections. One member interviewed reported plans to move from a unit rented from a friend due to a reported termite infestation that had not been successfully resolved.	• Consult with system partners, including other PSH service providers, about reliable mechanism for ensuring tenant safety in their units and that they meet housing quality standards during the public health emergency. Some programs train and certify staff to conduct HQS in addition to providing advocacy for maintenance and safety outlined in leases. • Explore options to complete HQS inspections for members who do not receive a subsidy. Continue efforts to maintain copies of most recent HQS reports. Track renewal dates to support tenants plan for inspections.
Dimension 4 **4.1 Housing Integration**				
4.1 Community Integration				

4.1.a	Extent to which housing units are integrated	1 – 4 4	Twenty-five of the 26 tenants live in scattered site or market rate units. Four members live in their individual apartments within a 160-unit complex. One member resides in a RBHA affiliated community living placement (CLP) without staff, and at least four other Seriously Mentally Ill (SMI) determined individuals were reported to reside at this location. It was not clear what percentage of tenants at this address are people disabilities and participants of a housing program. Staff acknowledge that some unintentional clustering occurs because housing that is within a range that members of the PSH program can find the means to pay are often located in specific geographical locations. Further, people with disabilities often have low income. PSH and clinic staff perceive that complexes that accept vouchers often have more tenants with behavioral health issues, as well as criminal histories. Neither PSH nor clinic staff interviewed were aware of how integration is monitored by the larger system.	• System partners should explore options for increasing the availability of small single site complexes, duplexes, or single-family homes with no more than five tenants to prevent unintentional clustering of persons with a disability.
Dimension 5 Rights of Tenancy				
5.1 Tenant Rights				
5.1.a	Extent to which tenants have legal rights to the housing unit	1 or 4 1	A review of data provided by the agency indicated the agency had copies of nearly 81% of tenant leases, however, only 69% were current. Staff reported that two members living with family or friends did not have leases and five other leases were not obtained.	• Educate members on the benefits of the PSH program maintaining a copy of tenant leases in order to confirm and advocate for tenants' legal rights of tenancy.
5.1.b	Extent to which tenancy is contingent on compliance with	1, 2.5, or 4 4	Staff and tenants interviewed do not report any special rules or provisions attached to their housing. Tenants of RBHA affiliated CLP units may have special provisions tied to their housing but none were identified as applying to a CLP unit	

	program provisions		where one tenant currently resides. One record showed that a tenant received a notice of action to leave a CLP where an expectation of group attendance had been in place; at the time of review, the tenant had relocated to independent housing.	
Dimension 6 Access to Housing				
6.1 Access				
6.1.a	Extent to which tenants are required to demonstrate housing readiness to gain access to housing units	1 – 4 3	Some clinic staff reported no readiness standards, although one Case Manager noted that members with income and tools such as mobile phones are easier to contact and subsequently house. Interviews showed evidence that some Case Managers lack familiarity with *Housing First* principles and may view psychiatric stability as a precursor to independent housing rather than housing as a precondition to it. Although no Case Managers reported that they would refuse to refer members for assistance in finding independent housing, it was not clear that all would advocate for it. PSH staff noted that clinics are oriented toward "level of care" practices respecting housing, where members step down or graduate to less restrictive environments as they achieve psychiatric goals. PSH staff said that clinics with a Housing Specialist are more knowledgeable about evidence-based practice of PSH which avoid readiness criteria. PSH staff said that novice Case Managers may lack knowledge of *Housing First* principles, inadvertently steering members toward staffed or semi-staff housing options that may have expectations related to clinical objectives. PSH staff express that this may be partly due to high	• Ensure that clinic staff assess members for needs, skill deficits, available resources, and strengths so that targeted services that support independent living goals can be offered and put in place. • Provide ongoing education to clinic staff on the *Housing First* approach and its role in recovery.

			turnover among clinic staff and insufficient training in the PSH model. AHCCMS staff said that they do not have a readiness requirement before assisting members to either obtain housing or participate in housing services; staff are available to provide supports and assist in finding necessary resources to be successful in independent units.	
6.1.b	Extent to which tenants with obstacles to housing stability have priority	1, 2.5, or 4 4	Most clinic and PSH staff interviewed reported that the behavioral health system prioritizes homelessness, imminent risk of homelessness and vulnerability as measured by the Vulnerability Index Service Prioritization Decision Assistance Tool (VI-SPDAT). AHCCMS staff said that they do not have a wait list that prioritizes members for service but, were this to change, they would prioritize homelessness and the VI-SPDAT score. PSH staff discussed the importance of wrap around supports and connection to resources and services to ensure housing stability for those most vulnerable to homelessness. PSH staff said that they do prioritize members referred with expiring vouchers. One Case Manager interviewed said that the agency lacked a clear referral process, and that confirmation of new referrals was not timely. Reviewers found that some records did not reflect urgency as measured by frequency and intensity of services by PSH staff.	
6.2 Privacy				
6.2.a	Extent to which tenants control staff entry into the unit	1 – 4 4	Tenants, and clinic and PSH staff interviewed reported that tenants control entry into their units. Staff do not have keys and do not enter without permission. Landlords are expected to give a 48 hours' notice. PSH staff said they educate members on rights related to entry. One record showed that a PSH Coordinator witnessed	

			unannounced staff enter a member's CLP unit; the PSH Coordinator educated the member that upon relocating to a scattered site unit that service staff could not enter without permission.	
Dimension 7 Flexible, Voluntary Services				
7.1 Exploration of tenant preferences				
7.1.a	Extent to which tenants choose the type of services they want at program entry	1 or 4 4	Most staff interviewed indicate that members decide the types of services they will receive at program entry, i.e., integrated behavioral health services. Tenants interviewed said that they control what is on their service plan. Clinic service plans and progress notes reviewed showed referrals to services requested by members such as vocational services, peer run programs, counseling, and therapeutic arts.	
7.1.b	Extent to which tenants have the opportunity to modify service selection	1 or 4 4	Staff interviewed reported that members' service plans are updated at least annually but also when they have a significant life change such as a move or discharge from a psychiatric hospital. Staff also said that members can update or change service plans upon request when wanting to add or change a service. Tenants interviewed reported that they have opportunities to modify services when they want. Clinic records sampled showed that service plans were updated at least annually.	• Ensure members are given the opportunity to update their service plan during this period of the public health emergency.
7.2 Service Options				
7.2.a	Extent to which tenants are able to choose the services they receive	1 – 4 3	Services at AHCCMS beyond housing search are focused on those that support tenancy such as identification and connection to resources and services, independent living skills, advocacy, and psychoeducational counseling. The program appears to attend to symptom management, encouraging active use of coping skills, and maintaining connection to clinical services as a means to housing stability. Staff reported that	• For RBHA affiliated vouchers, the agency may have limited ability to affect this area under the current system structure. If possible, considerations should be made to extend the voucher benefit for a period of time after disenrollment. Efforts may include exploring alternative funding sources that do not require enrollment in the RHBA system for eligibility.

			tenants do not have to use housing support services at AHCCMS in order to retain their housing. Members can discontinue PSH services at any time after being housed. Self-sufficiency in maintaining housing is identified as a goal for discharge. Members are encouraged to accept check-ins for at least 90 days after becoming housed in order to provide members an opportunity to identify immediate and distal housing needs. For members who decline to engage after being housed with minimal phone check-ins, PSH staff will notify the clinical team and send the member a 30-day notice to close services. Members receiving RBHA affiliated housing subsidy must be clinically enrolled in order to retain the subsidy voucher. Some PSH staff were unsure of the criteria to retain subsidy vouchers. Some clinic staff said that members who decline engagement with the clinical team are placed on navigator status rather than disenrolled.	• Educate PSH and clinic staff, and members about how choices of the services members do or do not select, impact other services. For example, if terminating clinic services, the impact on applicable subsidies and/or PSH services.
7.2.b	Extent to which services can be changed to meet tenants' changing needs and preferences	1 – 4 3	The PSH program service mix is predictable, focused on finding and retaining housing but service delivery appears to occur at the frequency and intensity at which tenants request. One record showed a member obtaining housing, but staff did not engage to update treatment goals, eventually closing the member due to lack of engagement. PSH records sampled showed tenants reviewing with PSH staff treatment plan goals and progress made during monthly home visits.	• Consider providing staff additional training on how to engage members in addressing other areas of vulnerability, concern, or prior issues that led to eviction or homelessness. Staff may benefit from training in motivational interviewing and co-occurring disorders to better support the needs of tenants whose tenancy may be at risk due to relapse or ongoing substance misuse.
7.3 Consumer- Driven Services				

7.3.a	Extent to which services are consumer driven	1 – 4 2	The agency does not have a clear mechanism for soliciting and incorporating the peer perspective in program design or service delivery. It was reported that the agency administers PSH satisfaction survey only. Although staff have discussed holding a member forum through videoconferencing, no action has been taken for its implementation.	• Explore means to solicit and incorporate member input on program design and service provision. For example, explore if members can serve on sub-committees to the agency board of directors, participate in quality management, or other processes that impact service design and provision. • Consider options to facilitate member/tenant forums using videoconference and/or conference calls so that members can voice their concerns and desires for program design. • Ensure members have an opportunity to anonymously submit questions, concerns, and suggestions for program improvement throughout the program year.
7.4 Quality and Adequacy of Services				
7.4.a	Extent to which services are provided with optimum caseload sizes	1 – 4 4	Two PSH Coordinators support the housing needs of 26 tenants at the time of the review. One PSH Coordinator reported a caseload of 15 tenants, while the other reported a caseload of ten. Two other staff were identified as available to provide housing support services so that caseloads do not rise above 15 members each. Staff said that since the public health emergency, referrals to the program have decreased and caseloads have been manageable for two direct service staff.	
7.4.b	Behavioral health services are team based	1 – 4 2	Most tenants are assigned to supportive level of care clinical teams. Records showed that, in addition to their assigned clinical teams and AHCCMS, some tenants received services such as counseling/psychotherapy, art therapy, and substance use treatment from various service providers. Some records showed coordination of care between the PSH program and clinical Case Managers, and occasionally other housing	• Ideally, all behavioral health services are provided by an integrated team. Due to the current structure of the system with separate service providers, this is not possible. Consider scheduling regular planning sessions between the PSH provider, clinic staff, and the member to coordinate member care. Soliciting input and sharing updated service plans and

			providers. PSH staff said that their services are rarely included on member clinical services plans, and this was confirmed in records sampled by the reviewers. PSH staff said that they provide monthly summaries of services delivered to members to clinical teams but copies of these were not found in member records. Progress notes, from a period before the public health emergency showed some evidence of PSH staff attending staffings with other providers, although these seemed to be directly related to housing. Staff said that most communications with clinical teams are over email or phone and some communication barriers exist. Staff said that some clinics have very few staff present, with case managers working from home due to the public health emergency. Staff said communication with the Housing Specialists at the clinics is usually only when a member is first referred for services.	other documentation is encouraged if an integrated health record and integrated team cannot be implemented. • Improve coordination upon referral to prevent delays in housing search efforts for members with a voucher considering how to obtain voucher type and deadlines upon referral. • The PSH program should develop a tracking system of which vouchers members have applied for and the correlating guidelines to those vouchers that may limit housing search.
7.4.c	Extent to which services are provided 24 hours, 7 days a week	1 – 4 4	PSH program staff reported that PSH Coordinators are available on-call to tenants 24 hours a day, seven days a week, including nights and weekends, and can go on site if it is safe to do so. Staff said that members usually call them for housing related matters. Staff will support members in calling a local crisis line in a behavioral health emergency, as well as notify the clinical team. Staff provide members with their phone number and will cover for each other when they are off. PSH progress notes reflecting coverage of another staff's caseload while out were located in tenant records.	

PSH FIDELITY SCALE SCORE SHEET

1. Choice of Housing	Range	Score
1.1.a: Tenants have choice of type of housing	1,2.5,4	4
1.1.b: Real choice of housing unit	1,4	4
1.1.c: Tenant can wait without losing their place in line	1-4	4
1.2.a: Tenants have control over composition of household	1,2.5,4	2.5
Average Score for Dimension		3.63
2. Functional Separation of Housing and Services		
2.1.a: Extent to which housing management providers do not have any authority or formal role in providing social services	1,2.5,4	4
2.1.b: Extent to which service providers do not have any responsibility for housing management functions	1,2.5,4	4
2.1.c: Extent to which social and clinical service providers are based off site (not at the housing units)	1-4	4
Average Score for Dimension		4
3. Decent, Safe and Affordable Housing		
3.1.a: Extent to which tenants pay a reasonable amount of their income for housing	1-4	3
3.2.a: Whether housing meets HUD's Housing Quality Standards	1,2.5,4	1
Average Score for Dimension		2
4. Housing Integration		
4.1.a: Extent to which housing units are integrated	1-4	4
Average Score for Dimension		4
5. Rights of Tenancy		
5.1.a: Extent to which tenants have legal rights to the housing unit	1,4	1

5.1.b: Extent to which tenancy is contingent on compliance with program provisions	1,2.5,4	4
Average Score for Dimension		2.5
6. Access to Housing		
6.1.a: Extent to which tenants are required to demonstrate housing readiness to gain access to housing units	1-4	3
6.1.b: Extent to which tenants with obstacles to housing stability have priority	1,2.5,4	4
6.2.a: Extent to which tenants control staff entry into the unit	1-4	4
Average Score for Dimension		3.7
7. Flexible, Voluntary Services		
7.1.a: Extent to which tenants choose the type of services they want at program entry	1,4	4
7.1.b: Extent to which tenants have the opportunity to modify services selection	1,4	4
7.2.a: Extent to which tenants are able to choose the services they receive	1-4	3
7.2.b: Extend to which services can be changed to meet the tenants' changing needs and preferences	1-4	3
7.3.a: Extent to which services are consumer driven	1-4	2
7.4.a: Extent to which services are provided with optimum caseload sizes	1-4	4
7.4.b: Behavioral health services are team based	1-4	2
7.4.c: Extent to which services are provided 24 hours, 7 days a week	1-4	4
Average Score for Dimension		3.25
Total Score		23.08
Highest Possible Score		28