**PERMANENT SUPPORTIVE HOUSING (PSH)**
**FIDELITY REPORT**

Date: March 3, 2023

To: Gus Bustamante, Permanent Supportive Housing Services Program Manager
Larry Villano, Chief Energy Officer

From: Nicole Eastin, BS
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AHCCCS Fidelity Reviewers

**Method**

On January 31 – February 2, 2023, Nicole Eastin and Vanessa Gonzalez completed a review of the Resilient Health Permanent Supportive Housing Services program. 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 the Central Region of Arizona.

Resilient Health offers behavioral health services to individuals diagnosed with a Serious Mental Illness (SMI) including Permanent Supportive Housing (PSH). The program brochure describes providing individualized assistance to persons in their home and the community, teaching skills aimed at maintaining independent housing and personal wellness.

Due to the system structure of separate treatment providers, information gathered at the Lifewell Oak and Copa Health Metro clinics were included in the review as sample referral sources. However, some data obtained reflects services provided by other partner clinics.

This review was conducted remotely, using videoconferencing or telephone to interview staff and members.

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

During the fidelity review, reviewers participated in the following activities:

- Interview with the PSH Services Program Manager.
- Interview with four PSH Housing Specialists.
- Interview with PSH Clinical Director, Quality Director, Quality Specialist, and Program Manager.
- Group interviews (2) with six Case Managers and the Housing Specialist from Copa Health Metro clinic, and four Case Managers from the Lifewell Oak clinic.

- Interviews with two members that are participating in the PSH program.
- Review of agency documents including intake procedures, Resilient Health Permanent Supportive Housing Organization Structure, *PSHS Outreach Procedure*, member leases and safety inspection documents, *PSHS Flyer, PSH Prioritization Flow Chart*, and the *Permanent Supportive Housing: PROGRAM DESCRIPTION*.
- Review of 10 randomly selected member records, including co-served members.

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 review. 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:

- Based on interviews and documentation located in records, Resilient Health (RH) PSH tenants are offered choices in housing and do not experience pressure to accept units that do not meet individual needs and preferences.
- RH PSH staff and clinical teams do not have a role in property management functions, nor do landlords play a role in provision of support services.
- Based on data provided, the majority of housed RH PSH members live in integrated settings in the community and control the composition of their household.

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

- Documents necessary to support member tenancy and safe housing, i.e., copies of leases and Housing Quality Standards inspections, were not consistently obtained by the program.
- Members/tenants have few options to provide program planning and input. Develop strategies to solicit and incorporate member input specific to PSH program design and service provision.
- The RH PSH program, and system partners, should ensure that clinical teams and service providers have a shared understanding of *Housing First* principles so that members expressing a need for housing are assisted in obtaining housing that aligns with their preferences. All clinical team staff should be aware of PSH service provisions to support members and then share that information of such programs available with members.
- Members, nor clinical team staff, were aware the RH PSH program provides 24/7 services. Consider updating program brochures to include the on-call number. Ensure members and clinic staff are aware of availability after hours.

**PSH FIDELITY SCALE**

| Item # | Item | Rating | Rating Rationale | Recommendations |
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| **Dimension 1<br>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<br><br>4 | Based on interviews with members and clinic staff, members can choose the type of housing desired based on their preferences. Case Managers assist members with identifying housing goals, securing housing that is affordable, and ensuring that it meets the member's expectation. Members interviewed reported being supported in searching for the housing of their choice based on their preferences. Both clinic and RH staff stated the lack of affordable housing limits independent living options available to members. | |
| 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<br><br>4 | Clinic and RH staff interviewed stated that members are allowed choice in the units that are offered. Examples included preferences identified of a second-floor apartment and an apartment with a specific layout being obtained by members. In one record reviewed, the member was requesting a first-floor apartment. | |
| 1.1.c | Extent to which tenants can wait for the unit of their choice without | 1 – 4<br><br>4 | RH staff reported there is no waitlist for PSH services. PSH staff interviewed reported there is no risk of members being discharged from the program when they decline a housing option. Staff reported members with vouchers have 90 days to | |

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| | losing their place on eligibility lists | | secure housing and that there are exceptions for members to obtain an extension. Staff reported Section 8 vouchers allow members six months to secure housing and are allowed one extension.<br><br>Per records reviewed, clinic and RH staff attempted to assist members applying to waitlists in the community, however some landlords were requiring an application fee to be placed on the waitlist that ranged from 3 months to 2 years; members ultimately declined, and staff continued the housing search. One member interviewed reported PSH staff accompanying them to apartments and applying to waitlists. | |
| **1.2 Choice of Living Arrangements** | | | | |
| 1.2.a | Extent to which tenants control the composition of their household | 1, 2.5, or 4<br><br>4 | Clinic and RH staff interviewed stated tenants have the final decision about the composition of their household. Members interviewed reported the ability to decide to live alone, with a roommate, children, or family. Staff also informed that members must report additional members of their household when applying to the housing subsidy to be considered, and that clinical teams and PSH staff do not provide insight or approval when requests are made to the voucher holder. Members can add persons to their household, but must go through the same process as other tenants, requiring credit and property management approval, etc. However, in rare circumstances, clinical teams and PSH staff may suggest members reconsider adding particular individuals to their household.<br><br>Data reflected, about 16% of members are in settings where there may be program control over housing composition, i.e., behavioral health residential facilities. | |

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| **Dimension 2<br>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<br><br>4 | Based on interviews with clinic staff, RH staff, and members, property managers do not have any role in providing clinical or social services to members. 13% of housed PSH members reside in settings where there may be overlap between housing management and service staff affiliated with the residence, such as halfway houses and behavioral health residential facilities. | |
| 2.1.b | Extent to which service providers do not have any responsibility for housing management functions | 1, 2.5, or 4<br><br>4 | Per interviews conducted, service providers do not have any responsibility for housing management functions. Clinic and RH staff denied collecting rent, serving evictions, and are not tasked to report lease violations. RH staff interviewed indicated they do not interfere with property management decisions, however, will assist in resolving issues and advocating on members' behalves. | |
| 2.1.c | Extent to which social and clinical service providers are based off site (not at the housing units) | 1 – 4<br><br>4 | Clinic and PSH staff reported that social service offices are based off-site and are not located in complexes where members of the program reside. RH staff identified several properties that had social services on site for tenant use, and reported only two tenants reside on those properties. Members interviewed reported receiving services through assigned integrated clinics and through other providers off site from their residences. RH staff interviewed reported that members are able to attend groups at RH such as cooking, and *Art Awakenings* in the community. | |
| **Dimension 3<br>Decent, Safe and Affordable Housing** | | | | |
| **3.1 Housing Affordability** | | | | |

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| 3.1.a | Extent to which tenants pay a reasonable amount of their income for housing | 1 – 4<br><br>3 | Clinic and RH PSH staff interviewed reported members are paying anywhere from 30 – 80%, or higher, of their income toward rent. Some member leases include utilities. One member interviewed reported paying more than 73% of their income toward rent. RH staff assisted the member in applying for a rental subsidy voucher and is currently on the waitlist. It was reported the current property management will be increasing rent again at lease end and that the tenant will possibly be facing homelessness due to lack of affordability.<br><br>Records reviewed showed clinic and PSH staff discussing employment goals and assisting members with resume writing and applying for jobs. It was also observed in records staff assisting members with completing applications for social security benefits, nutrition and utility assistance, and informing on budgeting practices to assist with offsetting income to rent ratio.<br><br>Based on rent to income data provided for 98 housed members, members of the program are paying an average of 33% of their income toward rent. | • To the extent possible, with consideration for market factors, continue to work with tenants that are paying over 30% of income toward housing to find more affordable units, assistance programs, or employment to help mitigate their rental costs. |
| **3.2 Safety and Quality** | | | | |
| 3.2.a | Whether housing meets HUD's Housing Quality Standards | 1, 2.5, or 4<br><br>1 | Data provided to reviewers showed the RH PSH program has less than 21% current and passing Housing Quality Standards (HQS) inspections on record. RH staff reported members that do not hold housing subsidy vouchers do not receive HQS inspections. RH staff reported that they can and do assist members in market rate housing walkthroughs, prior to lease signing, when requested. Additionally, RH staff complete a home visit checklist with the member every 90 days | • Consider consulting with system partners, including other PSH service providers, about reliable mechanisms for ensuring tenant safety in units and that units meet housing quality standards.<br>• Work to ensure that all tenants are housed in units that meet HQS, not just tenants that have a subsidy. Develop procedures to track market rate units that meet HQS. |

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| | | | looking for maintenance issues, and safety issues that need to be brought to property management's attention.<br><br>RH staff interviewed indicated coordination to obtain HQS inspections on unit's members occupy from HOM Inc. is effective, however, obtaining copies from other housing subsidy voucher administrators is more challenging. The RH PSH program reported it is in the process of hiring certified staff to perform inspections of member units. | Some programs track renewal dates and coordinate in order to ensure most recent copies are obtained and to be available to members when concerns arise. |
| **Dimension 4**<br>**4.1 Housing Integration** | | | | |
| **4.1 Community Integration** | | | | |
| 4.1.a | Extent to which housing units are integrated | 1 – 4<br><br>4 | Based on housing data provided, and reports from clinic and RH staff, nearly 95% of tenants within the PSH program live in units that are integrated within their communities. Few members are housed in units that have been set aside for people meeting disability-related eligibility criteria. | |
| **Dimension 5**<br>**Rights of Tenancy** | | | | |
| **5.1 Tenant Rights** | | | | |
| 5.1.a | Extent to which tenants have legal rights to the housing unit | 1 or 4<br><br>1 | Based on interviews with clinic and RH staff, the majority of members have a lease depending on where they live. RH staff interviewed reported that members have full rights of tenancy, particularly those living in independent settings and members that have copies of their lease. RH PSH staff attempt to obtain copies of leases from members, however, are not successful all of the time. PSH staff reported requesting assistance from clinical teams when attempting to obtain copies of members leases. | • PSH agencies should obtain and maintain current copies of all leases. For scattered site units, explore the feasibility of having voucher administrators providing copies of leases to PSH providers as leases are an important tool supporting tenant advocacy and eviction prevention. Members participating in PSH services should be educated as to the benefits of sharing the lease with the PSH services provider. |

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| | | | Members interviewed reported having a copy of their lease. One member reported PSH staff accompanied them to a lease signing with the landlord. One member record reviewed showed RH PSH staff reviewing a lease with the member in detail and another record showed staff assisting the member obtaining a copy of their lease from property management and reviewing it with the member.<br><br>Data provided by the RH PSH program indicates the agency obtains few copies of leases to support tenants when notices are received, or lease violations arise. Data showed 44% of members have a current lease on file with the PSH agency. | |
| 5.1.b | Extent to which tenancy is contingent on compliance with program provisions | 1, 2.5, or 4<br><br>4 | Most members reside in settings where tenancy is not contingent on adhering to program rules or treatment. Members interviewed reported only being required to follow rules on their individual leases and that there were no special requirements of program rules.<br><br>Based on housing data provided, the majority of housed RH PSH members, 87%, reside in settings where tenancy is not contingent on compliance with program provisions. A small number of housed members reside in staffed transitional or treatment settings where tenancy is contingent on treatment participation or program rules. | |
| **Dimension 6<br>Access to Housing** | | | | |
| **6.1 Access** | | | | |
| 6.1.a | Extent to which tenants are required to demonstrate | 1 – 4<br><br>3 | RH staff interviewed confirmed practicing a *Housing First* approach and that there is no other PSH program entry requirements other than a referral from clinic staff. RH staff reported | • PSH staff and system partners should collaborate with clinic staff to increase understanding of the *Housing First* model and how PSH supports that. Assessing |

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| | housing readiness to gain access to housing units | | members can self-refer to the program, and the PSH program will coordinate with members' clinical teams to obtain a referral packet, as observed in one member record reviewed.<br><br>Referring clinic staff interviewed were not familiar with the *Housing First* model nor were they able to describe services PSH programs offer to members. Clinic staff interviewed acknowledged training would be beneficial to better promote PSH services and the *Housing First* model to members. RH staffed interviewed reported that a lack of understanding about PSH services at the referral level can result in members feeling mislead and not appropriately receiving the services they were promised.<br><br>Reports from clinic staff varied in relation to screening members expressing an interest in housing. Some clinic staff indicated having conversations with members about their readiness for independent living and assessing for other housing options such as staffed settings based on the member's current lifestyle and history of independent living. However, some clinic staff interviewed reported referring members when the request is made without screening for readiness. Based on ten member records reviewed there was no indication of screening or assessing members for readiness. | members' needs would be an appropriate measure if the purpose were to identify skills and services needed to support the member in being successful in living independently. Members only need to express a desire for safe and affordable housing to be referred to PSH programs. |
| 6.1.b | Extent to which tenants with obstacles to housing stability have priority | 1, 2.5, or 4<br><br>2.5 | Per interviews, PSH services are available to members that request the support based on individualized needs. Supports reported include housing search, community resources, maintaining housing, budgeting, and money management, applying for housing subsidies, personal care, health and wellness, and advocating on the | • System partners should ensure that clinic staff assisting members with accessing permanent supportive housing and services across all provider clinics have a common and accurate understanding of eligibility and prioritization. Lack of accurate information may result in members being |

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| | | | members behalf. However, the RH *PSH Flyer* does not indicate that services include housing search or other services the PSH program offers.<br><br>RH PSH staff interviewed identified unhoused members as a high priority and reported utilizing *the PSH Prioritization Flow Chart* to indicate the member level of priority. The RH PSH program does not require a Vulnerability Index Service Priority Decision Assistance Tool (VI-SPDAT) as part of the referral process.<br><br>One clinic interviewed reported utilizing the VI-SPDAT tool when working with members with housing needs, however, does not base the scoring on whether to refer members to a PSH program. One clinic staff interviewed reported PSH program referrals are at times contingent on the member's individual needs and that referrals may require the member to have a source of income and independent living skills. And, in addition, suggested placements such as *Flexcare* or *Community Living Placements* would be available more rapidly than independent living housing subsidies. | dissuaded from pursuing housing or feeling frustrated with the results.<br>• Consider updating the RH PSH flyer to indicate all services the program has to offer to assist members based on individual needs. |
| **6.2 Privacy** | | | | |
| 6.2.a | Extent to which tenants control staff entry into the unit | 1 – 4<br><br>4 | Members interviewed reported having privacy in units and that staff do not enter without permission. RH PSH staff and clinic staff do not hold copies of tenant keys and confirmed that members control entry and have privacy in their units. About 13% of housed members are in settings where staff affiliated with the residence may have varying levels of access, including halfway houses, and residential programs. | |
| **Dimension 7<br>Flexible, Voluntary Services** | | | | |

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| **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<br><br>4 | Clinic staff interviewed reported members can choose the services they want at program entry and that members are the authors of their service plan with the help of clinic staff. Members interviewed stated they have choice on their goals and services they want and need at the clinic level. | |
| 7.1.b | Extent to which tenants have the opportunity to modify service selection | 1 or 4<br><br>4 | Staff interviewed at one clinic said service plans are completed at intake and annually thereafter. Clinic staff reported barriers to updating service plans relate to difficulties connecting with members or members not agreeing to update annual assessments and service plans. A barrier identified by staff at one clinic was that the assigned Clinical Coordinator must sign off on service plans within a specific timeframe of completion and when that does not occur, the service plan needs to be redone. One member interviewed reported speaking with their Case Manager every six months about service plan changes. RH PSH staff reported service plans provided by clinics often do not have goals pertaining to PSH program services and needs, therefore the PSH program completes a service plan with the member upon intake.<br><br>A review of six clinic member records showed three with housing goals identified on the service plans, and most were written in members' voice. However, not all service plans were updated with the members' current living situation goals or housing services they are receiving. | |
| **7.2 Service Options** | | | | |
| 7.2.a | Extent to which tenants are able to choose | 1 – 4<br><br>4 | Upon intake with RH, members develop treatment goals according to their needs, strengths, abilities, and preferences. Of the records reviewed, service | |

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| | the services they receive | | plans with the PSH provider appeared to be written in the members' voice, based on individual needs and objectives. Services identified on PSH service plans and in documentation in records reviewed included seeking safe and affordable housing, increasing independent living skills, assistance with time management, organizational skills, budgeting, increasing income through employment, seeking resources, assistance with housing vouchers, and gaining additional coping skills. | |
| 7.2.b | Extent to which services can be changed to meet tenants' changing needs and preferences | 1 – 4<br><br>2 | Based on interviews with RH PSH staff, members are able to update their services plans based on their needs and at least every six months. RH staff indicated changes to member service delivery are also documented on monthly summaries sent to the clinical teams. Based on PSH ten member records reviewed, three member's service plans were updated ranging 5 - 12 months and included goals pertaining to the member's status.<br><br>The RH PSH program literature states the program limits enrollment from 3 – 9 months based on the individual, and that members are seen by their primary clinician at least once a week, having access to on call staff 24 hours a day. Based on data provided, 49 members completed intake more than 30 days after the referral. Staff reported enrolling over 400 members into the PSH program in the past 12 months and discharged 390 members. RH staff interviewed stated that services through the program are voluntary and members can close at any time without losing their housing.<br><br>The *PSHS Outreach Procedure* provided outlines steps PSH staff are to follow for missed | • PSH programs should include services to support members to attain and *retain* housing at their preferred intensity. PSH programs are designed for those with the most significant challenges to housing stability and retention, and who often need long-term service and supports.<br>• Coordinate with clinical teams to develop a plan for how to best support the member.<br>• Ensure all outreach efforts to members is documented in member records. |

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| | | | appointments and lack of contact. However, documentation of outreach efforts to the member or clinical team was not observed as outlined in five out of ten member records reviewed. One recently housed member was discharged due to lack of contact. With a high turnover rate of program participants in the past 12 months, it is difficult to see how the program supports members through engagement and retaining stable housing.<br><br>Some clinic staff interviewed were unsure if the PSH program has a standard service package that all members receive. One staff reported that members choose the services they receive and shared an example of a member seeking and obtaining housing, then receiving additional services from the PSH program to assist with maintaining their housing. One member interviewed reported that staff at the PSH program were assisting them with securing affordable housing and was not aware of any other services offered by the PSH program once housing is obtained. | |
| **7.3 Consumer- Driven Services** | | | | |
| 7.3.a | Extent to which services are consumer driven | 1 – 4<br><br>2 | RH staff interviewed reported an anonymous survey is provided to members at least once a year to obtain feedback on the general services provided by the agency. Staff advised attempts at holding groups and *lunch and learns* to help with gathering input from members were unsuccessful. One member interviewed reported completing a satisfaction survey with the RH program. RH staff reported that persons with lived psychiatric recovery are part of the PSH team. | • Explore opportunities that allow tenant/member input on service design and service provision. Member input can be obtained in many ways, such as interviews by peers and involvement in quality assurance activities, and information gathered is then used to inform service design decisions.<br>• Consider creating a survey specific to members enrolled in the PSHS program. Some programs deliver these to members |

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| | | | | during community visits and provide a sealable envelope to support participation with the assurance of anonymity. Consultation with other PSH providers on survey formats may be helpful. |
| **7.4 Quality and Adequacy of Services** | | | | |
| 7.4.a | Extent to which services are provided with optimum caseload sizes | 1 – 4<br><br>3 | At the time of the review, the program had 180 members and eight Housing Specialists for an average member to staff ratio of 24:1. Housing Specialists have a range of 12 – 29 members assigned to their caseload. One Housing Specialist carries a smaller caseload due to other duties assigned within the PSH program. | • Optimum caseload size for PSH services providers is 15 members to every staff, providing flexibility and responsiveness to support members in retaining housing. |
| 7.4.b | Behavioral health services are team based | 1 – 4<br><br>2 | PSH staff interviewed reported a summary of PSH services provided is sent to the clinics monthly. Based on RH PSH member records reviewed, all members had monthly summaries completed, however, none were located in the six member records reviewed from the referring clinics. RH staff reported initial coordination with clinical teams occurs when referrals are received. Contact with clinical teams ranges from several times a week to monthly. RH PSH staff reported turnover of staff at the clinic level has negatively impacted coordination of care efforts. However, staff stated recently it has improved slightly.<br><br>Staff interviewed at one clinic reported little coordination with the RH PSH program, indicating they may receive an email when a member is not engaging in PSH services, and denied receipt of monthly summaries. Staff at another clinic reported receiving monthly summaries from the PSH program, and emails from the PSH program weekly or monthly, varying on the situation with the member. | • 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 other documentation is encouraged if an integrated health record and integrated team cannot be implemented. |

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| | | | Most clinic staff interviewed could not identify services the PSH program offers to members other than assistance with housing search. Some clinic staff reported members seek clinical team staff to assist with the housing search process and coordination with the housing voucher holder even when assigned to the PSH program. This was observed in at least two clinic charts reviewed of case managers meeting with members several times a week to assist in housing search including making phone calls to a list of apartments the PSH staff provided to the member to complete, speaking with landlords, and coordinating with housing voucher holders. In addition, no documented coordination of care was located between the clinical team and PSH program.<br><br>Based on clinic and PSH records reviewed, there was little evidence of coordination between the PSH program and clinical team staff. In an approximate three-month timeframe, documentation of coordination of care made with clinical teams was located in four of ten PSH member records, averaging once a month. There was no coordination of care documented in three member records reviewed. One record had a documented call with the clinical team to request utility assistance, and in two member records the PSH program contacted the clinical team to inform a letter of engagement was sent and the members were discharged 10 days later. | |
| 7.4.c | Extent to which services are provided 24 hours, 7 days a week | 1 – 4<br><br>3 | Per the *Permanent Supportive Housing: PROGRAM DESCRIPTION* provided by RH staff; the program offers supportive services 24 hours a day seven days a week. Staff interviewed reported the PSH program hours are 8 – 5pm, Monday – Friday. PSH staff reported staff are available 24/7, with staff | • Ensure all members are informed of PSH staff on-call availability. Consider including the hours of PSH staff availability and how to contact PSH staff after hours on the program brochure. Members in the PSH program should be able to contact the |

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| | | | rotating the on-call responsibilities every two weeks. Staff reported rarely receiving after hours calls to assist members. Staff reported that clinical teams also offer after hours services and members seem to reach out first to the clinics when needed. RH PSH staff reported adjustment of hours to accommodate members after hours and on weekends when members request.<br><br>Clinic staff and members interviewed, were not aware that the RH PSH program has an on-call number to contact after hours and weekends. | program's on-call staff member as a primary resource in the event of a crisis. PSH staff may be better positioned to respond to and support members in the community, including outside of regular business hours, than staff from general crisis lines or from their clinics. |

**PSH FIDELITY SCALE SCORE SHEET**

| 1. Choice of Housing | Range | Score |
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| 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 | 4 |
| Average Score for Dimension | | 4.00 |
| 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 | | 4.00 |
| 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 | | 4.00 |
| 5. Rights of Tenancy | | |
| 5.1.a: Extent to which tenants have legal rights to the housing unit | 1,4 | 1 |

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| 5.1.b: Extent to which tenancy is contingent on compliance with program provisions | 1,2.5,4 | 4 |
| Average Score for Dimension | | 2.50 |
| 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 | 2.5 |
| 6.2.a: Extent to which tenants control staff entry into the unit | 1-4 | 4 |
| Average Score for Dimension | | 3.17 |
| 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 | 4 |
| 7.2.b: Extend to which services can be changed to meet the tenants' changing needs and preferences | 1-4 | 2 |
| 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 | 3 |
| 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 | 3 |
| Average Score for Dimension | | 3.00 |
| **Total Score** | | 22.67 |

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| **Highest Possible Score** | | 28 |