PERMANENT SUPPORTIVE HOUSING (PSH)
FIDELITY REPORT

Date: December 22, 2020

To: Ebbonie Montague, Program Manager
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AHCCCS Fidelity Reviewers

Method

On October 26-28, 2020, TJ Eggsware and Karen Voyer-Caravona completed a review of the Copa Health 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 the Central Region of Arizona.

The PSH program, Hope, was managed by Marc Community Resources, Inc. (Marc). Since the prior fidelity review, Marc Community Resources, Inc. merged with Partners In Recovery and is now known as Copa Health. Copa Health operates multiple outpatient treatment centers. Copa Health offers employment related services, day program activities, integrated health and residential services. At the time of review, the Hope program served 71 members, 63 of whom were housed.

In order to effectively review PSH services in Maricopa County, the review process also includes evaluating the working collaboration between the PSH provider and the referring clinics with whom they work to provide services. For the purposes of this review at Copa Health, the two referring clinics included were the Copa Health Arrowhead and East Valley campuses. These campuses were selected due to the relative high number of members served at those clinics and the Hope program. Due to the public health emergency, the review was conducted remotely, using video or phone contact to interview staff and members. Copa Health provided records which were reviewed starting November 10, 2020.

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

The reviewers participated in the following activities:

- Program overview discussion with the Hope Program Manager and the Site Administrator/Program Director;
- Group interview with three direct service PSH staff (i.e., Housing Specialists, Housing Navigators);
- Individual videoconference interview with the Housing Specialist (HS) from the Arrowhead campus;

- Group interview with the Housing Specialist, a Case Manager, and a Rehabilitation Specialist from the East Valley campus;
- Individual phone interviews with three members who are participate in the PSH program;
- Review of ten randomly selected records; and,
- Review of agency provided member housing information and a copy of the *Abridged (Family/Friend) Lease Agreement*.

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:

- Based on clinic staff interviews, members are supported to pursue the housing type of their choice.
- After intake to the Hope program, staff assists members to locate housing with consideration of the member's preference.
- The majority of housed Hope members live in settings where there is no overlap in housing management and PSH services, where tenancy is not linked to compliance with services.
- Based on data provided, the majority of housed Hope members live in integrated settings in the community.

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

- System partners should collaborate to establish, preserve and improve relationships with property managers over issues such as working with rent assistance programs, prospective tenant income requirements, and member background issues.
- To the extent possible, work with tenants who are paying over 30% of their income toward housing to find more affordable units, assistance programs, or employment to help mitigate their housing costs.
- Hope program staff should continue its efforts to track and obtain copies of housing documents. With current leases on file, staff will be better informed to guide tenants when/if issues arise. Seek to ensure all members reside in settings where they have legal rights to tenancy (i.e., a lease) in units that meet Housing Quality Standards.
- Educate staff and members on how choices of the services members do or do not select impact other services. For example, if terminating clinic services is allowed, discuss the potential impact on applicable subsidies and/or PSH services. Based on records and interviews, it appears some clinic staff and members perceive that the Hope program directly provides housing units and/or housing vouchers. Hope staff should continue to orient clinic staff on the scope of Hope services. Consider including that information on the agency website. If it does not already occur, orienting members to the scope of services prior to referral or during the intake to the Hope

program may also be helpful.

- The agency should evaluate its approach to offering what appear to be time-limited services that end shortly after members are housed. PSH is designed for members with the most significant challenges to obtain and retain housing. Data provided by Hope staff and records reviewed suggest that the program is time-limited, with a focus on assisting members to obtain housing, but not to retain housing. If possible, system partners should monitor at what rate Hope served members retain housing after discharge from Hope.
- 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, records, record systems, etc. Copa Health seems well positioned to move toward integration of PSH and clinic services for those members who receive both services from the same provider.

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 said that members choose the type of housing and support they want. A clinic staff affirmed that PSH is available to members to assist with finding affordable housing, so that they have a safe place to live, and can explore other goals in their lives. Based on interviews, it appears that clinic staff support members seeking independent housing rather than directing those members to treatment settings. Staff at one clinic said that there is zero-exclusion of members from seeking the type of housing they want. Based on clinic staff interviews, if members voice an independent living goal, clinic staff provides support and referrals to services like the Copa Health Hope program. Clinic staff discussed determining whether members can financially support their housing choice. A clinic staff said that the Hope program has limited ability to assist members who have no income.	
1.1.b	Extent to which tenants have choice of unit within the housing model. For example, within apartment programs, tenants are	1 or 4 4	Interviewees confirmed that PSH staff assists members to locate housing, prioritizing member preference. Hope staff said that they discuss with members their housing preferences and the types of housing available. Records reviewed showed evidence of Hope staff researching and providing members with housing options based on member preferences, such as area of town or their budget. Some members have fewer options due to high rent costs, limited income, prior criminal justice	• 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. • Educate property owners about the benefits of the Hope program. Advocate for income qualifications based on the tenant’s portion of the rent, and seek to ensure

	offered a choice of units		involvement, or whether housing management will rent to someone with a prior eviction. In a record reviewed, documentation showed that a Hope staff worked with a member to attempt to set a payment plan to address a recent eviction, but the property management did not allow a payment plan. Hope staff said that after intake, they assist members to apply for voucher programs. Some waitlists are a year or more. Members said that Hope staff discussed housing goals and that Hope staff assisted them to apply for housing subsidy lists. Staff at a clinic said that members often have an idea of what area of the community they want to live. Staff said that members can select from units in the community that accept their voucher or are in the member's budget. Based on records reviewed, Hope staff's ability to support members has been impacted by the public health emergency, such as restrictions on most face-to-face contact. Hope staff or members may not be able to meet with property management or must have an appointment to view units.	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 3	Hope staff said that members can decline housing options offered, and that the program will continue to work with them. Staff at one clinic said that for housing through the Regional Behavioral Health Authority (RBHA), members can decline up to two times and stay on the waitlist. Staff said that RBHA staff track the reasons members decline a housing option. Although the majority of Hope PSH members do not receive a subsidy, it is unclear to what extent the management of the RBHA waitlist impacts Hope members. Staff at one	• System partners should inform staff and members if members can decline housing options without losing their place on waitlists. • Hope staff should continue to educate potential members and clinic staff that the Hope program does not directly provide subsidies and does not have housing placements.

			clinic voiced their frustration that they cannot provide to members an estimated wait-time for how long members might be on the RBHA affiliated housing waitlist. Based on records reviewed, some members and clinic staff believe that there are units or subsidies available within the Hope program.	
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	Hope staff reported that members determine the housing composition. Staff at one clinic said that housing providers require clinic staff approval if members with vouchers want to add someone to their lease. In those cases, the person that the member wants to add to their lease must pass financial and background checks but clinic team provides approval that the person added to the lease will not be problematic. Hope members who receive a subsidy may need approval if they want to add someone to their living situation. About 13% of members are in settings where there may be program control over housing composition.	• If tenants ask to have someone join their living situation, staff can discuss with the member the pros and cons of adding someone to their living situation. Clinic team approval should not be required, whether or not they receive a subsidy. Empower and advocate for members' self-determination in choosing the composition of their households. • Support members in treatment or transitional settings to locate independent housing if that is their living situation goal.
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	Staff interviewed said that property managers do not have any role in providing clinical or social services to members. PSH staff said that the agency has a housing management branch, but that the housing management staff does not provide social services. Of 63 housed tenants, eight, or about 13%, reside in settings where there may be overlap between housing management and service staff affiliated with the residence, such as half-way-houses, community living placement (CLP) or group homes.	

2.1.b	Extent to which service providers do not have any responsibility for housing management functions	1, 2.5, or 4 4	Clinic and Hope staff said that they provide services only and have no housing management role. Staff does not collect rent and are not tasked with reporting lease violations. If there are concerns with tenants' behaviors that could impact their housing, staff provide education and support. About 13% of tenants reside in settings where there may be overlap between housing management and service staff affiliated with the residence, such as half-way-houses, CLP, or group homes.	
2.1.c	Extent to which social and clinical service providers are based off site (not at the housing units)	1 – 4 4	Most housed members are in settings where social service staff are not on-site. Copa Health clinic and Hope staff do not have offices at the locations where members reside. About 13% of members reside in settings where staff affiliated with the residence may be on-site regularly, such as such as half-way-houses, CLP with staff, or group homes.	
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	Staff said that there is a limited supply of affordable housing in the community. For example, staff said that fewer units are available with utilities included. Staff and a member interviewed said that housing management at some locations require at the time of application proof of income to cover up to three month's rent, which disqualifies many potential tenants. As a result, true housing costs exceed what members with limited income can afford. Staff interviewed reported that all tenants of subsidy voucher units pay 30% or less of their income in rent. Nearly 24% of Hope members receive a subsidy. Most of the 18 members who	• 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.

			reside with family or friends pay none of their income toward housing costs according to data provided by Hope staff. Of the 63 housed members, 25 pay more than 30% of their income toward housing costs. About 25% of housed members pay more than 50% of their income toward housing costs. Clinic and PSH staff said that members with no income have few options. Staff said that voucher program waitlists can be a year or more. Staff reported that members with no income are encouraged and supported to apply for benefits or to seek employment in order to obtain an income.	
3.2 Safety and Quality				
3.2.a	Whether housing meets HUD's Housing Quality Standards	1, 2.5, or 4 1	Hope staff reported that 15 of the 63 housed Hope members have current HQS. The data provided by Hope staff shows that they have on file current HQS for most members who receive a voucher, but not for members with no subsidy. About 73% of the current housed Hope members do not receive a subsidy.	• 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	Based on data provided by Copa staff, the Hope program serves 71 members as of the date of the review. Of the 71 members, 63 are housed. The majority of the housed members reside in integrated settings. Most of the tenants reside in an independent residence, with friends or family. About 14% of housed members reside in non-integrated settings, including half-way-houses, CLP, or group homes. Staff said some members have fewer housing options. Factors that can contribute to	

			unintentional clustering include cost of housing, the decreasing number of landlords who accept vouchers, or locations that do not rent to those with a history of legal system involvement or evictions. Even with these factors, based on data provided by Copa staff, few Hope tenants live in the same apartment complexes.	
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	Hope staff reported that the program has on file current leases for 17 of the 63 housed members. Staff interviewed said that prior to the public health emergency; Hope staff accompanied members to lease signings and obtained copies. Based on data provided, about 10% of housed members are in settings where they likely do not have a standard lease, such as half-way-houses or group homes. About 26% of housed members live with friends or family. Hope staff said that they engage those members and the owner of the residence to complete an *Abridged (Family/Friend) Lease Agreement*, but that only about 20% of applicable members, and few family or friends, are willing to enter such an agreement.	• Maintain complete and accurate records of leasing information for at least 90% of tenants in all settings. • Continue efforts to educate members, and their family and friends with whom they reside, of the benefits and protections the written housing agreement may offer. Living with family does not guarantee rights of tenancy. • Review and track leases and term end dates so that PSH staff can plan with tenants to renew their lease, and to understand their lease conditions.
5.1.b	Extent to which tenancy is contingent on compliance with program provisions	1, 2.5, or 4 4	Clinic and Hope staff said that tenancy is not contingent on members complying with program provisions. Staff at one clinic said that they discuss with members potential lease infractions (e.g., excessive foot traffic). Based on housing information provided by Hope staff, the majority of housed members are in settings where their housing is not contingent on adherence to clinic, Hope, or residence program rules, such as independent living, or living with family or friends.	• Continue efforts to assist members who reside in transitional or treatment settings to explore their independent living options, if that is their goal.

			About 11% of housed members are in settings where there may be program provisions not found in a standard lease, where they do not have a standard rental agreement.	
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 4	Clinic staff said that members who state that they want their own residence can be referred to PSH services. Clinic staff said that they assess if the member has the financial resources to sustain housing. Staff at one clinic reported that members who need or want assistance with locating a new residence, moving locations, or those experiencing issues with a landlord are referred to the clinic HS. The clinic HS determines if the member's paperwork is up to date. The member's annual comprehensive assessment, treatment plan and At Risk Crisis Plan are required to be updated. The clinic HS makes the referral to the PSH provider. Clinic staff said that due to the public health emergency, they do not attend the member's intake to PSH services in-person. Clinic staff interviewed are familiar with a *housing-first* approach. One staff said that PSH assists members to obtain safe housing so that they can focus on other goals. Another staff said that even with voucher programs, if a member was known to be struggling with substance use, it does not disqualify members from receiving the subsidy. Clinic staff said that ideally, members with an income are candidates for Hope services. There was no indication that the Hope program imposes readiness standards prior to members receiving PSH services.	

6.1.b	Extent to which tenants with obstacles to housing stability have priority	1, 2.5, or 4 4	It appears PSH is available to members who request the support. Clinic staff said that members do not need to be homeless to receive PSH services. Clinic staff reported that they can refer members to PSH services and the providers can assist members to apply for housing voucher programs. Clinic staff reported a barrier to members obtaining housing is lack of income. The RBHA website differentiates who can access housing subsidies and PSH services. Per the RBHA website, "housing subsidies are available to homeless adults who have been determined to have a serious mental illness and are enrolled members of Mercy Care RBHA." Under the PSH section, the RBHA's website indicates that supportive services are available to enrolled Mercy Care RBHA members who are at risk of losing their home or need additional help to keep their housing. Staff at one clinic said that either the HS or the CM completes the Vulnerability Index – Service Priority Decision Assistance Tool (VI-SPDAT). It appears access to subsidies is prioritized, using VI-SPDAT information and whether members are unhoused.	
6.2 Privacy				
6.2.a	Extent to which tenants control staff entry into the unit	1 – 4 4	Clinic and Hope staff said that the tenants control entry to their units. The majority of housed members reside in independent housing, with friends, or family. About 13% of housed members are in settings where staff affiliated with the residence may have varying levels of access, including half-way-houses, staffed CLP, or group homes.	• Continue efforts to assist members who reside in transitional or treatment settings to explore their independent living options, if that is their goal.
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	In the records reviewed, members had a clinic treatment plan completed in the 12 months prior to the review. The goals seemed to be written using members' words, with some variability in needs and/or objectives. The plans generally identified housing and/or the plan to refer to a PSH service provider.	
7.1.b	Extent to which tenants have the opportunity to modify service selection	1 or 4 4	Clinic staff said that they update member plans when they experience a significant change in status or request a new service. Two of the three members interviewed said that they did not have a treatment plan with their clinic provider. It is not clear if the lack of clinic treatment plans impacts other Copa PSH members.	• Tenant service plans should be updated whenever there is a significant change in the tenant's life situation or goals, needs, and/or objectives.
7.2 Service Options				
7.2.a	Extent to which tenants are able to choose the services they receive	1 – 4 3	Members and staff interviewed said that members choose the services they receive. The members interviewed said that their goals are to obtain independent housing. The members confirmed that Hope staff helped them to apply to at least one housing list. One of the three members interviewed said that they did not have a treatment plan that they were aware of with the Copa PSH program. The Hope Integrated Service Plans were similar member-to-member. The goal to obtain housing usually referenced one to two member attributes, such as courage, knowledge, or patience. Documented Hope services in records reviewed include discussing housing preferences with members, assisting to secure identification documents needed for lease applications, providing housing leads to members, and securing	• 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. • Educate 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.

			move-in items and furniture. Documentation showed that Hope staff has the expectation that members will independently search for housing. Hope staff asked members about their independent housing search, based on leads provided by staff. Hope staff also conducted searches on behalf of members. Clinic staff said that members must continue clinic services if they receive a RBHA affiliated subsidy. Staff at one clinic reported that members must continue with clinic services in order to retain PSH services. Staff at one clinic was unsure if members needed to continue clinic services to retain PSH services.	
7.2.b	Extent to which services can be changed to meet tenants' changing needs and preferences	1 – 4 2	Clinic staff said that PSH services can help members obtain and move-into new residences. Clinic staff referenced move-in assistance funds, through the RBHA, that PSH staff can help to secure. However, Hope staff said that they are no longer allowed to directly submit requests to the RBHA. Two of the members were uncertain of the scope of Hope services. The members interviewed joined the Hope program four to six months prior to the review. Based on data provided by Hope staff, all of the 71 members joined the program from December 2019 through October 2020. Based on records reviewed, Hope staff generally made frequent contact with members seeking housing. There were exceptions to staff making regular contact with members. For example, there were lapses of a week or more with no documented outreach in some records, and nearly two months lapse in outreach for one member. Based on records	• Copa Health should continue evaluating aspects of their current model that appear to promote the expectation of time limited services and graduation soon after members are housed. PSH services should include services after members are housed. Services should be available to support members to attain and retain housing. 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 at their preferred intensity level. • Consider providing to staff additional training on how to engage members to address other areas of vulnerability, concern, or prior issues that led to eviction or homelessness.

			reviewed, Hope staff proposes discontinuing services soon after members are housed. Hope staff said that, due to the public health emergency, staff educated members on safety and worked to adjust services to meet members' needs, with their health and safety in mind. Hope staff said that face-to-face services are generally suspended, unless necessary to conduct an intake if the member prefers to meet in-person. Services have occurred over the phone and via telehealth. One of the three members interviewed affirmed that telehealth service was flexible and one said it was helpful.	
7.3 Consumer- Driven Services				
7.3.a	Extent to which services are consumer driven	1 – 4 2	Hope staff affirmed that multiple employees of the program have direct lived experience of psychiatric recovery. Hope staff said that they facilitated at least quarterly member forums prior to the public health emergency, but those are on hold. Staff said that member participation ranged from a few members to eight to ten, per forum. Copa Health conducts general surveys quarterly, per Hope staff report.	• Explore additional ways 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. • Explore options to facilitate member/tenant forums using videoconference and/or conference calls so that members can voice their concerns and desires for program design. • Offer members an opportunity that allows them to anonymously submit questions, concerns, and suggestions for program improvement. For example, determine if a program specific survey can be implemented.
7.4 Quality and Adequacy of Services				

7.4.a	Extent to which services are provided with optimum caseload sizes	1 – 4 4	At the time of the review, the program served 71 members based on data provided by Hope staff. The ratio of members to staff is about 13:1. The Program Manager oversees the Hope PSH and Supportive Housing and Permanent Employment (SHAPE) programs. Staff said that six staff provide direct services, one of whom is transitioning from the SHAPE program and continues to serve six members from that program. A seventh staff joined the Hope program but has not assumed a caseload. Staff said two of the six Hope staff carry caseloads of 16 members.	• Maintain caseloads of no more than 15 members per staff.
7.4.b	Behavioral health services are team based	1 – 4 2	Members receive their psychiatric care from clinics/campuses, where some also receive integrated health services. Hope staff assist with the housing search and services to maintain housing. Members may also receive services from other providers or other programs at Copa Health. Providers maintain separate service plans and records. Clinic staff said that prior to the public health emergency; clinic staff accompanied members to their Hope intake. Clinic services and Hope services are both managed by the Copa Health for nearly 58% of the current roster. However, even for those members it does not appear full integration has occurred. Members are served by staff from different branches of Copa Health. For members who receive Copa Health clinic services, two different Integrated Service Plans were located in the records reviewed; a plan completed by clinic staff and a plan completed at intake to the PSH program. Staff said that member records are not fully integrated, but that the agency is moving toward integrating member records. Monthly summaries and documentation that they were	• Optimally, behavioral health services should be provided through an integrated team. With separate sets of staff at each branch of Copa Health, there are barriers to integrated service, including maintaining separate record sets, with possibly redundant information. • Copa Health staff should explore if an integrated service plan can be developed so that members who receive clinic and Hope services from Copa have one unified plan. This may result in all involved service staff contributing to the same comprehensive plan. • Staff should obtain input from each other when modifying plans if an integrated plan is not an option. Share updated plans when completed. This collaboration may prompt staff to revise plans at their program when members have a change in status and raise awareness of stated goals.

			sent to clinic staff were found in Hope records reviewed. The summaries include the member's Hope service plan information. One clinic staff said that having PSH in the same agency resulted in improved coordination between PSH and campus staff, including Hope staff informing campus staff of a member's change in status or emerging need. The staff reported frequent coordination with Hope staff, by phone or email. Other clinic staff reported frequent coordination, around the time of referral and intake, but infrequent updates by Hope staff after program admission. It was not clear if clinic staff informs Hope staff of members' statuses. An example was found in a record of a member who transferred clinics, but documentation did not seem to indicate if Hope staff was informed prior to the change. In another record, Hope staff was informed of a member's hospitalization by the member's informal support. Hope staff also learned that a treatment placement application was submitted for the member.	
7.4.c	Extent to which services are provided 24 hours, 7 days a week	1 – 4 4	Hope staff said that after hours services are available. The Hope staff rotates coverage of an on-call phone monthly. If needed, the Hope Program Manager is available to triage calls. Staff said that prior to the public health emergency, service staff could respond to members in the community if a crisis arose after hours or over the weekend. Staff said that they provide the on-call information to members at the Hope program intake.	

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	3
1.2.a: Tenants have control over composition of household	1,2.5,4	2.5
Average Score for Dimension		3.38
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	4
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		4
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	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	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		3.13
Total Score		23.01
Highest Possible Score		28