Optimizing HMIS Applications For Centralized Intake

White Paper

CLARITY
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1. EXECUTIVE SUMMARY

The U.S. Department of Housing and Urban Development (HUD) changed the terrain of homelessness services with the 2014 implementation of the Centralized Intake and Coordinated Assessment requirement. Each Continuum of Care (CoC) is now mandated to adopt the significant policy changes that this requirement enforces.

As such, CoCs nationwide have worked tirelessly to update their service processes to meet these requirements. CoCs have determined the most appropriate Centralized Intake and Coordinated Assessment (hereafter referred to as Centralized Intake) model for their communities. They have selected lead agencies, established planning committees, mapped out existing assessment and intake processes, and identified the prevention and diversion resources that should be available at their coordinated assessment center(s).

This flurry of preparation has subsided, but a central question remains: *How to optimize a Homeless Management Information System (HMIS) for Centralized Intake?*

For many CoCs, minimal attention was allotted to the preparation of their HMIS during the Centralized Intake planning phase. In many instances, this marginalization was due to the common belief that HMIS applications are by default static, rigid, and inflexible systems – and these systems cannot be molded to meet every nuance of Centralized Intake.

As a result, many communities found themselves planning their Centralized Intake systems around the limitations of their HMIS, often compromising key process innovations under the assumption that their HMIS application could not support the process improvements. For far too many CoCs, the HMIS application is a barrier to basic service provision, as opposed to being a powerful tool for innovation. This does not have to be the case, however.

In reality, CoCs can have the ability to customize their HMIS application to fit innovative changes to service provision; an HMIS application can be an advantageous Centralized Intake tool as opposed to an unsurmountable barrier.

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Purpose

The purpose of this White Paper is to present the concept of the HMIS in a different light. More specifically, the remainder of this paper discusses the role of software usability, and its capabilities to transform the HMIS application in ways that enhance a CoC's ability to meet the requirements of Centralized Intake.

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2. CENTRALIZED INTAKE

Ultimately, the primary goals of a Centralized Intake system are to simplify service access, track system outcomes to inform and enhance decision-making, and improve overall system efficiency. The HMIS plays a central role in Centralized Intake, but in order to comply with the requirements, HMIS applications must meet four key challenges:

1. Assess

Support features and functionality that support comprehensive standardized assessment functionality, including a standardized assessment tool, to determine program eligibility.

2. Assign

Automatically generate accurate and timely referrals according to the eligibility criteria established by the CoC.

3. Monitor

Monitor Program- and System-Level Outcomes; Data Quality; Data Security and Privacy.

4. Evaluate

Process performance targets (as established by the CoC) to measure performance, evaluate outcomes, and meet all official HUD requirements for performance measurement.

HMIS applications that meet these four requirements will bolster CoC efforts to provide the advanced levels of service provision required to earn the HUD designation of a high performing community. While one subsequent result is increased funding, a more important result is the ability to connect clients with the services they need in a swift, organized, and standardized manner.

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2.1 Assess

Requirement: CoCs must develop features and functionality that support a comprehensive standardized assessment method to determine program eligibility.[1]

Client assessment lies at the heart of all efforts to end and prevent homelessness. HMIS software must support comprehensive assessment measures that ensure accurate and swift client placement. These assessment tools must enable CoCs to foster a 'housing- first' approach, as opposed to a 'first-come-first-serve' method, which has proven itself ineffectual.

Solution: An HMIS must support a robust assessment system that is tailored to Centralized Intake. This assessment system should support both general assessment measures as well as a standardized assessment tool designed specifically for Centralized Intake. This is accomplished via two HMIS tools: An Eligibility Determination Engine and a Standardized Assessment Tool. Each are discussed below.

2.1.1 Eligibility Determination Engine

Eligibility Determination Engine technology makes Centralized Intake simple and intuitive. This logic engine should be fully customizable, allowing for eligibility determination based upon the Centralized Intake requirements per HUD. Other important information, such as Area Median Income (AMI) and Poverty Guidelines should also be implemented to streamline intake and assessment, as well as any other determination criteria specific to the CoC. Additionally, this Eligibility Determination Engine should be completely integrated with a referral management queue to allow for a truly seamless Centralized Intake system.

[1] *(CoC Program Interim Rule 578.7 (a)(8),(9) and 578.23 (c)(9))*

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2.1.2 Standardized Assessment Tool

A standardized assessment tool that is utilized on a system-wide basis is required for effective Centralized Intake. CoCs should choose their standardized assessment tool based on four selection criteria: evidence informed, criteria driven, accurate, and user-friendly. The VI-SPDAT is an example of a standardized assessment tool that meets these criteria:

Evidence Informed

Both the Vulnerability Index (VI) and the Service Prioritization Decision Assistance Tool (SPDAT) are backed by extensive research. The VI stems from medical research, and the SPDAT is the result of years of research into the social factors associated with homelessness. The result is a highly valid evidence-based tool to inform professionals in the field.

Criteria Driven

The VI-SPDAT is composed of four domains, each encompassing a category of factors contributing to homelessness: 1.) History of Housing and Homelessness, 2.) Risks, 3.) Socialization and Daily Function, and 4.) Wellness. Each domain is designed to uncover specific homelessness risk factors in order to create a comprehensive constellation of factors that are unique to the client.

Accurate

The VI-SPDAT consistently matches clients with the appropriate intervention and levels of assistance in order to make meaningful recommendations for housing and services. This consistency is achieved across demographics and geography.

User-Friendly

The VI-SPDAT is a brief assessment that is easily administered, even by non-clinical staff. Its verbiage is easy to understand by those being assessed, and it fosters clear communication and trust between caseworker and client.

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2.2 Assign

Requirement: The HMIS must have the capacity to automatically generate a accurate and timely referrals according to the eligibility criteria established by the CoC.[2]

Solution: The HMIS should have a substantial portion dedicated to the referral process. It should be fully customizable with the features listed in the following table.

2.2.1 Fundamental HMIS Features For Referral Processes

Powerful Eligibility Determination Engine to allow for seamless transitions between each step of the intake, assessment, and referral process.

Interactive and fully customizable dynamic assessments, including a standardized assessment tool designed specifically for Centralized Intake.

Customizable database field designer and screen editor that allow the System Administrator to easily create targeted assessments that accurately depict client need and status.

Customizable and completely secure **cross-agency data sharing capabilities** as well as programs customizable with requirements.

Functionality that allows the user to **automatically refer clients to eligible programs while simultaneously making bed/unit reservations, tracking communication, and tracking approvals/ denials** through an integrated interface with the ability to securely communicate with other agencies.

The ability to **review real-time housing program availability before referral** with real-time bed/unit availability numbers plotted and graphed.

In-system referral communication system that provides **secure email-based and internal system-based messaging** to document referral communication.

Sophisticated **waitlist maintenance functionality**, including Community Queue functionality for referral processes.

Fully mobile platform that is designed to enhance outreach, and allow for mobile eligibility determination and referral.

[2] *((CoC Program Interim Rule 578.7 (a)(8),(9) and 578.23 (c)(9))*

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2.3 Monitor

Requirement: The HMIS must monitor Program- and System-Level Outcomes; Data Quality; Data Security and Privacy.[3]

Solution: The solution to these challenges lies in sophisticated reporting capabilities. The HMIS must be equipped with a Report Library featuring multi-tiered drill-down functionality for any data element to provide sub-report details of the underlying data that make up the total. This effectively provides advanced auditing techniques. All reports must be generated from real-time data.

2.3.1 Centralized Intake Reports

- CoCs should have reports dedicated to Centralized Intake. Examples include a Housing Census Report that can be run at any time for any date range to detail bed/unit utilization. In addition, a Housing Inventory Report should be available to provide details on housing services within the implementation for HIC comparison. Weekly and monthly housing reports should also be available for the purposes of utilization review. (Note that these reports could also be used for purposes other than Centralized Intake.)

2.3.2 Reports for Program and System Outcomes

- Reports that measure client cash and non-cash benefits present at time of exit from mainstream programs as well as for the CoC.
- Reports that measure housing outcomes for transitional housing and permanent supportive housing programs.
- Obtain information on program participation duration for active and inactive clients, while also gathering data quality scores for the chosen program.
- Obtain program outcome information that includes program client exit information, housing status of exited clients, and efficiency/process measures. It also should provide agency participation totals, and unduplicated counts of clients exited from either each program category and/or collectively.
- Measure the amount of clients placed into selected housing services for specified dates and timeframes.

[3] *(CoC Program Interim Rule 578.7 (6); 578.39 (c); and 578.103 (1)(ii))*

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2.3.3 Data Quality Control Functionality

- Data quality control data elements and fields that control user access based upon customizable access roles and customizable sharing rules.
- HMIS metrics reporting.
- Multiple reports measuring data quality.
- Built-in automated security and privacy data elements.

2.4 Evaluate

Requirement: The HMIS must be able to process performance targets (as established by the CoC) to measure performance, evaluate outcomes, as well as meet all official HUD performance measures.[4]

Solution: Performance measurement is crucial to system planning. It holds CoCs accountable for funding decisions and ensures that resources and services are coordinated in ways that foster the principles of Centralized Intake.

An effective HMIS that is prepared for the rigors of Centralized Intake should be equipped with built-in standard HUD reports and forms. Examples include the Annual Performance Report (APR), the Annual Homeless Assessment Report (AHAR), and the Supportive Services for Veterans (SSVF) Activities report. In addition to reports designed specifically to measure program performance, the HMIS should also contain numerous program- and system-level performance reports that capture performance from all angles.

[4] *(CoC Program Interim Rule 578.7 (a)(6) and (7); McKinney-Vento Homeless Act as amended by S.896 the HEARTH Act of 2009, Section 427 (b)(1)(a))*

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3. USABILITY & THE HMIS

Organization planning is of paramount importance to establishing an effective service provision structure for Centralized Intake; however, software lies at the heart of this service provision structure. The interaction between the software and the end user must foster fluid service provision as opposed to impeding it, or even inhibiting it all together. As such, end users must be able to interact with the HMIS application effectively in order to establish and maintain a cohesive, streamlined service provision for Centralized Intake.

This productive interaction between the HMIS and the end user is fully dependent upon one thing: Usability.

3.1 Fundamental Characteristics of a User-Friendly HMIS

The following are characteristics of a user-friendly HMIS that is successfully optimized for Centralized Intake:

User interface usability

Successful HMIS applications have interactive design and HTML/AJAX technology that enables an easy user experience, which in turn decreases resource utilization on the part of the CoC (e.g. system training and technical support).

Information process flow

Successful HMIS applications offer intersystem communication features (e.g. messaging, email, etc.), customizable share settings, and customizable access roles to streamline communication processes, lending to standardized operations. This also decreases task redundancy and eliminates paper processes.

Information quality

Successful HMIS applications have data quality assurance features, data quality/ auditing reporting capabilities, and system usability that lead to high quality data, which, in turn, results in increased funding potential and an accurate portrait on the scope of homelessness from all angles.

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Alignment of human computer interaction with users' skills

The interface of a successful HMIS applications is easy to master, even for end users with only modest computer abilities. This simplifies activities where minimal time can be allotted to training (e.g. data entry conducted by volunteers).

Perceived usability

Simply stated, successful HMIS applications should be unintimidating. This increases user engagement and confidence, allowing end users to focus on client services without the hindrance of software concerns.

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3.2 Four Components of Usability

When it comes to HMIS software, usability stems from a constellation of four components, each vital in their own right:

1. Interactivity
2. Automation
3. Customization
4. Mobile Technology

Each of these are discussed in the following sections.

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4. INTERACTIVITY

4.1 Interactivity For Usability

In regards to HMIS software, design focus should be centered around the concept of interactivity; a dynamic interface with interactive features creates a fluid end user experience.

To begin, an HMIS that is optimized for Centralized Intake is one that requires minimal resource utilization. Technology such as HTML5/AJAX will reduce resource requirements and server load, which allows for quick page loading and swift processing with less network and server resource utilization. This, in turn, leads to decreased user request latency, resulting in efficient and frustration-free end user experience. These features alleviate all technical burden from the end user, allowing them to focus on interpersonal dynamics as they work to determine the client's needs.

An optimized HMIS application should also be able to fetch data from the server without refreshing the entire page. This allows appropriate and relevant data fields to be dynamically loaded and added to the page as necessary in response to user actions. This type of functionality is particularly effective during client intake, program enrollment, and assessments.

For example, during intake screening, a client might indicate that they have Veteran status. In an HMIS that is optimized for Centralized Intake, the screen should automatically populate with Veteran-specific questions without the user needing to switch screens to find a Veteran-specific form. These Veteran-specific questions should only appear on the screen if Veteran status is 'yes'. The same functionality can be applied to gender; when a client defines herself as female, the screen should expand to include questions regarding pregnancy status (this should occur only for age appropriate clients).

Examples of interactive features include:

- Tooltip integration
- Real-time data entry
- Auto-complete functionality

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Example: Tooltip Integration

HMIS interfaces that offer tooltip explanations are exceptionally beneficial when it comes to Centralized Intake. With tooltip integration, a user can mouseover a data field and a popup box will appear offering a short explanation of the data field. This enhances user understanding, improves data quality, and streamlines intake processes.

Scenario:

A volunteer is entering data into the HMIS application when they come across a data element with which they are not familiar. Two common scenarios would typically unfold: a.) The volunteer has to interrupt their data entry in order to seek assistance from a caseworker, or b.) The volunteer enters the data incorrectly, resulting in inaccurate reporting.

Tooltip integration usability feature enables the volunteer to learn the meaning of the data element. They can then seamlessly continue their data entry tasks, saving time while also maintaining data integrity.

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Example: Real-Time Data Entry

HMIS applications that are developed with HTML5/AJAX based technology are equipped with real-time data intake functionality, which enhances service provision (e.g. non-duplication of services, immediate documentation of expense items, etc.), streamlines referral processes, and allows for accurate bed availability information for precise reservation management.

Scenario:

During an outreach assignment, a caseworker encounters a homeless single mother with two young children. It quickly becomes apparent that the family needs immediate shelter. The caseworker uses a mobile device to reserve a unit with three beds at the emergency shelter for that evening, and assures the mother that she and her children will have a warm place to sleep as well as a hot meal that night. However, once the family arrives at the emergency shelter, they learn that their reservation was not confirmed. Because the HMIS was not updated in real-time, the caseworker was unable to see that the unit she reserved was actually already reserved – the information had not yet been updated in the system when the caseworker made the reservation.

Real-time functionality eliminates the possibility that such a disruptive event can occur. A reservation system that updates in real-time will immediately update bed/unit availability information, thus eliminating risk of 'double booking'.

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Example Auto-Complete Functionality

AJAX autocomplete toolkits/widgets allow for auto-complete functionality, making client search easy and accurate. For example, a client record can be located easily if the user is unsure of the exact spelling of a client's name. This feature can also detect instances of duplicate entry.

Scenario:

Client Jaymes Smith enters the emergency shelter. A caseworker begins to search the database for the common spelling of the name: "James Smith". However, unbeknownst to the caseworker, the client has already been entered into the system under "Jaymes Smith". The common result of such a scenario would be a duplicate file for the same individual, one with the name James Smith, and the other with the name Jaymes Smith.

The auto-complete functionality feature eliminates this risk of duplication. The caseworker would have seen the alternative spelling of the name ('Jaymes') within the dropdown below the search box. They would then have the opportunity to clarify the spelling with the client, and subsequently enter the new client information into the correct client record. This preserves data integrity, decreases time and resources lost to troubleshooting, and contributes to accurate reporting.

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5. AUTOMATION

5.1 Automation for Usability

Referral and assessment are mission-critical core processes that are complex and event-driven; an HMIS that automates these processes will foster productive Centralized Intake. For the purposes of Centralized Intake, assessment and referral processes must operate automatically and in tandem. In order to understand the role of automation in service provision, it is critical to first discuss the best practices for homeless services.

5.2 Best Practices for Homelessness Services

To begin, best practices for homelessness services can be divided into two categories:

- **Large scale best practices:** These pertain to the primary segments of the homeless population.
- **Service-oriented best practices:** These govern the effectiveness of service provision.

5.2.1 Large Scale Best Practices

Reducing homelessness in any client community requires successful deployment of evidence-based Centralized Intake strategies that are tailored for the primary homeless subpopulations.

Large-Scale Best Practices include:

- Permanent Supportive Housing coupled with supportive services (Chronically Homeless).
- Transitional Housing and Rapid Re-Housing (Homeless Families).
- Intervention services, housing options, and supportive services (Unaccompanied Homeless Youth).

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Achieving these high level best practices for Centralized Intake requires strategic automation of the assessment and referral processes.

HMIS Solution: Experts in the HMIS industry should be the ones to drive the development of any HMIS. Their expertise makes it easy to precisely configure automated features that streamline the assessment and referral processes, thereby enabling the CoC to meet these large-scale best practices

5.2.2 Service-Oriented Best Practices

The success of the large-scale best practices is dependent upon strategic orchestration of individual service provision tasks (e.g. client intake, assessment, referrals, etc.). This is made possible by applying the concept of automation to best practices for homelessness service provision.

The following are essential best practices for preventing and ending homelessness, as set forth by the National Alliance to End Homelessness.[5] They identify effective permanent solutions to homelessness that are supported by research and grounded in practical experience.

Best Practice: Data

First and foremost, in order to maintain productive Centralized Intake processes, CoCs must be able to utilize data to understand the scope of homelessness in their service population.

HMIS Solution

Through the use of automated data quality tools and outcome reporting features, the CoC can fully and accurately understand the strengths and weaknesses of their Centralized Intake service infrastructure. Such automation also unveils the characteristics of their service population, as well as the antecedents of homelessness in their community.

[5] *http://www.endhomelessness.org/pages/ten-essentials*

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Best Practice: Emergency Prevention

The most economical and efficient way to end homelessness is to prevent it from happening in the first place. CoCs must be able to maximize bed utilization, generate relevant and timely referrals, and optimize outreach services.

HMIS Solution

Automated attendance-based data entry features allow CoCs to track services provided through their emergency shelters, such as meals, showers, etc. Additionally, mobile functionality enables caseworkers to manage referrals and make reservations for treatment or shelter while they are in the field. ID cards & biometrics should also be included among this solution.

Best Practice: Systems Prevention

In communities nationwide, persons fall into homelessness after release from state-run institutions (e.g. jail, prison, foster care system, etc.). Still others come to homelessness from mental health programs and other medical care facilities. CoCs must be able to create a clear path to housing from such institutions in their community through automated assessment and referral processes.

HMIS Solution

The implementation of an integrated and automated referral and assessment system removes service barriers. In turn, these processes can be monitored through performance and outcome measurement.

Best Practice: Outreach

CoCs require the ability to integrate outreach efforts in order to connect their homeless population to housing and services. Many people living on the streets exhibit mental illness, substance addiction, and other patterns that require automated real-time assessments and referrals.

HMIS Solution

An HMIS with fully automated and mobile capabilities allows for real-time assessments and referrals for caseworkers in the field. Additional convenience features should be included, such as finger signature and mobile geo-location integration to further streamline outreach services.

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6. CUSTOMIZATION

6.1 Customization for Usability

While the ultimate goal of Centralized Intake is streamlined and enhanced service provision, getting to this utopic point is a challenge, and often this challenge originates between the end user and the HMIS. However, when CoCs are equipped with a *customizable* HMIS, they can overcome the barriers to service, and ultimately fulfill the expectations enforced by HUD.

Customization and usability share a symbiotic relationship – one cannot exist in the absence of the other. In order for an HMIS to be user-friendly, it must be easy to customize in ways that fit the needs of the CoC. Likewise, each element of the HMIS must be fully customized in order for it to be relevant and highly intuitive to the end user. As such, a customizable HMIS offers CoCs endless opportunities to adapt each aspect of service provision to meet their needs.

Many HMIS applications in the Human Services arena claim customizability, and rightfully so in most cases. However, the customizability they claim is often static in nature – meaning that the HMIS is indeed customizable, but only to its developers. That being said, there is one distinguishing factor that separates static customizability from true customizability - the element of autonomy. Customizability loses its value if the System Administrator must rely heavily upon IT staff, or even their HMIS vendor, to customize their system. Nobody knows service needs better than the System Administrator. Thus, it is infinitely important that they be empowered to customize their own system with minimal guidance from outside resources. Therefore, an effective HMIS, one that can withstand the demands of Centralized Intake, should be built with autonomous end-user customization in mind.

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6.2 Requirements for HMIS Customization

In order to promote usability, the following HMIS elements and service processes must be fully customizable in the following ways:

ACCESS/SHARING & SECURITY

- Agency Sharing Rights and Exceptions: Manage agency data sharing policies and grant 1 to 1 sharing exceptions at the agency, department, program, and end user levels.
- Access Roles and Rights: Ability to create and manage access roles at a granular level. This limits users to gain function to only the areas of the system that their role provides them.
- User Setup and Management: Create new users, edit existing users, reset passwords, disable users, manage client PKI certificate, manage IP Whitelist address, manage PDF user policies, set access roles, create default profile screens, force password changes, grant additional agency access, and other additional user level management functions.

SYSTEM DESIGN

- Screen Designer: Completely customizable, easy to use, and extremely powerful screen designer to allow for the custom creation of assessment screens and program management screens (i.e. profile, enrollment, status, exit, follow-up screens).
- Field Editor: Simple interface to allow for the creation and management of custom database fields. Text, checkbox, pick-list, number, dollar, and other additional data formats should be added. The HMIS should automatically create and translate the management to the relational database.
- General Settings: Full customization of system variables, such as session idle limits, maximum password attempts, Area Median Income (AMI), Poverty Guidelines, email templates, client forms, file categories, and other additional customizations should be available.
- Report Library Management: Ability to register and modify customized reports for inclusion in a user accessible Report Library. Reports should be able to be assigned to specific agencies, and certain designated access roles that can allow only select users to view specified reports should be available.

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PROGRAM & SERVICE CONFIGURATION

- Program Template Management: Ability to create and manage Program Templates. For example, the system can be used to manage any non-HUD programs that use completely separate Enrollment, Status, and Exit screens. These templates can be defined to provide standardized work flow.
- Goal Template Management: Ability to create and manage Program Goal Templates. Goals can consist of items such as "Receive Mental Health Services within 90 Days," or "Obtain Permanent Housing within 30 Days." The Goals Editor should be highly configurable, and allow for Pass/Fail of goals to be automatically assigned to client- enrolled programs.

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7. MOBILE TECHNOLOGY

7.1 Mobile Technology For Usability

User-friendly mobile geo-location integration provides users in the field with every capability they need for successful and efficient outreach. Optimally, it should be possible for users on mobile devices such as Apple iOS (iPhone, iPad), Google Android, or Windows Phone to gain additional functionality through GPS and camera hardware, as well as through a fully optimized touch interface for a native user experience.

The following mobile capabilities enhance usability through simplified outreach activities and elimination of numerous daily hassles:

- Geolocation for street outreach and field assignments
- Finger signature feature that will allow clients to sign consent forms and other documents electronically, saving both time and resources. This is particularly effective during field and outreach efforts.
- Assessments and subsequent referrals/reservations can be processed in real-time using the advanced mobile interface.
- Photos can be taken, cropped, and integrated directly from the mobile interface.
- GPS coordinates for each interaction can be stored progressively.
- Locations can further be secured via IP Whitelisting or browser installed and encrypted personal PKI Certificates for Mobile or Desktop interface.

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8. CONCLUSION

HMIS software by itself cannot support nor foster Centralized Intake – it's how the HMIS software stabilizes and molds service provision that determines its effectiveness. Writing great code is not sufficient for usability – it's how that code is deployed onto the hardware and how it subsequently affects the end user that determines true usability. This reinforces the fact that usability must be the fulcrum in each stage of HMIS software development, from initial individual feature conceptualization to the subsequent hands-on experience of the end user.

User friendly HMIS applications play a vital role in efforts to end homelessness. The information gathered by HMIS applications nationwide have the potential to spur significant change in how clients are guided through the system, and they can help to turn the tables in the battle against homelessness in America. This is why it is crucial that each CoC, large or small, be supported by highly intuitive and user-friendly HMIS.

Policy-makers and stakeholders alike eagerly anticipate the quality data that sophisticated, usable HMIS systems will generate, as they know that this information will better inform them to make evidence-based policies that will, in time, eliminate and prevent homelessness in America

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9. GLOSSARY

Admission – using authority to admit the client into the program.

Assessment – a deeper level of inquiry into the actual problem and the client's strengths and needs related to solving the problem. Assessment helps with service-matching and provides the information needed to determine the expected type, intensity, and duration of assistance a client or household might receive;

Continuum of Care (CoC) – A network of organizations designated by HUD to oversee homeless assistance grants from HUD in a particular geographic area. Each CoC coordinates with homeless assistance agencies in its area to produce annual plans identifying the needs of local homeless populations, the resources currently available in the community to address those needs, and any gaps in resources that could be filled with additional funding.

Intake – the general process between the client's first point of contact and the decision whether or not to admit the client to a program. The intake process can include screening, assessment, referral, and verification. Intake may or may not result in program admission;

Information – specific facts about a program, such as its location, services proved, eligibility requirements, hours of operation, and contact information;

Permanent Housing (PH) – Permanent Housing is community-based housing, the purpose of which is to provide housing without a designated length of stay. There are two types of Permanent Housing: Permanent Supportive Housing and Rapid Re-housing.

Permanent Supportive Housing (PSH) – Service-enriched long-term housing for homeless persons with a disabling condition. Al l permanent supportive housing has some level of service designed to strengthen the homeless individual or family's ability to live independently and guide them to the appropriate self–sufficiency necessary to maintain independent living. Permanent supportive housing does not have a designated length of stay, and may exist in one building or in multiple scattered sites. It may also be limited to a portion of a complex or development project.

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Rapid Re-Housing (RRH) – Rapid Re-Housing is a type of Permanent Housing designed to quickly transition individuals and families (with or without disabilities) experiencing homelessness into permanent housing and achieve stability in that housing. Intensive case management along with short to medium term rental assistance is provided to households in RRH programs for no more than 24 months.

Referral – referring a client to a particular program for possible help, without any obligation on the part of the receiving program to actually offer or provide the help;

Screening – a first-level decision about whether the client is eligible for a program and/or would have a priority for those services. Screening determines who receives assistance;

Street Outreach – Programs that provide essential services for unsheltered persons who are sleeping in places not meant for human habitation. Services include emergency health or mental health care, engagement, case management, and services for special populations.

Supportive Housing Program (SHP) – This program provides funding for development, operation and services for transitional housing, permanent supportive housing, service only programs, and the Homeless Management Information System. Funding is applied for through the CoC and is contracted by HUD directly to the applicant agency. Effective FY 201 2, the HEARTH Act consolidated the SPC, SRO and SHP programs into the CoC Program.

Targeting – process of determining the population to whom assistance will be directed. That is, the target population. The targeting process can occur at both the system and the program levels.

Verification – the gathering and review of information to substantiate the crisis situation and support program eligibility and priority determinations;

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