PERMANENT SUPPORTIVE HOUSING
FIDELITY REPORT

Date: December 12, 2025

To: Leanne Jividen, Regional Director
Rhonda Kiphuth, Clinical Director

From: Melissa Porphir, MS
Allison Treu, BS
AHCCCS Fidelity Specialists

Introduction

Arizona Health Care Cost Containment System (AHCCCS) has contracted with the Western Interstate Commission for Higher Education Behavioral Health Program to conduct fidelity reviews using the Substance Abuse and Mental Health Services Administration (SAMHSA) Permanent Supportive Housing (PSH) Fidelity Scale, an evidence-based practice (EBP). PSH refers specifically to the EBP of helping members with a serious mental illness (SMI) designation find and maintain safe and affordable housing in integrated communities rather than communities with disability-related eligibility criteria.

Method

On November 3 – 6, 2025, Fidelity Specialists completed a review of the **Arizona Health Care Contract Management Services (AHCCMS)** PSH program. This review is intended to provide specific feedback on the development of your agency's PSH services in an effort to improve the overall quality of behavioral health services in Maricopa County.

AHCCMS, under its parent company Sevita Health, provides behavioral health residential treatment, community living placements, and permanent supportive housing services. The individuals served through the program are referred to as *clients*, but for the purpose of this report and for consistency across fidelity reports, the term *member* or *tenant* will be used. At the time of the review, the program was serving 13 members.

In order to effectively review PSH services, the review process includes evaluating the working collaboration between each PSH provider and the referring outpatient behavioral health clinics (clinics) with whom they partner to deliver services. For the purposes of this review, the referring clinics include Copa Health - East Valley and Chicanos Por La Causa - Centro Esperanza. Some data obtained also reflects services provided by other partner clinics.

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

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

- Group videoconference overview of the PSH program with the Regional Director and Clinical Director.
- Individual videoconference interview with the PSH Program Manager/Clinical Lead.
- Group videoconference interview with two Case Managers from Copa Health – East Valley clinic.
- Group videoconference interview with three Case Managers from Chicanos Por La Causa – Centro Esperanza clinic.
- Individual videoconference interview with one Clinical Lead from the PSH program.
- Individual phone interviews with members participating in PSH services. Of the five members' information that was provided, four were successfully contacted and interviewed.
- Closeout discussion with the PSH Program Manager/Clinical Lead, Clinical Director, Regional Director, and representatives from AHCCCS and the contractor with a Regional Behavioral Health Agreement (RBHA).
- Review of documents: Tenant Advisory Luncheon documents, member leases and safety inspection documents, rent-to-income worksheets, PSH referral form, AHCCMS Client Handbook, PSH referral information, organizational chart, policies and procedures, PSH handout, and clinical supervision log.
- Review of 10 randomly selected member records, including charts of interviewed members/tenants, as well as remote review of member records from the two partnering clinics, including a sample of co-served members. The sample only included members from the contractor with a Regional Behavioral Health 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 measures the degree of fidelity to the 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, with little room for improvement*). Seven items (1.1a, 1.2a, 2.1a, 2.1b, 3.2a, 5.1b, and 6.1b) are rated on a 3-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 been fully 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 and Key Recommendations

The agency demonstrated strengths in the following program areas:

- 1.1.a, 1.1.b, 1.1.c Choice of Housing: Members choose the type of housing they prefer from a range of housing types and units, including an integrated unit in the community and choice of unit within a housing complex. Members can wait for the unit of their choice without risking discharge from the program or losing housing subsidy waitlist priority.
- 2.1.a, 2.1.b, 2.1.c Functional Separation of Housing and Services: The program does not have housing staff located on site where members reside. Landlords and property management do not cross over into providing support services to tenants. PSH staff do

not have any responsibility for housing management functions.

- 4.1.a Housing Integration: Of the 12 housed members, 10 (83%) are living in integrated settings in the community, rather than in those set aside for people meeting disability-related eligibility criteria.
- 7.3.a Extent to Which Services are Consumer Driven: The PSH program uses multiple methods to gather member feedback to support a member-driven approach.
- 7.4.c Extent to Which Services are Provided 24 hours, 7 Days a Week: PSH program staff are available to members 24/7 and adjust schedules as needed to accommodate employed members. Members can contact staff after hours, including evenings and weekends, as a primary resource.

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

- 3.2.a Safety and Quality: Inspection checklists were provided for 50% of housed members. Develop procedures such as training staff to conduct inspections to ensure that all members are in housing that meets decent and safe standards. Optimally, 90% or more of housed members (including those without rental subsidy vouchers) meet Housing Quality Standards (HQS) with inspection copies on file.
- 5.1.a Tenant Rights: Data indicated 33% of members did not have leases or full tenancy rights. Ideally, PSH programs maintain current copies of leases for 90% or more of housed members. Explore options for utilizing formal agreements for members living with family or friends.
- 7.4.b Quality and Advocacy of Services: The PSH program is a separate service provider from members' clinical teams. Ideally, behavioral health services, including housing support services, are delivered through an integrated team. Develop and implement a protocol to improve coordination and communication between the PSH program and clinical teams to enhance member care.

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., recovery home, private landlord apartment)	1, 2.5, or 4 4	Clinic staff reported supporting member choice in housing type by educating members on available and affordable options, including low-income apartments integrated in the community, sober living settings, and residential treatment facilities. Staff reported that member choice is largely driven by availability, with unhoused members selecting housing based on the earliest available option. Neither partnering clinic had Housing Specialists on staff at the time of review. Staff expressed uncertainty about the scope of PSH services and reported assisting members in applying for housing waitlists directly. Members interviewed reported having a choice between housing types and being supported by clinic staff via discussion about needs and preferences.	
1.1.b	Extent to which tenants have choice of unit within the housing model. For example, within apartment programs,	1 or 4 4	PSH staff reported that members choose from available units and are not restricted in choice of unit within the housing type. PSH staff assist members during the housing search by prioritizing the members' preferences, such as location of the unit within the complex. PSH staff accompany members to view potential units; if a member declines a unit, staff continue to assist the member in the housing search.	

	tenants are offered a choice of units		Clinic staff reported minimal housing options and choice of units due to lack of market availability. Members interviewed stated they were able to choose a unit based on preferences such as an upstairs unit.	
1.1.c	Extent to which tenants can wait for the unit of their choice without losing their place on eligibility lists	1 – 4 4	PSH and clinic staff reported members can decline a housing unit and wait for one of their choice without losing their voucher or place on a waitlist. Voucher and housing subsidy administrators maintain waitlists independently. Clinic staff reported uncertainty if members are required to utilize their housing voucher by selecting a unit within a certain timeframe. PSH staff collaborate with voucher administrators to advocate for members when additional time is needed to find a preferred unit. One member interviewed reported waiting for the unit desired and maintaining their housing voucher during that time.	
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	Per the data received, 12 of the members engaged in the PSH program are housed. Four (33%) members reside in treatment settings or with family/friends where they do not control the composition of their household. PSH staff reported members with housing vouchers can notify the voucher administrator to have individuals added to their household. Members must also notify their landlord and complete the process to add someone to their lease.	• For members living with family or friends, assist them in acquiring an informal signed lease, outlining the "tenant's" and "landlord's" responsibilities. This may support housing stability and member rights when disagreements occur. • Continue assisting members living in environments where they lack control of household composition to find independent housing when it aligns with their personal living goal. • Educate members how to add others to their lease and voucher.

			Clinic staff were uncertain if members had control of household composition. Three members interviewed with housing vouchers stated they are not permitted to add others to their households according to the voucher administrator.	
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	Interviews with PSH staff indicate housing management staff do not have authority or any role in providing clinical or social services to the vast majority of members. Of the 12 housed members, two (17%) reside in settings in which housing management staff may also deliver certain social services, such as group treatment. Members in all other housing settings do not receive any social services from housing management staff. All members interviewed reported that social service providers are located off site.	
2.1.b	Extent to which service providers do not have any responsibility for housing management functions	1, 2.5, or 4 4	Per interviews, service providers do not have any responsibility for housing management functions. PSH staff are not tasked with reporting lease violations, collecting rent, or serving evictions.	
2.1.c	Extent to which social and clinical service providers are	1 – 4 4	Clinic and PSH staff reported they do not have offices at locations where members reside. Per data received, 83% of members live in settings independent from social service staff and providers, and 17% of members live in units where	

	based off site (not at the housing units)		service providers are based on-site and provide supportive services. Members interviewed confirmed clinical and social support services are provided by their outpatient behavioral health clinics in locations separate from their residences.	
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	PSH staff reported that members with housing vouchers or other rental subsidies pay no more than 30% of their income toward rent; however, for some members, utilities are not included and are paid separately. Clinic and PSH staff indicated they assist members experiencing housing affordability challenges by providing food boxes, facilitating utility reimbursements, and offering budgeting support. Members interviewed reported paying 30 – 50% of their income towards housing and utilities. PSH staff have assisted them with submitting applications for programs that reduce utility costs, applying for housing subsidy waitlists, and developing budgeting skills. Records reviewed showed PSH staff assisted members with dental care programs, food boxes, grocery shopping, budgeting, employment, and health plan benefits. Of the 12 housed members, eight members (67%) pay less than 30% of their income towards rent. Four members (33%) pay between 38 -51% of their income for housing.	• To the extent possible with consideration for market factors, continue to work with members that are paying over 30% of their income toward housing to find more affordable units. Consider supporting members in applying to assistance programs or finding employment to help mitigate rental costs.

3.2 Safety and Quality				
3.2.a	Whether housing meets HUD's Housing Quality Standards (HQS)	1, 2.5, or 4 1	Reviewers received current and passing HQS inspection reports for 50% of housed members. PSH staff reported informally assessing member safety during each home visit and assisting members in advocating with landlords and property management companies for urgent repairs to units. Staff stated members without housing subsidies are encouraged to document any maintenance issues or concerns so they may be addressed.	• Work to ensure that all members are housed in units that meet HQS, not just those that have a rental subsidy. Develop procedures to ensure market rate units meet HQS. Some programs/agencies have trained staff that conduct HQS inspections for the PSH program.
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 and interviews with PSH staff, most housed members (83%) live in housing that is integrated within the community. Data showed 17% were in housing set aside for those meeting disability related criteria. Members interviewed reported choosing their neighborhoods, feeling safe in their communities, and having access to a nearby bus line.	
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	PSH staff reported that most members are independently housed and have full tenancy rights. Data indicated 33% of members did not have leases or full tenancy rights. Two members living with friends did not have leases, and two additional members in treatment settings did not have legal rights to their housing unit.	• In the EBP of PSH, programs obtain and maintain current copies of leases for 90% or more of housed members. Ideally, PSH programs accompany members during new lease signings and renewals. Work with members to support them during these times, consequently obtaining a copy of the lease to be

			Of the 12 housed members, the PSH program provided six current lease agreements (50%); however, data provided indicated a higher percentage of leases were on file. Members interviewed reported having legal rights of tenancy and lease agreements.	used later as a reference when educating members on their rights and responsibilities with the intent to maintain stable housing and prevent eviction. • Explore options of utilizing formal agreements so that members living with family or friends know their responsibilities and expectations as either tenant or landlord.
5.1.b	Extent to which tenancy is contingent on compliance with program provisions	1, 2.5, or 4 4	According to the data provided and confirmed with PSH staff, 83% of members reside in settings where tenancy is not contingent on treatment compliance. Two (17%) members reside in treatment settings where tenancy depends on compliance with program provisions. Members interviewed reported typical lease expectations without any special clauses or provisions in their leases.	
Dimension 6 Access to Housing				
6.1 Access				
6.1.a	Extent to which tenants are required to demonstrate housing readiness to gain access to housing units	1 – 4 3	PSH staff and staff from one clinic were able to articulate the *Housing First* approach and reported that members do not have to demonstrate readiness to access housing or to receive PSH services. Staff at this clinic indicated they do not assess for housing readiness before referring members to PSH programs, recognizing that when members have housing, other treatment variables can be addressed. Staff evaluate each member's needs, including substance use treatment and budget, discuss the housing options available, verify income, and compile lists of available apartments. Ideally, member service plans are	• Ideally, PSH staff and system partners collaborate with clinic staff to increase their understanding of the *Housing First* model and how PSH fits. Assessing members' needs would be an appropriate measure if the purpose was to identify skills and services needed to support the member in being successful in living independently. Members need only to express a desire for safe and affordable housing to be referred to PSH programs.

			updated to include PSH services prior to referrals; however, this is not required. Staff will proceed with referrals and update service plans promptly when the PSH program requests it. Staff at another clinic were unfamiliar with the *Housing First* approach. Staff will refer to PSH when members request services but believe income may be required to be a candidate for referral. Staff described a case in which a member's referral was initially declined by the PSH program due to not meeting criteria. Staff advocated on behalf of the member, presenting information to support reasons for the service. The PSH program was reported to be more beneficial for members with housing vouchers or those already in stable housing who need assistance maintaining it. During the four-hour PSH intake process, PSH staff utilize a screening form to gather basic information about members and their needs and review what PSH services entail. One member interviewed reported being required to have income and demonstrate stability prior to obtaining housing.	• PSH is specifically designed to support individuals with significant behavioral health challenges in living independently in the housing of their choice through a combination of affordability tools and wraparound supports that are available upon request. In the EBP of PSH, individuals that are the most vulnerable to housing instability/homelessness are prioritized for housing supports.
6.1.b	Extent to which tenants with obstacles to housing stability have priority	1, 2.5, or 4 2.5	Clinic staff interviewed were unable to articulate a member population prioritized for PSH services and instead reported staffing member goals or behavioral health issues preventing housing stability internally. Staff were unaware of how housing voucher administrators prioritize members with obstacles to housing stability. PSH staff reported promoting equal access to services and housing support. Intakes are	• Ensure staff across all provider clinics have an accurate and common understanding of eligibility and prioritization of PSH services. A lack of accurate information may result in members being dissuaded from pursuing housing or feeling frustrated with the results.

			prioritized for high-risk members such as those who are unhoused, at risk of losing housing, or hospitalized members above those already in stable housing. Per PSH staff, referral packets which include a high score on the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) would also be prioritized for earlier intake. PSH staff reported that housing voucher administrators utilize the VI-SPDAT to determine priority when offering subsidies.	
6.2 Privacy				
6.2.a	Extent to which tenants control staff entry into the unit	1 – 4 4	PSH and clinic staff reported members control entry to their own units. The PSH program does not retain copies of member keys, and members can refuse staff entry. In cases where there are concerns for a member's welfare, staff may coordinate with landlords to verify their well-being, provided the member has signed a Release of Information authorizing such communication. Per data provided, most housed members live independently on their own or with friends. Approximately 17% of members reside in settings where staff may enter without member permission. Members interviewed reported having privacy and control over entry into their units.	
Dimension 7 Flexible, Voluntary Services				
7.1 Exploration of Tenant Preferences				
7.1.a	Extent to which tenants choose the type of services they	1 or 4 4	PSH and clinic staff reported that members can select the services they wish to receive upon enrolling with their clinic, including groups, counseling, psychiatric and nursing services,	

	want at program entry		employment support, and co-located primary care, among others. Members interviewed stated that services are voluntary and flexible. Members choose their goals and the services they would like to engage in when developing service plans. One member and one clinic staff reported that seeing the clinic's psychiatric prescriber once every three months is required to maintain active clinic enrollment. A review of member records revealed that clinic service plans included living or housing goals, with most plans written in the members' voice.	
7.1.b	Extent to which tenants have the opportunity to modify service selection	1 or 4 4	Clinic staff reported member service plans are updated semi-annually; however, service plans are reviewed regularly, and when changes occur, plans are updated. Staff from both clinics reported member engagement in the process is a common barrier to updating service plans. Members interviewed confirmed that they can modify their service plans as goals evolve and add or remove services at any time. Records reviewed demonstrated changes in clinic services provided to members over time as requested by the members. One example included a member who had been closed from PSH services which prompted an updated clinic treatment plan with PSH services removed.	
7.2 Service Options				
7.2.a	Extent to which tenants are able to choose the	1 – 4 3	PSH staff reported providing members with a basic overview of PSH services during intake. Members have the flexibility to select the services they receive, including the option to decline	• Provide training to PSH staff regarding how to work with members to develop personalized needs and/or objectives to reflect

	services they receive		services entirely and may also close PSH services after obtaining housing if desired. PSH staff and staff from one clinic reported that the Housing Choice Voucher required enrollment with both the RBHA and a clinic, as the application was completed through the member's clinic. Members interviewed expressed uncertainty about whether closing PSH or clinic services would affect their housing vouchers. Records reviewed indicated that PSH service plans included individualized goals, but lacked tailored service delivery, with all members generally receiving the same frequency and type of contact from PSH staff.	members' voice and individualized needs and preferences. Match specific PSH services to directly address those needs. Review the content of plans to determine when revisions are needed, such as upon being housed. Document the shift from services to obtain housing, to specify needs and services to maintain that housing on service plans. • 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, inform of the impact on applicable subsidies and/or PSH services.
7.2.b	Extent to which services can be changed to meet tenants' changing needs and preferences	1 - 4 4	PSH staff reported the program offers services to members that are based on individual preferences. Some of the services the program offers include assistance with applying to low-income housing waitlists, assistance applying for nutritional support, food box provision, budgeting, and transportation. Service plans are updated annually or more often when members' goals change. Staff reported that there is no time limit for members receiving PSH services, and records confirmed that some members have participated in the program for over nine years. Two members interviewed stated that the PSH program offers a regular set of services to all members with the ability to modify based on individual preference.	

			Based on records reviewed, documentation showed that services were adjusted to reflect members' changing goals.	
7.3 Consumer-Driven Services				
7.3.a	Extent to which services are consumer driven	1 – 4 4	A quarterly Tenant Advisory Luncheon between members and PSH staff was recently reinstituted to solicit member feedback on program design and services. PSH staff also reported an anonymous survey is provided to members every six months. Staff indicated researching monthly washer/dryer fees being assessed in addition to rent by property management companies as a result of member feedback. Two of the four members interviewed were aware of the quarterly Tenant Advisory Luncheons, and three were aware of member surveys. One member reported discussing individual needs with PSH staff during monthly home visits.	• Continue efforts to support member input on program design and service provision. For example, determine if members can serve on sub-committees to the agency board of directors or participate in quality management or other processes that impact service design and provision
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 team consisted of two full-time PSH staff with caseload sizes of nine and five. The overall member-to-staff ratio averaged 7:1, and staff reported more referrals were in progress.	
7.4.b	Behavioral health services are team based	1 – 4 2	PSH staff reported that in addition to housing services, members receive external support such as counseling and psychiatric services through their outpatient behavioral health clinics. PSH staff collaborate with clinical teams by inviting them to participate in intakes and quarterly staffings to review member needs and services. Clinic staff interviewed reported no regular communication with PSH staff regarding mutually served members.	• Optimally, all behavioral health services are provided through an integrated team. Separate providers create barriers, such as separate intake processes and electronic records systems, redundancy in information gathering and record keeping, etc. When an integrated service plan is not possible, obtain input from other service providers when modifying plans.

			Records reviewed showed evidence of PSH staff coordinating with members' case managers, including inviting them to intakes and staffings.	• Improve efforts to coordinate member care with outpatient behavioral health clinic staff with focused attention on having the most current case manager assignments.
7.4.c	Extent to which services are provided 24 hours, 7 days a week	1 – 4 4	While the PSH program operates during typical business hours, staff are available to members after hours, including nights and weekends for emergencies. Staff also reported offering flexible service hours to accommodate employed members. Clinic-based member crisis plans are included in referral packets and are reviewed during intake with members. Members interviewed indicated awareness of the program's after-hours availability but reported not needing or choosing to contact staff outside of regular business hours.	

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

5.1.b: Extent to which tenancy is contingent on compliance with program provisions	1, 2.5, 4	4
Average Score for Dimension		2.5
6. Access to Housing		
6.1.a: Extent to which tenants are required to demonstrate housing readiness to gain access to housing units	1 - 4	3
6.1.b: Extent to which tenants with obstacles to housing stability have priority	1, 2.5, 4	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 or 4	4
7.1.b: Extent to which tenants have the opportunity to modify services selection	1 or 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	4
7.3.a: Extent to which services are consumer driven	1 - 4	4
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		3.63
Total Score		22.93
Highest Possible Score		28