PERMANENT SUPPORTIVE HOUSING (PSH)
FIDELITY REPORT

Date: September 18, 2015

To: Gus Bustamante, PSH Program Manager

From: Georgia Harris, MAEd
Karen Voyer-Caravona, MA, MSW
ADHS Fidelity Reviewers

Method

On August 17 – 18, 2015, Georgia Harris and Karen Voyer-Caravona completed a review of the PSA Behavioral Heath Agency's Permanent Supportive Housing Program (PSH). This review is intended to provide specific feedback in the development of your agency's PSH services, in an effort to improve the overall quality of behavioral health services in Maricopa County. In order to effectively review PSH services within the current behavioral health system, the review process includes evaluating the working collaboration between each PSH provider and referring clinics with whom they work to provide services. For the purposes of this review at PSA, the reviewers visited referring clinics: Lifewell's Arcadia clinic and the Southwest Network's Highland clinic.

PSA Behavioral Health Agency (PSA) has provided services in the Phoenix area since 1971. In addition to housing support, the range of services include outpatient counseling, recovery and wellness, and Art Awakenings. Because, PSH was a new concept to PSA in 2014, that year's review focused on their "house model" program, Supportive Living Assertive (SLA), which the agency identified as most closely aligning with the evidence-based practice of PSH. In November 2014, PSA launched their PSH program, which provides supportive services to individuals living in, or preparing to live in, scattered-site and other independent housing. The Regional Behavioral health Authority (RBHA) contracts with PSA to provide the services for 60 scattered-site housing voucher recipients. Chicanos Por La Causa (CPLC) contracts with PSA for an additional 40. Services include assistance with locating a housing unit, but the clinics also refer for services only for people who need support to remain in their current housing. Unlike the SLA housing sites, the scattered-site units are integrated throughout the community, and services are attached to the member(s) served, rather than a voucher and/or housing unit. PSH services are provided by six PSA staff, often referred to as Primary Workers, a Lead Worker, and the Program Coordinator. Three of the Primary Workers identify as individuals with lived experience of an SMI and/or co-occurring disorder and are Certified Peer Support Specialists. At the time of the review, PSA reported a roster of 78 members. The Program Manager said program capacity is between 100 – 115 members.

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

During the site visit, reviewers participated in the following activities:

- Interview with the agency Clinical Director and PSH Program Manager;
- Group interviews with five clinic Case Managers (CM);
- Group interview with six direct service PSH staff, including five Primary Workers (direct service) PSH staff, and the Lead Worker;
- Interviews with four tenants who are participating in the PSH program;
- Review of agency documents including intake procedures, eligibility criteria, team coordination and program rules; and
- Review of 10 randomly selected agency tenant records, and 10 clinic member records.

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:

- Staff trained in the evidence-based practice model of PSH: PSA staff interviews and documentation found in tenants' agency records suggested that staff are well-trained and knowledgeable about the evidence-based practice model of PSH and the principles of housing first.
- Functional Separation of housing management and social services: Property managers have no role in clinical or treatment services, and PSA staff do not accept a role in housing management or act as agents to property managers to collect rent, deliver eviction notices or report violations of the lease agreement.
- Tenancy is not contingent on compliance with program provisions: Tenants do not have to accept program services or treatment in order to remain housed in their units. Tenancy is only contingent on full payment of rent and compliance with the rules of the standard lease agreement.
- Services can be changed to meet tenants' changing needs and preferences: Tenants decide on the types of assistance and services they would like to

accept, as well as the frequency of contact, the location and intensity. Support can take the form of guidance with routine tasks such as organizing a kitchen or creating a monthly budget to as unique as teaching a tenant how to bathe his dog.

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

- Decent, safe and affordable housing: The RBHA and PSA should collaborate to develop policies and procedures to verify that tenants are paying no more than 30% of income toward rent, and that units pass HQS. The agency cannot verify this without documentation, in the form of leases, income/rent calculation forms, and HQS reports, in the agency tenant record.
- Extent to which services are consumer driven: PSA should explore opportunities to increase tenant voice into the design and provision of services. Platforms such as tenant advisory councils and program improvement forums provide agencies opportunities to gain valuable insight into the tenants' view on the effectiveness of their services.
- Education and training in the PSH model at the clinic level (Items 1.1.a, 6.1.a, 6.1.b): Clinical teams, the primary housing gatekeepers, restrict housing choice through the use of level of care determination. While some Case Managers (CMs) appear to have embraced the housing first philosophy and the value of choice, others believe members should demonstrate readiness as measured by sobriety, compliance with medication and psychiatric stability, and will only refer for independent housing if pressed by the member or if it appears more readily available than staffed or more restrictive settings.

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 1	PSA's PSH program provides supportive housing services to assist tenants in attaining self-sufficiency within their preferred housing type. Housing choice is constricted at the clinic level. Clinical teams consider housing readiness and use a "level of care" designation (assessment of functioning) in making recommendations for "appropriate" housing. Scattered site, the lowest level of care, is often viewed as the best option for individuals who are psychiatrically stable and complying with treatment recommendations. While some Case Managers (CMs) stated housing type is always the member's choice, others said that the clinical team makes the decision but will concede to a member's preference. Several CMs reported that they encourage members to accept whatever housing option becomes available or refer members to whichever housing type is likely to be first available. At the time of the review, most CMs felt that scattered site vouchers are more available than Community Living Placement (CLP) or residential options. Factors within the private housing market and within current housing policy appear to restrict housing choice for individuals with histories of felony convictions, poor credit histories, and histories of evictions.	• The RBHA and provider agencies should provide clinical teams training and education to improve their knowledge of the evidence based practice model of PSH, and how the use of intensive, flexible, wrap-around supports can meet the ever-changing needs of those with an SMI diagnosis. • Empower clinical staff to welcome PSH programs as the default option for SMI tenants.
1.1.b	Extent to which	1 or 4	The PSH program at PSA is designed to provide support	

	tenants have choice of unit within the housing model. For example, within apartment programs, tenants are offered a choice of units	4	services to tenants residing in scattered-site housing (RBHA or CPLC vouchers) or other independent housing. If requested, PSA staff, usually the Program Manager, will assist tenants in locating a unit that meets his or her needs. Tenants with a voucher have a choice of any housing unit available on the open market that is within their budget. The voucher, if accepted by the landlord or property management, can be applied to the monthly rent.	
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	When tenants receive a scattered-site housing voucher they are given 30 days to find a housing unit. Tenants who need more time to find a suitable unit can apply for extensions up to 120 days without losing their place on the eligibility list and having to resubmit a new housing application. Applications for extensions are submitted by clinical team CMs.	
1.2 Choice of Living Arrangements				
1.2.a	Extent to which tenants control the composition of their household	1, 2.5, or 4 4	Tenants decide whether or not to live alone or with other people such as roommates, children, partners or other family. Other people living in the unit must be on the lease. Additions to the lease must pass whatever screening (i.e. credit and background checks or personal/landlord reference check) is typically required of all tenants by the property manager and must be approved by the clinical team to help ensure that tenants are not exploited or their tenancy threatened. Roommates who are not designated caregivers to the tenant are responsible for half of the market rate rent.	
Dimension 2 Functional Separation of Housing and Services				
2.1 Functional Separation				
2.1.a	Extent to which housing management providers do not	1, 2.5, or 4 4	Property managers have no role in providing social services. Property managers are encouraged to alert PSA staff if they suspect that tenants have needs that should be addressed by the Primary Worker or clinical	

	have any authority or formal role in providing social services		team.	
2.1.b	Extent to which service providers do not have any responsibility for housing management functions	1, 2.5, or 4 4	PSA staff are responsible for housing support services only, and have no role in delivering eviction notices or other actions, enforcing rules, or reporting violations of the lease agreement. Primary Workers engage tenants in "eviction education", helping them to understand the requirements of their lease and, using motivational interviewing techniques, to consider how their choices and behaviors can affect tenancy. PSA staff report they strive to build cooperative relationships with property managers to ensure "win-win" outcomes for tenants and landlords.	
2.1.c	Extent to which social and clinical service providers are based off site (not at the housing units)	1 – 4 4	PSA's PSH staff do not maintain offices at housing sites or dwellings. Services are offered where the tenant requests them. Services, such as learning to use a washing machine, assistance with bathing a pet, or organizing bills, may be conducted in the home, while services such as grocery shopping or shopping for a new toaster may occur in the community. When appropriate, or upon request, staff also meet with tenants at the PSA office for tasks such as performing an on-line search for community resources. Additionally, PSA staff reported that they declined the property manager's offer of dedicated work space for groups and activities at the apartment community.	
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 1	PSA does not have policies and procedures to collect leases and rent/income calculations from tenants. PSA staff reported that tenants using scattered site vouchers pay no more than 30% of their income toward rent. Tenants who do not have an income do not pay rent. Most tenants interviewed said they paid 30% of their income toward rent; however, one tenant said he was determined ineligible for a voucher and pays 80% of his income toward rent. Because PSA does not have policies and procedures prior to the review for collecting leases and income/rent calculation forms, and was only able to obtain copies of 32 leases out of 73 tenants, the income-to-rent ratio could not be verified.	• Maintain documentation, such as leases and rent/income calculation forms, in tenant records to verify affordability. Tracking affordability can also help to bolster independent living activities (i.e., budgeting, advocacy, etc.) with the tenants.
3.2 Safety and Quality				
3.2.a	Whether housing meets HUD's Housing Quality Standards	1, 2.5, or 4 1	Because PSA does not have a policy and procedure for obtaining copies of the HQS, it was not possible for the reviewers to verify this item. PSA was able to collect five copies of HQS inspection reports for tenant units. One tenant reported that his unit initially did not pass the HQS and that ABC Housing paid for a hotel while necessary repairs were completed. Tenants, PSA staff, and Case Managers had differing perspectives on whether or not properties are properly maintained or if repairs are made in a timely manner.	• The RBHA and ABC Housing should develop a policy and procedure for ensuring that PSH service providers obtain copies of the HQS inspection reports as soon as possible upon the tenant obtaining housing and/or upon enrollment in the PSH program. • To fulfill this item, some agencies find it beneficial to partner and/or request copies of completed HQS inspections from the agency who already conducts them.
Dimension 4 **4.1 Housing Integration**				
4.1 Community Integration				
4.1.a	Extent to which housing units are integrated	1 – 4 4	PSA's PSH program has capacity for 100 – 115 units, with 40 vouchers available through Chicanos Por La Causa (CPLC) and 60 vouchers available through the RBHA. Currently, the program, which has been open for 10 months, is operating below capacity with 78 tenants, some of whom live in their own homes or in	• Though PSA's acquisition of the Cheryl property is in response to the lack of sufficient housing options for individuals with criminal histories, it is recommended that the agency guard against becoming reliant on single-site housing to address need. Single-site housing reserved for

			the home of a family member. PSA and tenants interviewed report that housing options are well integrated and dispersed through the Maricopa County. PSA and clinic staff agree that some unintentional clustering of people with disabilities may occur due to the lack of affordable housing options, and the relationship between low income (along with histories of evictions and poor credit) and disability status. They also said that clustering may also occur as a result of limited housing options for people with felony convictions. PSA staff reported that the agency recently acquired the 10-unit Cheryl apartments for a single-site program for tenants with both SMI status and felony convictions. Currently, three units house tenants, while the other seven remain leased by tenants of the previous property owner. Eventually, all 10 units will house tenants with felony convictions.	people with criminal histories or disabilities may increase risks to their ability to integrate into the community and may lead to further stigmatization. Some tenants who are monitored by probation and parole report concerns that being housed in places with high concentrations of other people with criminal convictions may compromise their terms of probation and parole or result in presumed guilt by association.
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	Of the 78 tenants participating in PSA's PSH program, approximately 62 rent units (primarily apartments, but also houses and townhomes) through the use of the RBHA voucher program. Of the remaining 16, 11 own their own home, three live with family, one resides in 16-hour care, and one is homeless and awaiting a voucher. PSA staff assist (usually the Program Manager) with the housing search and typically attend lease signings with the tenants. However, PSA staff usually do not obtain copies of leases. PSA staff and tenants report that they have legal rights of tenancy, with the same types of leases that anyone renting on the open market would sign. Because PSA was able to	• The agency should offer to retain copies of tenant leases in their files. Continue to review leases with tenants, helping them to learn the terms of their lease agreements while providing clarity on areas of concern to ensure tenants' legal rights are being met. • For housing that is supplied by RBHA contracted agencies, policies and/or procedures for PSH agencies to attain these records should be developed.

			obtain 32 of the 78 copies of leases, legal rights of tenancy could not be verified.	
5.1.b	Extent to which tenancy is contingent on compliance with program provisions	1, 2.5, or 4 4	Tenancy is not contingent on compliance with program provisions or participation in treatment. Tenants are not required to accept PSH services in order to maintain tenancy. Supportive housing services are completely voluntary; tenants can start, stop and restart services at any time they choose. Tenants who disenroll from the RBHA system become ineligible for the scattered-site voucher but can maintain tenancy as long as they adhere to the lease and standard community rules, and rent is paid.	
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 2	PSA staff support tenants, including those with co-occurring disorders, to develop knowledge, skills, habits and resources leading to self-sufficiency in independent living. The PSH program does not impose readiness standards on tenants who are seeking independent scattered site housing. Evidence was found in the agency's tenant record that PSA staff supported a tenant through a recent alcohol relapse without threat to housing services or tenancy. Though the PSH agency does not maintain readiness requirements for program admission, clinical teams use the level of care determination system. Some Case Managers report that they encourage tenants to accept the recommended housing option, although they will concede to tenant preferences.	• The RBHA should provide training and support to clinical staff on the opportunities to expand housing options for tenants by utilizing in-home support programs, such as PSA's PSH program. Highlights might include: ○ PSH and Housing First has been shown to be more effective with respect to housing stability, reduced homelessness and hospitalizations than non-model housing and are as effective as forms of housing that are more restrictive. Placing conditions on housing is not supported by the evidence. ○ PSH is effective with a wide range of tenants, including families, people with corrections histories, and people with addictions and chronic diseases. ○ Studies comparing housing with sobriety requirements to housing

				without such requirements found little or no meaningful differences in housing stability or other outcomes. • PSA should continue to market its PSH program to clinical teams with a focus on how it can assist clinical teams in supporting tenants' housing stability and recovery in integrated community settings.
6.1.b	Extent to which tenants with obstacles to housing stability have priority	1, 2.5, or 4 2.5	Members seeking a scattered site voucher are placed on the RBHA wait list and effectively in line. Members who are homeless or coming out of psychiatric institutions, both prioritized by the RBHA and ABC Housing for vouchers, may jump ahead on the list. Some CMs said more affordable housing and/or vouchers are needed, and that members in need of housing must first be homeless or hospitalized in order to receive it. Clinical teams, on the other hand, use the level of care system and may preference members who demonstrate psychiatric stability and compliance with medication and treatment. One tenant interviewed said that he needed to demonstrate improvement while residing in CLP before his clinical team graduated him to the scattered site program. PSA staff offer assistance to any tenant referred for services. Primary Workers are prepared to assist tenants who require more intensive services on the front end and taper off as they gain housing stability. Evidence was found that PSA will continue to provide support and guidance to tenants in scattered site despite relapse, crisis situations, or behaviors that threaten tenancy.	• The system and key community stakeholders should explore opportunities to work together to increase the capacity to respond to the housing needs of people with SMI and co-occurring disorders, so that tenants do not have to experience high risk situations and crisis in order to be housed. • See Item 6.1.a, regarding demonstrating housing readiness criteria.
6.2 Privacy				
6.2.a	Extent to which tenants control	1 – 4	PSA staff reported that they do not enter units without permission from tenants. This was confirmed by	

	staff entry into the unit	4	tenants interviewed. If PSA staff determine that a welfare check of the tenant is warranted, they will seek assistance from the clinical team and/or the tenant's support system. If the CT or support system is unable to help confirm the tenant's welfare, PSA staff will contact the property manager and the police in order to gain entry into the unit.	
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 1	While tenants appear to be the primary authors of their service plans at PSA, on the clinic level there is little evidence of tenant voice in Individual Service Plans (ISP). Goals and objectives appear rote, focused on adhering to medication, attending appointments, and learning coping skills rather than individualized to tenant's stated needs.	• The RBHA and providers should provide regular trainings on how to engage tenants in creating ISP goals and objectives that are individualized and reflect their voice. Team Leaders and Clinical Directors should review ISPs to ensure that housing goals and objectives are specific to each tenants' needs. • The RBHA and providers should consider ways to support interagency sharing from agencies that score well in this area.
7.1.b	Extent to which tenants have the opportunity to modify service selection	1 or 4 4	PSA staff begin assisting tenants with the creation of a service plan upon enrolling in housing support services. After approximately a month, PSA staff revisit the initial service plan with tenants to discuss possible revisions to the service plan based on what tenants learned about themselves and their needs and preferences since entering the program. Additionally, PSA staff reported that during this time the new relationship may be more sufficiently established, so that the tenant is ready to share more information about needs and preferences. Staff additionally said that tenants can modify services at any time upon request.	
7.2 Service Options				
7.2.a	Extent to which	1 – 4	PSA marketing materials indicate that tenants are	• The RBHA should consider expanding the scope

	tenants are able to choose the services they receive	3	offered services in the following areas: housing transition and navigation (tenant obligations, rights and responsibilities of holding a lease), home management and personal care, budgeting and fiscal management, health and wellness, and community resources. Within those categories tenants can further fine-tune services to meet highly individualized needs such as learning to use a city bus, guidance with organizing a closet or storage space, social skills support in meeting neighbors or assistance in finding a yoga class in their neighborhood. Tenants are free to stop and start support services when they deem appropriate without losing a scattered-site voucher or tenancy. Tenants must remain enrolled in the RBHA system in order to retain their scattered-site voucher.	of the voucher program to include a provision that may 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 RBHA system for eligibility.
7.2.b	Extent to which services can be changed to meet tenants' changing needs and preferences	1 – 4 4	Reviewers found evidence in detailed documentation of staff responding to changing tenant concerns, needs and preferences. Support is largely defined by tenants. For example, one tenant requested that PSA staff attend his graduation from a drug treatment program, while another sought staff assistance with bathing his dog. Evidence was found that Primary Workers are prepared to respond to needs that can vary with each encounter, with staff helping a tenant identify neighborhood resources at one home visit, while the next was spent assisting the tenant with steps to self-advocate with her CM.	
7.3 Consumer- Driven Services				
7.3.a	Extent to which services are consumer driven	1 – 4 2	PSA Primary Workers do not follow a standard tenant skills training or curricula. Tenants report satisfaction with PSH services and appear to drive their service plan goals and objectives, and the frequency of staff contacts. Several Primary Workers identify as people with the lived experience in recovery from SMI and co-occurring disorder and appear to be highly valued by	• PSA should explore opportunities for an obvious tenant "feedback loop" or procedures for tenants to provide regular input or shape the overall program.

			the PSH leadership and their coworkers. However, PSA appears to drive the PSH program policies and procedures.	
7.4 Quality and Adequacy of Services				
7.4.a	Extent to which services are provided with optimum caseload sizes	1 – 4 4	PSA's PSH program is currently operating at below capacity. The Program Manager reported that program capacity is 100-115 based on the number of scattered site vouchers assigned to them by the RBHA and ABC Housing. With a roster of 78 tenants at the time of the review, the average caseload for seven Primary Workers is approximately 11 tenants. At any given time, Primary Workers reported carrying caseloads of between 10 – 15 tenants.	
7.4.b	Behavioral health service are team based	1 – 4 2	PSH staff make efforts to schedule monthly staffings with each member/tenant and his or her Case Manager. The reviewers found PSH service plans and updates that were signed by Case Managers, but PSH staff are not assigned to or function as part of a clinical team. PSH staff, however, reported that communication with clinical teams and CMs is an on-going problem, primarily due to the high caseloads carried by CMs. Evidence was found in agency tenant records that some CMs have not responded in a timely manner to Primary Workers' concerns about possible tenant evictions or requests for assistance. In one case, a CM acknowledged to PSH staff that housing was not a priority for the clinic unless the tenant was coming out of the hospital or was homeless.	• Based on the structure of the system, with separate providers involved primarily for housing services, and other providers for case management and psychiatric services, it may not be possible for PSA to provide services through a team approach. To the extent possible, PSA should continue efforts to coordinate with the SMI treatment teams. A first step could be to reach out to clinical management on the benefits and key principles of the PSH program to encourage collaboration.
7.4.c	Extent to which services are provided 24 hours, 7 days a week	1 – 4 3	PSH services are available on a flexible schedule. Staff generally provide services from 8 a.m. – 5 p.m. but can alter their schedule to provide assistance and support in the evening or on the weekends. Each tenant is provided with a list of important phone numbers that include the phone numbers of their	• It is recommended that the system consider opportunities to involve and take advantage of the strengths peer run agencies may offer to help meet the needs of tenants participating in PSH programs 24 hours a day, seven days a week.

			Primary Worker, the Program Manager, and their clinical team CM. For assistance with support and overnight needs that do not rise to the level of crisis, tenants can contact the PSA After Hours line, available from 8 p.m. – 8 a.m. and the Peer Support Warm Line. For crisis situations, tenants can call the Crisis Line, or 911 for emergency assistance.	

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	1
1.1.b: Real choice of housing unit	1,4	4
1.1.c: Tenant can wait without losing their place in line	1-4	4
1.2.a: Tenants have control over composition of household	1,2.5,4	4
Average Score for Dimension		3.25
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	1
3.2.a: Whether housing meets HUD's Housing Quality Standards	1,2.5,4	1
Average Score for Dimension		1
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	2
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		2.83
7. Flexible, Voluntary Services		
7.1.a: Extent to which tenants choose the type of services they want at program entry	1,4	1
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	4
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	3
Average Score for Dimension		2.87
Total Score		20.45

Highest Possible Score		28