PERMANENT SUPPORTIVE HOUSING (PSH)
FIDELITY REPORT

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To: Dr. Shar Najafi-Piper, CEO

From: Kristy Crawford, MA, MBA
Nicole Eastin, BS
AHCCCS Fidelity Reviewers

Introduction

Arizona Health Care Cost Containment System has contracted with 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 Fidelity Scale, an evidence-based practice (EBP). Permanent Supportive Housing refers specifically to the EBP of helping members with a serious mental illness (SMI) determination find and maintain safe and affordable housing in integrated communities, not those with disability-related eligibility criteria.

Method

On April 22 - 25, 2024, Fidelity Reviewers completed a review of the Copa Health Permanent Supportive Housing Program (PSH). This review is intended to provide specific feedback in the development of your agency's PSH services in an effort to improve the overall quality of behavioral health services in the Central Region of Arizona.

Copa Health provides a multitude of services throughout the region, including integrated healthcare, permanent supportive housing, residential services, employment related services, day program activities, and counseling, among other services, to a range of persons with intellectual developmental disabilities and/or mental health conditions. The PSH program at Copa Health is referred to as the *Hope Program*. The individuals served through the agency are referred to as *members,* but for the purpose of this report, the term *tenant* or *member* will be used. At the time of the review, the program was serving 33 members.

Due to the system structure of separate treatment providers, information gathered at the Southwest Network Northern Star and Copa Health Gateway outpatient behavioral health clinics were included in the review as sample referral sources. However, some data obtained reflects services provided by other partner clinics, as well.

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

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

- Group program overview via videoconference with the Copa Health Program Director of Housing, and the Vice President of Housing and Community Support Services.
- Individual videoconference interview with the PSH Program Manager.
- Group videoconference interview with two PSH Housing Specialists and one Intake Specialist.
- Group videoconference interview with two Case Managers and one Housing Specialist from Southwest Network Northern Star clinic.
- Group videoconference interview with two Case Managers and a Housing Specialist from Copa Health Gateway clinic.
- Individual phone interviews with five members participating in the PSH program.
- Closeout discussion with PSH Program Manager and a representative from the contractor with a Regional Behavioral Health Authority.
- Review of agency documents including *Copa PSH Brochure*, policies and procedures, *PSH Welcome Letter*, open referrals spreadsheet, job descriptions, PSH program meeting minutes, admission and discharge criteria, and member data collection.
- Remote review of 10 randomly selected 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) are rated on a 4-point scale with 2.5 indicating partial implementation. Four items (1.1b,5.1a, 7.1a, and 7.1b) allow only a score of 4 or 1, indicating that the dimension has either been implemented or not implemented.

The PSH Fidelity Scale was completed following the review. A copy of the completed scale with comments is attached as part of this report.

Summary & Key Recommendations

The agency demonstrated strengths in the following program areas:

- Tenants of PSH Hope confirmed they are provided options in housing units and do not feel pressured to accept accommodations that do not align with their individual needs and preferences.
- PSH staff and clinical teams do not have a role in property management functions, nor do landlords play a role in provision of support services.
- The PSH program assists members in acquiring scattered-site housing that is integrated into the community.
- Members enrolled in the program have the option to select and adjust services with the clinics they are enrolled in. Progress notes indicate clinic staff are attentive and responsive to members' needs and concerns.

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

- The PSH program lacks policies and procedures in obtaining and retaining copies of tenant current leases, Housing Quality Standards (HQS) reports, and documentation of rent-to-income data. It is essential to establish a dependable practice for gathering and preserving this information to ensure easy access to effectively support and advocate on behalf of tenants for safe and affordable housing.
- Collaborate with system partners to ensure outpatient behavioral health clinical teams and service providers have a thorough understanding of *Housing First* principles and are able to assist members in obtaining housing that aligns with their preferences. Educate all clinical team staff on how PSH service provisions support members and share knowledge with members about program availability.
- Evaluate the program's expectation of *time limited* services. PSH programs provide services to support members, not just in attaining housing but also to retain housing. PSH programs are designed for those with the most significant challenges to housing stability and retention and often need long term service and supports at their preferred level of intensity.
- Develop opportunities and strategies to incorporate member input specific to PSH program services. Members have few options to provide program planning and input, and no anonymous outlet to provide feedback or suggestions to improve PSH services.

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 2.5	Per interviews, members receive assistance to pursue their preferred housing options. Staff at one clinic shared an understanding that it is member preference when choosing the type of housing desired and a referral for PSH services is made. Staff at the other clinic limits choice in housing options. When members are actively using substances or determined not to be able to live on their own, integrated housing settings are not offered. In addition, staff indicated members need an income, or a voucher, to be referred to the PSH program. One reviewed record indicated that while a member's family required them to live in an assisted living placement, the member preferred independent living. Both clinic and PSH staff accommodated the member by basing the search on the member's preferences.	• Ensure that clinical teams receive ongoing training and education in PSH and *Housing First* principles. Members seeking independent housing benefit from being supported through identification of needs and offering of relevant wraparound supports and resources. • Educate clinic or referring agency staff about the range of options without screening for readiness to live independently. Offer services and engage members to support them in the setting of their choice. In the EBP of PSH, services are structured to meet the needs of members with the most significant housing challenges.
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 report that members have the freedom to select their preferred unit. Staff will accompany members to view units, and members may decline if they desire something different, with the search continuing. Clinic staff from both locations confirm members can choose the unit during their search for independent living. One member interviewed reported particular preferences for a unit, including wood flooring, avoiding proximity to	

	tenants are offered a choice of units		power lines and heavy traffic, and identified an apartment complex meeting these criteria, has secured a lease and a scheduled move-in date. PSH service plans specify location preferences, such as proximity to a grocery store, and preferred geographical areas, which the team actively prioritizes.	
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 members decline units, they can continue the housing search, as reported by staff. Members that hold subsidy vouchers have up to 60 days from the voucher date to secure a unit. When an extension is necessary, PSH staff will collaborate with the clinical team, and/or the subsidy holder, to request an extension. When a member declines a unit, they may be informed that it is the only option available in the area of their choice and can choose to wait for another unit without losing their place on the waitlist.	
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	PSH staff indicated assisting members who wish to include additional individuals, such as spouses, children, or friends, on their lease. Staff at one clinic reported voucher holders have contacted the clinical team inquiring about eligibility and approval of proposed individuals. Clinic staff reported some members have required live-in support and/or home-aid services; in these instances, the assigned psychiatric prescriber submits a reasonable accommodation letter on the member's behalf. Any prospective additions must undergo financial and background checks as mandated by the property management. Staff at the other clinic reported that they have never been asked to provide clinical input to add an additional person to a member's voucher.	• Support members in treatment or transitional settings to locate independent housing if that is their living situation goal. • Ensure that all system partners have an accurate understanding of policies regarding composition of household and is communicated consistently to tenants and members seeking housing assistance. In the EBP of PSH, tenants decide who they live with, and the only restrictions are those usually applied by property managers of market rate units. Clinical team approval should not be required.

			Members report being able to choose the composition of their household with no restrictions. Members interviewed indicated having additional members to include, children, and significant others as additions to their vouchers or leases. Data reviewed reflects 27% of members are in settings where there may be program control over housing composition, i.e., behavioral health residential facilities, and shelters.	
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	Based on interviews with members, PSH, and clinic staff, property managers are not involved in delivering clinical or social services to residents. Of the 30 housed members, 27% reside in settings where there may be overlap between housing management and staff providing services associated with residences, such as behavioral health residential facilities and shelters.	
2.1.b	Extent to which service providers do not have any responsibility for housing management functions	1, 2.5, or 4 4	According to the interviews, service providers are not tasked with any housing management duties. Clinic and PSH staff reported they do not handle rent collection, eviction procedures, or reporting of lease violations.	

2.1.c	Extent to which social and clinical service providers are based off site (not at the housing units)	1 – 4 3	Clinic and PSH staff reported they do not have offices at locations where members reside. Approximately 73% of PSH tenants live in settings separate from social service staff and providers. Roughly 27% of members live in places where on-site staff may offer supportive services.	• Educate members in residences where social service staff are on-site or frequently visit (without member control) of other housing arrangements based on members preference.
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	The majority of members in the PSH program are actively seeking housing with the support of program staff. Staff aid members to apply for low-income housing waitlists to ensure they do not exceed paying more than 30% of income on rent if approved. Based on data provided of housed members, on average, tenants currently allocate 24.31% of income toward rent. Nine members are paying more than 30% of income on housing, and four members are paying over 50%. PSH staff reported members residing with family or friends do not pay rent. PSH and clinic staff report collaboration with members in creating budgets that identify what they can afford with their existing income and without any subsidy. Despite most members having some form of income, high rent costs make living independently unattainable. Staff engage members in discussions of options that may make housing more affordable, such as living with a roommate; however, many members prefer independent living.	• To the extent possible with consideration for market factors, continue to work with tenants that are paying over 30% of income toward housing to find more affordable units. Continue assisting tenants in applying to assistance programs or finding employment to help mitigate rental costs. • Seek to maintain documentation of rent to income data to better support members in budgeting as a step to maintain housing.

			PSH staff and clinical team staff also engage members in conversations about employment opportunities to improve choice in housing. Clinic staff indicated they do not refer individuals that lack income to PSH programs. The PSH staff aids individuals by referral to employment programs and assists in applying for benefits. Waitlists for voucher programs are an average of 1 - 2 year wait time.	
3.2 Safety and Quality				
3.2.a	Whether housing meets HUD's Housing Quality Standards	1, 2.5, or 4 1	Per the data provided, the PSH program does not hold copies of HQS inspection reports for housed members. The data indicates three tenants in the PSH program hold a rental subsidy. Upon securing housing for those without vouchers, staff reported guiding them through the leasing agency's checklist to ensure safe housing. PSH staff reported that HQS inspections are being replaced by National Standards for the Physical Inspection of Real Estate (NSPIRE).	• Explore options to complete HQS inspections for members that do not receive a rental subsidy. Continue efforts to maintain copies of most recent HQS reports. • Consider tracking renewal dates to support tenants plan for inspections.
Dimension 4 **4.1 Housing Integration**				
4.1 Community Integration				
4.1.a	Extent to which housing units are integrated	1 – 4 4	Per the data provided by PSH staff, the program supports 33 members, 30 of whom have a residence. Most housed members live in independent residences, with family or friends, and clusters of members living at the same address do not exist. There are two members currently in the same residential treatment program.	
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	According to interviews with clinic and PSH staff, most members have leases depending on their living situation. PSH staff interviews revealed members maintain complete tenancy rights, especially those in independent settings and those who possess lease copies. PSH staff make efforts to acquire lease copies from members and seek assistance from the clinical team in this endeavor, but they are not always successful. Data provided by PSH staff indicates the PSH program has four leases on file, which is 13% of housed members. Ten members are living with family and friends and limited rights to tenancy; nine members are residing in residential facilities, shelters, or halfway homes.	• PSH agencies obtain and maintain current copies of all leases. For scattered site units, explore the feasibility of having voucher administrators providing copies of leases to PSH providers as leases are an important tool supporting tenant advocacy and eviction prevention. Members participating in PSH services should be educated as to the benefits of sharing the lease with the PSH services provider. • Continue efforts to educate members, and their family and friends with whom they reside, of the benefits and protections a written housing agreement may offer. Living with family does not guarantee member's rights of tenancy.
5.1.b	Extent to which tenancy is contingent on compliance with program provisions	1, 2.5, or 4 2.5	Based on the housing data provided, 73% of members reside in settings where tenancy is not dependent on compliance with program provisions. The remaining members live in staffed transitional or treatment settings, where tenancy is contingent on treatment participation or program rules. Among the 30 housed members, nine are currently in residential treatment settings, shelters, assisted living facilities, or halfway houses.	• Continue efforts to assist members that reside in transitional or treatment settings to explore independent living options, if that is their goal.
Dimension 6 Access to Housing				
6.1 Access				
6.1.a	Extent to which tenants are required to demonstrate housing readiness to	1 – 4 3	PSH staff verified their adherence to a *Housing First* model and clarified that apart from a referral from a provider clinic, there are no additional requirements for entry to the PSH program. All referrals are accepted, and members are assisted based on identified	• Ideally, PSH Hope staff, and system partners, collaborate with clinic staff to enhance understanding of PSH services and the *Housing First* model, as well as how PSH reinforces these principles. Assessing members' needs would be an

	gain access to housing units		needs. While the PSH program requests a Vulnerability Index Service Priority Decision Assistance Tool (VI-SPDAT) along with the referral, staff reported the score is not utilized to determine a member's eligibility for the PSH program. Reports from clinic staff varied in relation to screening members expressing an interest in housing. Some clinic staff have conversations with members about their readiness for independent living and offer other housing options, such as staffed housing or treatment settings, based on the member's lifestyle and history of independent living. Other clinic staff emphasized housing is pivotal for stability in members' lives and reported members are referred upon request, without screening for readiness; Staff observed members' quality of life, and physical and mental health, improved significantly upon securing housing. Some additional clinic staff reported members need to have income to be referred to a PSH program.	appropriate step if the aim is to identify the skills and services required to support members in successful independent living. Members only need to express a desire for safe and affordable housing to be referred to PSH programs.
6.1.b	Extent to which tenants with obstacles to housing stability have priority	1, 2.5, or 4 2.5	PSH staff and clinic staff report no knowledge of how system administrators prioritize members on subsidized waitlists. PSH staff report that no priority is given to members for intake or enrollment. Staff have the resources to support members facing eviction and assist during eviction proceedings. Reviewers were provided *Copa PSH Brochure,* identifies candidates for the PSH program must be SMI, identify a want/need for housing, and have financial means. The brochure also states members without financial means can receive	• System partners should ensure that clinic staff assisting members with accessing permanent supportive housing and services across all provider clinics have a common and accurate understanding of eligibility and prioritization. Lack of accurate information may result in members being dissuaded from pursuing housing or feeling frustrated with the results. • PSH is specifically designed to support individuals with significant behavioral health challenges in living independently

			assistance from staff to get on low-income or affordable housing waitlists and will then be discharged back to the clinical team for ongoing assistance and support. Both clinics reported offering resources to anyone seeking assistance, ensuring access to shelters, domestic violence support, group homes, and more. No one is denied support, even when navigating through various systems. At one clinic, newer staff members exhibit a lack of familiarity with PSH program services and the *housing-first* approach, including the specific qualifications for waitlists that members could meet. Additionally, it was disclosed that staff conduct a VI-SPDAT assessment with all members seeking housing and make referrals based on the assessment scores. However, it is important to note that the PSH agency does not require the completion of a VI-SPDAT.	in the housing of their choice; through a combination of affordability tools and wrap around 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 support.
6.2 Privacy				
6.2.a	Extent to which tenants control staff entry into the unit	1 – 4 3	Clinic and PSH staff emphasized tenants have sole control over entry to their units. PSH staff schedule home visits with members and do not enter without explicit member permission. In cases where member safety is concerned, staff notify the clinical team and emergency contact. As a last resort, staff may request a wellness check be conducted by Law Enforcement. Members interviewed confirmed staff cannot access member units without permission. One member reported willingly welcoming staff into their home during visits.	• Continue efforts to assist members that reside in transitional or treatment settings to explore independent living options when that is the identified goal.

			The majority of housed members live independently, with family or friends. Approximately 27% of members reside in environments where service staff associated with the residence may have different levels of access, such as halfway houses, shelters, or residential facilities.	
Dimension 7 Flexible, Voluntary Services				
7.1 Exploration of tenant preferences				
7.1.a	Extent to which tenants choose the type of services they want at program entry	1 or 4 4	Staff from both clinics reported members are the primary authors of their service plans and have the freedom to select the services they desire. Members reported being the authors of their service plans, with guidance from clinic staff. Based on review of ten member records, seven members had specific housing goals outlined in their clinic service plans, all of which were expressed in the members' own words.	
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 revised annually, when there is a change in member goals, or when the member experiences significant life events. Staff cited allocating the necessary time and being unable to get ahold of members as the primary obstacles to completing service plan updates. Members interviewed stated that they have the ability to adjust their services with clinical teams whenever they wish to add or remove goals tailored to their needs.	
7.2 Service Options				
7.2.a	Extent to which tenants	1 – 4	According to PSH staff, members have the option to decline services without jeopardizing	• Provide training to PSH staff regarding how to work with members to develop

	are able to choose the services they receive	3	housing. Records reviewed indicated member's PSH goals appeared personalized; however, most goals contained the same general information, with minimal tailoring to individual member needs. Service plans lacked details about the steps staff would take to assist members in achieving goals; instead, primarily focused on the members' actions. Additionally, housed members are not usually referred for PSH services aimed at maintaining housing stability. Members interviewed had varying levels of understanding about the PSH program's duration and services. All believed that once housing was secured, involvement with the PSH program would end, as they would no longer be searching for housing. Additionally, members were uncertain about any other services the PSH program could offer them.	personalized needs and/or objectives. Match specific PSH services to directly address or support the member to address those needs. Review the content of plans to determine if revisions are needed, such as when members obtain a residence. On plans, document the shift from services to obtain housing, to specify needs and services to maintain housing.
7.2.b	Extent to which services can be changed to meet tenants' changing needs and preferences	1 – 4 2	Staff indicated member service plans are generally not updated to reflect new goals, focused on ensuring stability through continued support, after a member is housed; member goals are typically established during intake and remain the same until closure. The service plans outline goals related to how the member will engage with housing waitlists, among other aspects. Most members remain on PSH caseloads for 30 to 90 days after securing housing; staff indicated the PSH program is a "short term housing program" depending on individual needs. According to the data provided, all members, except one, have been in the program for less than eight (8) months. PSH staff may recommend a referral to another Copa	• Evaluate aspects of what appears to be an expectation of time limited services, i.e., graduation after members are housed. In the EBP of PSH, services are available to support members to not just attain housing but also to retain housing. PSH programs are designed for those with the most significant challenges to housing stability and retention, and often need long-term service and support at their preferred level of intensity. • Consider providing additional training to staff on how to engage members to address other areas of vulnerability, concern, or prior issues that led to

			Health program for additional ongoing support to maintain housing Clinic staff note that members are typically discharged from the PSH program 30 days after securing housing. Staff at one clinic expressed uncertainty regarding the type of supportive services provided to housed members. Referrals primarily occur when individuals are seeking housing, with fewer referrals aimed at providing services to stabilize housing for struggling members.	eviction or homelessness in an effort to support housing retention.
7.3 Consumer- Driven Services				
7.3.a	Extent to which services are consumer driven	1 – 4 2	PSH staff report that quarterly forums to gain member input into program planning no longer occur. PSH staff reported members complete satisfaction surveys on a quarterly rotation, however, is not specific to the PSH program. Based on the *PSH Welcome Letter*, and interviews, the PSH team includes individuals with lived experience in mental health, homelessness, and navigating through the system.	• Explore ways to solicit and incorporate member input on program design and service provision. For example, explore if members can serve on sub-committees to the agency board of directors, participate in quality management, or other processes that impact service design and provision. • Consider options to facilitate member/tenant forums using videoconference and/or conference calls so that members can voice their concerns and desires for program design. • Offer members an opportunity that allows them to anonymously submit questions, concerns, and suggestions for program improvement. For example, determine if a program specific survey can be implemented.
7.4 Quality and Adequacy of Services				

7.4.a	Extent to which services are provided with optimum caseload sizes	1 – 4 3	During the review period, the program employed two PSH housing specialists, one staff member responsible for conducting intakes, and one PSH program manager. Per the data provided, the PSH program is comprised of 33 members. Interviews with staff revealed recent turnover caused intakes to be temporarily suspended, resulting in caseloads exceeding 15 members for some staff. At the time of the review, the team was in the process of onboarding two housing specialists. The ratio of members-to-staff averages 17:1. At the time of the review, the PSH program was on hold for accepting new referrals, with five members waiting to be assigned to PSH staff. When a member's preferred program is not accepting new referrals, their choice regarding participation in PSH services is limited.	• Maintain caseloads of no more than 15 members per staff. • Continue efforts to hire staff to provide adequate member coverage of changing needs and to be readily available. Optimum caseload size for PSH services providers is 15 members to every staff, providing flexibility and responsiveness to support members in retaining housing.
7.4.b	Behavioral health services are team based	1 – 4 3	PSH staff reported monthly summaries of the PSH services provided to members are forwarded to the clinics. PSH staff reported the initial coordination with clinical teams takes place upon receipt of the referral. Contact with clinical teams varies, ranging from weekly updates to monthly summaries. One clinic reported receiving weekly updates; clinic staff reported weekly updates provide a play-by-play of tasks completed, but a monthly summary would be beneficial. The other clinic reported communication in general is inconsistent and the level of communication depends on which housing specialist is assigned. Records reviewed indicated weekly updates from the PSH program are typically sent to clinical	• Consider scheduling regular planning sessions between the PSH provider and clinic staff to coordinate member care. Soliciting input and sharing updated service plans and other documentation is encouraged if an integrated health record and integrated team cannot be implemented. • Explore options to develop an integrated record system can be developed so that members that receive both clinic and PSH services from Copa Health have one unified system. This may result in all involved service staff contributing to a shared comprehensive member service plan as well as improved member care coordination.

			teams via email and were documented in PSH records. The PSH Hope program and one partnering clinic reviewed are considered the same agency; however, each have separate electronic health records for members.	
7.4.c	Extent to which services are provided 24 hours, 7 days a week	1 – 4 3	PSH staff work Monday – Friday, 8:00am to 4:30pm. Per interviews, staff have the ability to adjust work hours to accommodate members' needs by working specific evenings and weekends upon request. Additionally, PSH staff provide after-hours services that involve monthly rotating coverage of an on-call phone. Members are provided with a contact list within the *Welcome Packet* providing staff contact information including the 24-hour on-call program services number. Staff also shared they rarely receive after-hour calls from members. Staff from one clinic was unaware the PSH program provided 24/7 services and assumed members would contact the clinical team when in need of assistance after hours. During member interviews, members demonstrated a lack of awareness regarding the PSH program's on-call number. Zero members reported knowledge of being able to contact PSH staff after hours or on the weekends.	• Ensure all members are informed of PSH staff on-call availability. Consider including the hours of PSH staff availability and how to contact PSH staff after hours on the program brochure. In the EBP of PSH, members are able to contact program on-call staff as a primary resource in the event of a crisis. PSH staff are likely better positioned to respond to and support members in the community, including outside of regular business hours, than staff from general crisis lines or outpatient behavioral health clinical teams.

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	2.5
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	2.5
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	3
Average Score for Dimension		3.67
3. Decent, Safe and Affordable Housing		
3.1.a: Extent to which tenants pay a reasonable amount of their income for housing	1-4	3
3.2.a: Whether housing meets HUD's Housing Quality Standards	1,2.5,4	1
Average Score for Dimension		2
4. Housing Integration		
4.1.a: Extent to which housing units are integrated	1-4	4
Average Score for Dimension		4
5. Rights of Tenancy		
5.1.a: Extent to which tenants have legal rights to the housing unit	1,4	1

5.1.b: Extent to which tenancy is contingent on compliance with program provisions	1,2.5,4	2.5
Average Score for Dimension		1.75
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	3
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	4
7.1.b: Extent to which tenants have the opportunity to modify services selection	1,4	4
7.2.a: Extent to which tenants are able to choose the services they receive	1-4	3
7.2.b: Extend to which services can be changed to meet the tenants' changing needs and preferences	1-4	2
7.3.a: Extent to which services are consumer driven	1-4	2
7.4.a: Extent to which services are provided with optimum caseload sizes	1-4	3
7.4.b: Behavioral health services are team based	1-4	3
7.4.c: Extent to which services are provided 24 hours, 7 days a week	1-4	3
Average Score for Dimension		3
Total Score		20.50

Highest Possible Score		28