Oakland County Centralized Housing Registry
Policies and Procedures

ADOPTED January 17, 2017

BACKGROUND

The Alliance for Housing (Oakland County's Continuum of Care) established a centralized housing registry to provide equitable and consistent access to all potential program participants seeking permanent supportive housing in our local community. A workgroup was established through the Alliance's Systems and Integration Committee, under the CIST (Community Interagency Service Team) to develop both a centralized intake process with prioritization standards, and to provide continued implementation and oversight of the disposition process.
Referrals that are populated on the registry contain information that is compiled from a basic screening which can include self reporting from the individual/household related to their demographics, including history of homelessness and disability. These factors must be verified in order to determine eligibility for programs, including determination of homelessness. As HUD and the community are emphasizing the goal to end chronic homelessness, this will include certification of chronic homelessness as applicable. In addition all potential program participants must meet a minimum of Category I Homelessness. Due to changes in HUD's recommended order of priority the certification will include where the person is experiencing homelessness (streets, shelter, safe haven, transitional housing, etc.). Upon referral, the PSH partner begins the process of contacting the program participant and verifying all information. The PSH partner is also responsible for updating the HMIS record to reflect up to date and accurate information throughout this process.

Membership

The workgroup consists of members beyond the Permanent Supportive Housing (PSH) Providers to make sure that decisions made are transparent. This measure also safeguards that all prioritizations would be with the community and potential program participant's benefit in mind, rather than to serve any organizations' needs.

Currently the Oakland County's PSH Partners include representation from the following groups/entities:

- Alliance for Housing
- Housing Assessment and Resource Agency (HARA)
- PSH Provider - Community Housing Network
- PSH Provider - Hope Network/New Passages
- PSH Provider - Lighthouse (*Additionally Transitional Housing Provider*)
- PSH Provider - South Oakland Shelter
- PSH Provider - Training and Treatment Innovations

- PSH Provider - Training and Treatment Innovations
- Common Ground (Youth Transitional Housing)
- Oakland County Homeless Management Information System (HMIS)
- HAVEN – local shelter for Domestic Violence
- HOPE, Inc. - Local Low Barrier Shelter and Recuperative Care Center
- Oakland County Community Mental Health Authority
- Oakland County Schools Homeless Liaison
- Oakland County Health Division
- OLHSA HOPWA
- MSHDA
- Veteran's Administration
- Oakland County Veterans' Administration
- MSHDA Voucher Agents, as needed

PROCEDURE

Screening
A QSOBAA (Qualified Service Organization Business Associate Agreement) was put in place to allow for sharing of information for those that share data in HMIS. PSH Partners are able to utilize a community wide assessment that allows a PSH Partner utilizing HMIS to assess and refer those presenting as homeless. This assessment was tailored to include the essentials (including new HUD standard questions related to chronicity and other factors, as well as the VI SPDAT) to determine potential eligibility for permanent supportive housing, and to streamline the system without duplication of HARA duties. Each partner agency, with the exception of the DV Shelter, has the ability to make a referral or to choose to have the potential program participant call the HARA. If a potential program participant qualifies for Permanent Supportive Housing based on the assessment, a referral is made in HMIS to the Permanent Supportive Housing Centralized Housing Registry. Additionally it should be noted that anyone that is reported to be chronically homeless is added to the registry regardless of VI SPDAT score as those who are chronically homeless are prioritized in the community. Please refer to page 6 of this document – Order of Priority – for further detailed information.

Because of the need to share information beyond the partners covered in the QSOBBA, an MOU was put in place that allows for the partners to share program participant information to coordinate services. Additionally, changes were made to the Alliance's HMIS Release of Information to allow for continued coordinated assessment and services.

Based on HUD's guidance for prioritization and the emphasis on assisting those who meet the definition of chronic homelessness, those who report as "chronically homeless" during initial screening will be placed on the Registry regardless of VI SPDAT score. To ensure the ability to also manage and monitor other subpopulations who report as homeless but who do not meet the chronic definition, the community has established a threshold of 9 for families, or 8 for individuals, for the VI-SPDAT V2 in order for potential program participants to qualify for referral to the PSH Centralized Housing Registry. At times this score may be expanded to

include lower VI scores if the vacancies are increased and the community has more capacity to assist more potential program participants that meet other eligibility requirements.

While those who are reported to be chronic are prioritized for PSH, there may be times that a slot of PSH may not be immediately available due to capacity. For this reason, and for other potential program participants that are on the registry, the team coordinates with Rapid Rehousing Programs and other housing resources in the CoC to explore all other potential housing assistance for presenting households. This may include using "bridging" to provide a potential program participant with a shorter term program, while maintaining the name on the registry for when a vacancy may become available to transition into a longer term housing option.

While the Registry takes into account the vulnerability of a potential program participant as part of the prioritization process, there may be instances where a potential program participant refuses to participate in this screening process or is unable to complete the interview. Community members will continue to attempt to engage the potential program participant in this process but this will not hinder the person from being placed on the registry. In these situations the referral will be made and length of time homelessness will be utilized for placement on the list. For instance if a person is reported to be "chronic" and has been homeless for 12+ months, the person will be placed on the registry in that appropriate spot based on this information. In situations where the person is not chronic, the potential program participant will be placed in the appropriate category with a note and reviewed by the team to place in the appropriate section of the registry during scheduled meetings. The community partner referring the potential program participant will have opportunity to discuss mitigating factors and the situation to ensure that any vulnerability factors can be considered in this discussion for appropriate prioritization.

External Reporting Details

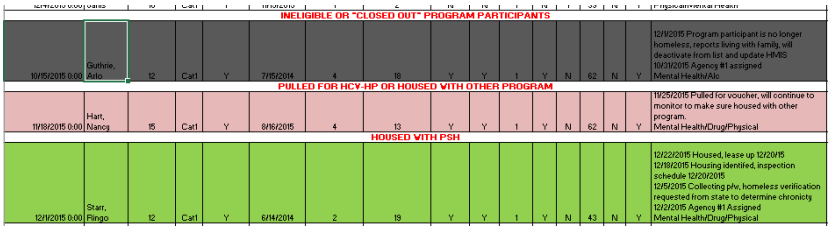
1. A Referral report is run from ServicePoint and exported to Excel by the HMIS System Administrator. The HMIS System Administrator was assigned this task to ensure transparency as this position is neutral when it comes to PSH vacancies and disposition as there is no invested role in this process as this is a completely separate function than PSH. This document serves as the Registry for the community.

2. The registry is provided to the HARA before disposition to review and research any gaps. As needed, the HARA will refer to HMIS or a service provider/source of referral to get additional information or clarification for the record of a particular individual. This could include a missing VI score, clarification of Category of homelessness, more information about a disability, length of time homeless, etc.

3. The HARA then prepares the registry for weekly disposition and facilitates a meeting of the PSH Partners. This occurs generally on a weekly basis. Typically the group meets weekly on a virtual basis (GoToMeeting and phone call meeting) with a face to face meeting scheduled once per month.

SAMPLE OF PSH CENTRALIZED HOUSING REGISTRY

	Name/ID	VI SPDAT Score	Housing Status	Client entering from the streets/ESSH	If, entering from streets, ES or SH Approx start Date	Number of times the client has been on the streets/ESH in past 3 yrs	Total number of months homeless on the street/ES/SH in past 3 yrs	Homeless at least 1 year	Chron	HH	Vet	DV	AGE	HIV/AIDS	Dis	Disposition
12/21/2015 0:00	Mann, Stan	7	Cat1	Y	10/1/2015	1	14 months	Y	Y	1	N	N	37	N	Y	Alc/chronic health/drug/mental health/phy
12/15/2015 0:00	Holly, Buddy	VIFSPDAT Score of 12 for family.	Cat1	Y	9/15/2015	1	2	N	N	2 Adults, 2 Children	N	Y	40	N	Y	Mental Health/Phy
PREVIOUS DISPOSTIONS																
12/17/2015 0:00	Presley, Elvis	VIFSPDAT Score of 14 for family.	Cat1	Y	9/17/2015	3	15	Y	Y	1 Adult, 1 child	Y	N	55	N	Y	12/22/2015 Agency B4 assigned Mental Health/Alc
12/4/2015 0:00	Joplin, Janis	10	Cat1	Y	11/15/2015	1	2	N	N	1	N	Y	28	N	Y	12/22/2015 Agency B3 Assigned Physical/Mental Health



INELIGIBLE OR "CLOSED OUT" PROGRAM PARTICIPANTS																
10/15/2015 0:00	Guthrie, Arlo	12	Cat1	Y	7/15/2014	4	10	Y	Y	1	Y	N	62	N	Y	12/1/2015 Program participant is no longer homeless, reports living with family, will deactivate from list and update HMIS 10/31/2015 Agency #1 assigned Mental Health/Alc
PULLED FOR HCV-HP OR HOUSED VITH OTHER PROGRAM																
11/18/2015 0:00	Hart, Nancy	15	Cat1	Y	9/16/2015	4	13	Y	Y	1	Y	N	62	N	Y	11/25/2015 Pulled for voucher, will continue to monitor to make sure housed with other program. Mental Health/Drug/Physical
HOUSED VITH PSH																
12/1/2015 0:00	Starr, Ringo	12	Cat1	Y	6/14/2014	2	19	Y	Y	1	Y	N	43	N	Y	12/22/2015 Housed, lease up 12/20/15 12/18/2015 Housing identified, inspection schedule 12/20/2015 12/5/2015 Collecting phv, homeless verification requested from state to determine chronicity 12/2/2015 Agency #1 Assigned Mental Health/Drug/Physical

Prioritization and Disposition

The registry is an Excel spreadsheet and is sorted with new referrals provided at the top of the document.

At the beginning of each meeting, each PSH provider reports on any available vacancies in their programs. The group then reviews the potential program participants on the list that have not yet been referred to a PSH Provider.

The prioritization process is as follows:

1. The available referrals are first sorted to distinguish between those who reported as "chronically homeless" vs. those who did not. For ease of organization and review, several subcategories will be grouped within the registry to include chronic, potential program participants that have experienced 12+ months of homelessness but do not meet chronic definition, those who are homeless less than 12 months but have severe service needs, and youth (under 25) who may also not meet the community established threshold. Once the registry is sorted into these groups, each group is again sorted by VI-SPDAT score, ranked from highest score (highest need) to lowest score (less need).

2. In accordance with guidance from HUD, the community will prioritize at least 85% of available beds to chronically homeless individuals and households available from turnover. The chronic definition is in accordance with the "final rule" published on December 4, 2015:

1. An individual who:

- *Is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter, and*
- *Has been homeless and living or residing in a place not meant for human habitation, a safe have, or in an emergency shelter continuously for at least 1 year or on at least four separate occasions in the last 3 years, where the cumulative total of the four occasions is at least one year. Stays in institutions of 90 days or less will not constitute as a break in homelessness, but rather such stays are included in the cumulative total; and*
- *Can be diagnosed with more or more of the following conditions: Substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000 (42 U.S.C.15002)), post traumatic stress disorder, cognitive impairments result from brain injury, or chronic physical illness or disability;*

2. An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility for fewer than 90 days and met all the criteria in paragraph (1), before entering the facility; or

3. A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all the criteria in paragraph (1), including a family whose composition has fluctuated while the head of household has been homeless.

- It will be the responsibility of each organization, and subsequent PSH program, to track their individual turnover rate and numbers in regard to vacancies filled by households and individuals experiencing chronic homelessness.

- There may be situations where a housing unit is not the appropriate fit for a particular program participant with their specific needs. For instance, some programs have minimal supportive services provided in the program (i.e. one housing case management face to face contact every six months). In these situations the group will discuss the appropriateness of the available slot of housing and ensure that an alternate slot of PSH is identified.

- In situations where housing can be made available to a potential program participant that is not chronically homeless, the group will consider the person with the most need who meets the eligibility for the available slot of PSH, as evidenced by the highest VI score, on the registry as well as length of homelessness.

3. In accordance with guidance from HUD, the following system to prioritize households will be used, prioritizing those who meet chronic homelessness first, and then other potential program participants secondly:

ORDER OF PRIORITY

Order of Priority	Meet's HUD's Chronic Homeless Definition (Final Rule)	Has Severe Service Needs	Other Requirement
	Potential Program Participant Meets HUD's Chronic Definition		
1	Yes	Yes	Meets HUD's Final Rule for Chronic Homelessness: At least 12 months of continuous or at least 12 months cumulative across 4 occasions in three years. High services needs as evidenced by a VI-SPDAT V2 Score (9+ for families, 8+ for individuals). HOH must have a qualifying disability.
2	Yes	No	Meets HUD's Final Rule for Chronic Homelessness: At least 12 months of continuous or at least 12 months cumulative across 4 occasions in three years. Low services needs as evidenced by a VI-SPDAT V2 Score (-9 for families, -8 for individuals). HOH must have a qualifying disability.
	Potential Program Participant Does Not Meet HUD's Chronic Definition		
3	No	Yes	Does not meet the new HUD Final Rule for Chronic Homelessness:

			Individual/Household has 12+ months cumulative homelessness with *less than 4 occasions* in three years. High services needs as evidenced by a VI-SPDAT V2 Score (9+ for families, 8+ for individuals). HOH must have a qualifying disability. The homeless status must include coming from streets, shelter, and safe haven or uninhabitable. TH is not included in this category.
4	No	Yes	Does not meet the HUD Final Rule for Chronic Homelessness: Less than 12 months cumulative homelessness. High services needs as evidenced by a VI-SPDAT V2 Score (9+ for families, 8+ for individuals). HOH must have a qualifying disability. The homeless status must include coming from streets, shelter, and safe haven or uninhabitable. TH is not included in this category.
5	No	No	Does not meet the new HUD Final Rule for Chronic Homelessness: Less than 12 months cumulative homelessness. Low services needs as evidenced by a VI-SPDAT V2 Score (-9 for families, -8 for individuals). HOH must have a qualifying disability.
6	No	N/A	Individual or family that is eligible for PSH and is currently residing in a transitional housing projects and had been Category I homeless immediately prior to entry into Transitional Housing. HOH must have a qualifying disability.

As noted earlier in this document, there may be situations where a potential program participant refuses to complete, or is unable to complete, the VI SPDAT which provides a score for vulnerability. Community members will continue to attempt to engage the potential program participant in this process but this will not hinder the person from being placed on the registry. In these situations the referral will be made and length of time homelessness will be utilized for placement on the list. For instance if a person is reported to be "chronic" and has been homeless for 12+ months, the person will be placed on the registry in that appropriate spot based on this information. In situations where the person is not chronic, the potential program participant will be placed in the appropriate category with a note and reviewed by the team to place in the appropriate section of the registry. The community partner referring the potential program participant will have opportunity to discuss mitigating factors and the situation to ensure that any vulnerability factors can be considered in this discussion.

4. While there is an emphasis and commitment to serve those who are experiencing chronic homelessness first, through both dedicated and prioritized beds, there are times when there are not enough potential program participants on the registry who meet the criteria for chronic homelessness who can be "matched" to available open slots of permanent supportive housing in the community. In these situations, as advised by HUD, the group will move to house non-chronically homeless individuals or families who are eligible for permanent supportive housing to prevent ongoing vacancies in programs. Documentation will be placed in each program participant's file when this occurs, using the PSH Non-Chronic Placement Form. Additionally, the placement will be noted on the registry in the comments section.

5. In accordance with guidance from HUD, certain groups or subpopulations should be prioritized in situations when there is not a chronically homeless household available (for dedicated/prioritized beds within the 85% turnover rate) or in situation where a bed may be used to serve a non-chronically homeless household (not dedicated or within the 85% prioritized at turnover). Additional consideration will be provided for those who have been living on the street the longest, homeless households with children living in unsheltered situations and those who are medically vulnerable. These additional factors will be included in consideration when the group meets for disposition.

   For additional clarification the group will consider the following information to determine the individual or household meets these considerations as follows:

   - Homeless households with children living in unsheltered situations will include those households staying in a car, on the streets or another place not meant for human habitation, versus those utilizing shelter, transitional housing, or a program that provides short term temporary financial assistance.

   - For medically vulnerable the definition will include those that have been recently discharged from a hospital or have a chronic or acute health condition. Referrals to the registry that are initiated by the HOPE Recuperative Care Center will automatically be considered "medically vulnerable." The PSH partners will also identify program participants that they are aware of during disposition that have serious medical issues as the partners will often have knowledge from their referrals.

6. In accordance with guidance from HUD, veterans who are unable to be served effectively with VA housing and services should receive priority over non-veterans with the same level of need when using a standardized tool for assessment.

   If the potential program participant is unable to access veteran-specific programs, the veteran will then be considered for PSH disposition. In situations where the veteran has the same level of need as another potential program participant, and matches eligibility criteria, the veteran will be prioritized for the available slot of housing.

7. The individuals referred to the Registry are then compared to the available vacancies/slots of PSH per provider. The potential program participant with the highest score that "matches" specific eligibility for the grant and vacancy characteristics is referred to the PSH provider. To illustrate this point, a few examples follow:

   - A provider's grant may have a preference for a veteran. The potential program participant with the highest VI score may not meet this characteristic but a person ranked "third" on the list may be a veteran. In this case, if the potential program participant meets all other program eligibility, the PSH provider will receive a referral for the

program eligibility the PSH provider will receive a referral for the veteran.

- Some grants have a requirement to serve individuals/households that are experiencing chronic homelessness. In these cases the potential program participant that has the highest VI score that is chronically homeless will be the referred household. This may mean a potential program participant with a higher VI score, who is not chronically homeless, is not served. As noted in earlier portions of this document, the community will prioritize at least 85% of available beds to chronically homeless individuals and households available from turnover. See Item #2 for further details as outlined on page 6.

- Some grants have additional criteria that are associated with the specific targeted population. For instance some grants that service those who are experiencing chronic homelessness may have additional eligibility requirements for co-occurring disorders. In these situations the particular service provider will receive a referral for the person who meets first the definition of chronic homelessness, and then the highest VI score, that matches the particular grant requirements.

- An available vacancy may be a family unit, meaning the vacancy has the ability to serve multiple potential program participants within a household unit (more than a one bedroom unit). In these situations the family with first chronicity, and then the highest VI score, that meets additional grant specific eligibility program will be served.

- A provider's grant may have more limited eligibility requirements related to disability. For instance, a provider may only be able to serve a potential program participant with a diagnosis of SPMI (severe and persistent mental illness) but cannot serve those that have a primary diagnosis of a developmental disability or substance use. In these situations the provider will be assigned the potential program participant with the chronicity, and then the highest VI score, that meet the grant's specific eligibility criteria

8. There may be situations where two or more potential program participants present with similar circumstances and VI scores that do not allow for the PSH Partners to use other eligibility criteria and grant preferences to guide the disposition for the single vacancy.

    - If two potential program participants have been determined to be chronically homeless, the potential program participant with more cumulative total months homeless will be prioritized.

    For instance, two potential program participants reported to be chronically homeless, with a single episode of homelessness lasting over a year. Both have a VI-SPDAT score of 15. One potential program participant's cumulative total is reported at 18 months, the other potential program participant has a cumulative total of 13 months. The potential program participant with total of 18 months will be prioritized to receive the slot of PSH.

When a slot of housing is available for potential program participants that are not chronically homeless, the group will examine the cumulative total of months of homelessness to determine who has been homeless longer to provide priority, similar to the standards used for those experiencing chronic homelessness.

If the above criteria cannot be used to determine who should be prioritized, the PSH Partner will conduct a full SPDAT to get a more detailed assessment of needs and will begin working with the potential program participant that has the higher Full SPDAT score.

9. There may be certain situations that require additional consideration beyond the VI-SPDAT Score. In these situations the PSH Partner group will discuss as a team and come to a general consensus regarding any dispositions. To illustrate this point, a few examples follow:

- Additional consideration will be provided to potential program participants that are unable to access other programs to resolve their homelessness that would provide long term resources to assist with the housing crisis. This includes those who are unable to access vouchers or other subsidized housing due to the "one strike rule" that prohibits those that are lifetime registered sex offenders or have been convicted of manufacturing methamphetamine in public housing. Because there are no other options available and there is a need for supportive housing, the group will examine these situations on a case by case basis. In these situations the potential program participant may be prioritized for immediate disposition if a suitable vacancy is presented in the community.

- VI-SPDAT provides an extra point when the household composition includes more children than adults in the household. The one point is provided for one extra child in proportion to adults. However, the assessment does not provide extra points for each additional child. In the event two families with similar VI scores and other eligibility characteristics are presented, the team will look at how many household members are present in the familial unit.

  For instance, two potential program participants may score 12 points on the VI and have similar characteristics but one family includes 1 adult and 3 children and the other household consists of one adult and five children.

  If all other characteristics are the same, the team may elect to provide the one slot to the family of six (1 adult plus five children).

- There have been instances where new or updated information has been provided to a community partner that has led to discussion that the VI should be reassessed. When this occurs, the provider brings the information to the group prior to a new assessment being conducted and the team makes a recommendation based on consensus.

  Examples of this occurring include but are not limited to: 1. Potential program participant was diagnosed with a chronic health condition

while in the shelter, after initial VI occurred, 2. Potential program participant reported no use of substances at initial intake but later revealed, after trust was established, that he/she had a history of substance use and was actively using. Documentation was provided in regard to involvement with rehabilitation and supportive services by the individual.

In both these situations the group met and discussed, making a recommendation for a new VI to be conducted. In these cases the VI is conducted again and placed in HMIS with notes explaining why the assessment was repeated. The original VI stays in the record as well, as we do not overwrite initial results.

- A specific PSH partner may be able to serve a population that cannot be served by other partners in the group. In these situations the group may elect to use this spot to serve someone that would not typically have access to the PSH programs despite documented need.

  For instance, a person with a developmental disability may have a need for housing but will often not meet the criteria set forth by individual grants that may limit access to those who have a primary diagnosis of SPMI. There are some HUD grants in the community that are limited, by the grant, to a specific identified target population.

  In these situations the PSH team may elect to reserve this spot for a potential program participant that would typically not be able to access PSH without these more flexible guidelines. In these situations the group may make a decision to provide PSH to a person on the list that does not have the very highest VI but has a demonstrated need.

10. The above methodology for prioritization will be utilized during all disposition meetings. As potential program participants are "matched" to available slots of PSH, the registry will be updated to reflect which agency has received the referral. Those who are unable to be referred, due to lack of available slots, will remain on the registry for further review at subsequent meetings. Notes will be updated as needed on these potential program participants.

11. At subsequent meetings the team will review progress towards successfully securing housing for those individuals referred through the each PSH program. PSH partners will provide updates and these will be recorded during the disposition meetings on the registry.

12. Once a potential program participant has successfully completed the process and is housed, the record will be highlighted in green and placed in the "housed" section of the registry.

13. If a potential program participant is unable to successfully access the PSH program the team will review the reason why. If a program was unable to provide the housing because of specific grant requirements the group will work to place the potential program participant in the next available slot / vacancy.

For instance, a potential program participant may have been reported initially to be "chronically homeless" but does not have the necessary documentation to be placed in a grant that specifically serves chronically homeless individuals despite concerted and intensive efforts to verify status.

In this situation if there is an available slot of PSH for those who are homeless but not chronically homeless, another provider will work with the potential program participant.

Another example is a potential program participant who has military service history and was slated for a program that preferences veterans but does not have the supporting documentation to meet that criteria.

In this situation another program that does not have a preference for veterans could serve the individual.

14. If a potential program participant is unable to successfully access the PSH program because he/she is ineligible (no qualifying disability, not literally homeless, etc.) or has not maintained contact with the PSH provider, the group will update notes in the record and deactivate the record, by graying out the line on the spreadsheet. Permanent Supportive Housing Providers will use a consistent approach to attempt to contact potential program participants in an effort to engage and link the individual, using all avenues provided in HMIS for contact, as well as alternate email addresses, as noted in the community policy. In these situations the record will be sorted and placed in the "inactive" section of the registry. Becoming "inactive" does not remove someone from the registry. Rather, the person is placed in a different section of the registry so that community partners can continue to attempt to engage through the coordinated system. This insures that if the individual or household connects with the homeless service delivery system they can be quickly reactivated for prioritization and the referral updated. Additionally each name is reviewed by the partners to work through any possible interactions and means of engagement. It should be noted that if the potential program participant reengages with a provider, a new updated referral will be made. If the potential program participant's situation changes and he/she does become eligible, an updated referral will also be made.

15. There have been situations that while working with a potential program participant through the PSH Disposition process he/she has also received notice about being pulled for a Housing Choice Voucher (sometimes referred to as "Section 8"). This is predominantly through the MSHDA program that provides a preference to those who are homeless. In these situations, if the potential program participant has met all the eligibility criteria for the available PSH slot, he/she is provided a choice between the two housing programs with the potential program participant receiving education about the differences between the two programs. While both the PSH programs and the voucher provide continued subsidy to make the housing affordable, the voucher does not come with built in supportive services. In these situations the community partners that are working closest with the individual or household will be asked to work through this process with the potential program participant, explaining the risks and benefits of each option. In all situations the PSH partners will honor the potential program participant's choice.

When a potential program participant chooses the voucher over PSH the record will be shaded pink and the record moved to the voucher section of the registry.

There may be situations where a potential program participant initially chooses the voucher over an available PSH slot but then is denied access to the voucher through the administrative process. The potential program participant may also change their mind and decide to access PSH instead. At that point a new referral will be made to the PSH register with notes added to the original record. Prioritization with the standards set forth

added to the original record. Prioritization with the standards set forth above will be utilized to consider referral.