



# Department of Veterans Affairs

**U.S. Department of Veterans Affairs  
Supportive Services for Veteran Families (SSVF) Program  
Quarterly Grantee Performance Certification**

*Instructions: Please complete the following form and email, along with your Quarterly Financial Report (Attachment 1), to the VA SSVF Program Office at [SSVF@va.gov](mailto:SSVF@va.gov). Please clearly mark any information that is confidential to individual participants.*

**Grantee Name:** \_\_\_\_\_

**SSVF Grant Amount:** \_\_\_\_\_

**Grant Award Number:** \_\_\_\_\_

**Name and Title of Contact Completing Form:** \_\_\_\_\_

**Contact Email:** \_\_\_\_\_

## **FINAL RULE**

- 1. I certify that this SSVF program is in compliance with the Final Rule (38 CFR part 62).  
Yes/No**
- 2. I certify that I am operating in compliance with my signed grant agreement.  
Yes/No**

## **DATA QUALITY**

- 3. I certify that our program is participating in the SSVF Client Participant Satisfaction survey to maintain compliance with our grant agreement.  
Yes/No**
- 4. I certify that I am reviewing the monthly data quality/upload summary reports.  
Yes/No**
- 5. I certify that data received by the VA via our monthly HMIS uploads accurately represents our program performance.  
Yes/No**

**5a. If the answer to the previous question was no, please outline your plan to improve upload quality including timelines/dates.**

**6. I certify that our program is actively working to improve data quality for all “zero tolerance” data elements identified by the VA. These data elements are expected to have 100% data quality. Note: Zero tolerance data elements are: Veteran SSN, Head of Household (note only 1 per household), VAMC Station Code, Client CoC Code, AMI, and Residential Move-In Date.**

**Yes/No**

**7. I certify that our program is actively working to improve data quality for all non-zero tolerance data elements with a score below 95%.**

**Yes/No**

**8. I certify that full SSN information is entered for all Veterans served in our SSVF program.**

**Yes/No**

**9. I certify that accurate CoC codes are entered for all clients served in our SSVF Program.**

**Note: CoC codes should be linked to the client/head of household**

**Yes/No**

**10. I certify that accurate 3 or 5-digit VA Medical Center (VAMC) codes are entered for all clients served in our SSVF Program. Please refer to station codes provided by the SSVF Program Office.**

**Yes/No**

**11. I certify that Residential Move-In Dates are entered as soon as Rapid Re-Housing clients move in to a permanent residence.**

**Yes/No**

**12. I certify that Housing Prevention Threshold Scores are entered for all prevention clients served in our SSVF Program.**

**Yes/No**

**13. I certify that accurate Destination information is entered at program entry and exit for all clients served in our SSVF Program. The use of "Other" as a destination option is used sparingly and only in instances where no other destination code is a viable option.**

**Yes/No**

**14. I certify that our program is addressing all erroneous records indicated in our monthly Data Quality/Data Summary Reports.**

**Yes/No**

15. I certify that I have reviewed and resolved all enrollment duplication issues identified in the monthly Data Quality/Upload Summary report. Please refer to the section of the report listing records with duplicate enrollments in one or more SSVF program.

Yes/No

16. I certify that all duplicate enrollments have been reviewed and our program has made all efforts to ensure that individual TFA payments have not exceeded the limitations in the Final Rule/NOFA.

Yes/No

17. Were any incidents identified in which the Veteran and/or Landlord knowingly received duplicate TFA payments from multiple SSVF providers?

Yes/No/NA

17a. If the answer to the previous question was "yes", please provide an explanation of the situation.

**SUPPORTIVE SERVICES**

Type of Benefit/Service (See 38 CFR 62.33 for definitions of these services)*	Grantee/program provided benefit directly (Yes/No)	Grantee/program assisted participants in obtaining benefit through referrals to other organizations (Yes/No)
Health care services	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Daily living services	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Personal financial planning services	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Transportation services	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Income support services	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fiduciary and representative payee services	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Legal services	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child care	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Housing counseling, housing search	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**TRAININGS AND WEBINARS**

18. I certify that all new employees have completed the webinars listed in the New Staff Training Guide available on [www.va.gov/homeless/ssvf/index.asp](http://www.va.gov/homeless/ssvf/index.asp).

Yes/No

19. I certify that SSVF staff (new and existing) review all trainings/webinars provided by the SSVF Program Office.

Yes/No

**HHS SUBACCOUNTS AND DRAWDOWNS**

**20. Required**

**I certify that payment requests from HHS Payment Management System reflect actual spending.**

**Yes/No**

**21. I certify that all expenditures are for costs approved on the SSVF Budget.**

**Yes/No**

**22. I certify that I have received approval from the SSVF Program Office for any modifications made to my approved SSVF budget.**

**Yes/No**

**23. I certify that all spending is in compliance with all OMB regulations.**

**Yes/No**

**Additional feedback for SSVF Compliance Office:**

**CERTIFICATION AND SUBMISSION**

**I certify that I am authorized to submit this response on behalf of this SSVF program. Please note: Documentation supporting all certifications must be maintained by the grantee and made available for monitoring visits and audits.**

