Coordinated Entry Process

Policies and Procedures Manual

Mendocino County Homeless Services Continuum of Care

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by the Mendocino County Homeless Services Continuum of Care
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Purpose and Background

The Mendocino County Homeless Services Continuum of Care (MCHSCoC) has developed the following Coordinated Entry Process for the geographic area of Mendocino County to meet federal and state regulations. The primary goals of this Coordinated Entry process are that assistance be allocated as effectively as possible and that it be easily accessible no matter where or how people present. This Coordinated Entry Process is mandated for all recipients of Continuum of Care (CoC) and Emergency Solutions Grant (ESG) funding and was developed in accordance with the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 and its implementing regulations.

This Manual has been developed in conjunction with CoC recipients and other homeless service providers. There was no ESG recipient within the geographic area at the time of the drafting of this Manual and development of the Coordinated Entry Process.

Coordinated Entry processes help communities prioritize assistance based on vulnerability and severity of service needs to ensure that people who need assistance that most can receive it in a timely manner. Coordinated Entry processes also provide information about service needs and gaps to help communities plan their assistance and identify needed resources. Accordingly, the Coordinated Entry Process described in this Manual covers the entire geographic area of Mendocino County and was designed with the following guiding principles:

- **Prioritization:** The Coordinated Entry process ensures that people with the greatest needs receive priority for any type of housing and homeless assistance available in the MCHSCoC geographic area, including permanent supportive housing (PSH), Rapid Re-housing (RRH), and other interventions.
- **Low Barrier:** The Coordinated Entry process does not screen people out for assistance because of perceived barriers to housing or services, including, but not limited to, lack of employment or income, drug or alcohol use, or having a criminal record. In addition, housing and homelessness programs lower their screening barriers in partnership with the Coordinated Entry process.
- **Housing First orientation:** The Coordinated Entry process is Housing First oriented, in such that people are housed quickly without preconditions or service participation requirements.
- **Homelessness prevention:** ESG and CoC recipients of homeless prevention funds will utilize the BNL, including using the VI-SPDAT as an assessment tool. For those identified for homelessness prevention the most vulnerable (as identified by the VI-SPDAT) will be assisted first. The tie breaker for these funds will be the date and time of assessment.
- **Person-Centered:** The Coordinated Entry process incorporates participant choice which is facilitated by questions in the assessment tool and through other

methods. Choice can include location and type of housing, level of services, and other options about which households can participate in decisions.

Fair and Equal Access: All people in the MCHSCoC's geographic area have fair and equal access to the Coordinated Entry process, regardless of where or how they present for services. Fair and equal access means that people can easily access the Coordinated Entry process, whether in person, by phone, or some other method, and that the process for accessing help is known. Marketing strategies include direct outreach to people on the street and other service sites, informational flyers left at service sites and public locations, announcements during MCHSCoC or other community meetings, and educating mainstream providers. Entry points are accessible to people with disabilities and there are methods by which people can access these entry points. The Coordinated Entry process is able to serve people who speak languages commonly spoken in the community.

Emergency services: The Coordinated Entry process does not delay access to emergency services such as shelter.

Standardized Access and Assessment: All Coordinated Entry locations and methods (phone, in-person, online, etc.) offer the same assessment approach and referrals using uniform decision making processes. A person presenting at a particular Coordinated Entry location is not steered towards any particular program or provider simply because they presented at that location.

Inclusive: The Coordinated Entry process includes all subpopulations, including people experiencing chronic homelessness, Veterans, families, youth, and survivors of domestic violence, although the MCHSCoC may adopt different processes for accessing Coordinated Entry, including different access points and assessment tools for the following different populations: (1) adults without children, (2) adults accompanied by children, (3) unaccompanied youth, or (4) households fleeing domestic violence. The MCHSCoC will continuously evaluate and improve the process ensuring that all subpopulations are well served.

Referral to projects: The Coordinated Entry process makes referrals to all projects receiving Emergency Solutions Grants (ESG) and CoC Program funds, including emergency shelter, RRH, PSH, and transitional housing (TH), as well as other housing and homelessness projects. Projects in the community that are dedicated to serving people experiencing homelessness fill all vacancies through referrals, while other housing and services projects determine the extent to which they rely on referrals from the Coordinated Entry process.

Referral protocols: Programs that participate in the MCHSCoC's Coordinated Entry process accept all eligible referrals until the MCHSCoC has a documented protocol for rejecting referrals that ensures that such rejections are justified and rare and that participants are able to identify and access another suitable project.

Outreach: The Coordinated Entry process is linked to street outreach efforts so that people sleeping on the streets are prioritized for assistance in the same manner as any other person assessed through the Coordinated Entry process.

Ongoing planning and stakeholder consultation: The MCHSCoC will engage in ongoing planning with all stakeholders participating in the Coordinated Entry process. This planning will include evaluating and updating the Coordinated Entry process at least annually. Feedback from individuals and families experiencing homelessness or recently connected to housing through the Coordinated Entry process will be regularly gathered through surveys, focus groups, and other means and is used to improve the process.

Informing local planning: Information gathered through the Coordinated Entry process is used to guide homeless assistance planning and system change efforts in the community.

Leverage local attributes and capacity: The physical and political geography, including the capacity of partners in a community, and the opportunities unique to the community's context, inform local Coordinated Entry implementation.

Safety planning: The Coordinated Entry process has protocols in place to ensure the safety of the individuals seeking assistance. These protocols ensure that people fleeing domestic violence are provided safe and confidential access to the Coordinated Entry process and domestic violence services, and that any data collection adheres to the Violence Against Women Act (VAWA).

Accurate Data: Using HMIS and other systems for Coordinated Entry. The MCHSCoC uses HMIS to collect and manage data associated with assessments and referrals.

The policies and procedures in this manual have been established to ensure that persons experiencing homelessness who enter programs throughout the MCHSCoC will be given similar information and support to access and maintain permanent housing. All programs that receive ESG or CoC funding are required to abide by these policies and procedures. Agency program procedures should reflect the policy and procedures described in this document. The MCHSCoC strongly encourages programs that do not receive either of these sources of funds to accept and utilize these policies and procedures.

The MCHSCoC Governing Board shall review and update these policies and procedures, as needed, but at least annually.

Definitions & Key Terms

Terms used throughout this manual are defined below:

By Name Only List (BLN):

The BLN is the CoC wide waitlist for housing programs. Because housing resources in our CoC are scarce and because most programs will not have immediate openings, it is assumed that each assessed household will spend some amount of time on the BNL before being referred to a program. The BNL is maintained by the HMIS lead agency (HMIS administrator) and is organized according to VI-SPDAT score, veteran status, and length of time homeless.

Chronically Homeless (24 CFR 578.3):

(1) A "homeless individual with a disability," as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:

i. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
ii. Has been homeless and living as described in paragraph (1)(i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in
iii. Homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1)(i).
iv. Stays in institutional care facilities for fewer than 90 days will not constitute as a break in homelessness, but rather such stays are included in the 12- month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility;

(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 of the criteria in paragraph (1) of this definition, before entering that 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 of the criteria in paragraphs (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Disability (24 CFR §583.5):

(1) A condition that:

i. Is expected to be long-continuing or of indefinite duration;
ii. Substantially impedes the individual's ability to live independently;
iii. Could be improved by the provision of more suitable housing conditions; and

iv. Is a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury;

(2) A developmental disability, as defined in this section; or

(3) The disease of acquired immunodeficiency syndrome (AIDS) or any conditions arising from the etiologic agent for acquired immunodeficiency syndrome, including infection with the human immunodeficiency virus (HIV).

Developmental Disability (24 CFR §578.3.)

Developmental disability means, as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002):

(1) A severe, chronic disability of an individual that—

i. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
ii. Is manifested before the individual attains age 22;
iii. Is likely to continue indefinitely;
iv. Results in substantial functional limitations in three or more of the following areas of major life activity:
    a. Self-care;
    b. Receptive and expressive language;
    c. Learning;
    d. Mobility;
    e. Self-direction;
    f. Capacity for independent living;
    g. Economic self-sufficiency.
v. Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

(2) An individual from birth to age 9, inclusive, who has a substantial developmental delay or specific congenital or acquired condition, may be considered to have a developmental disability without meeting three or more of the criteria described in paragraphs (1)(i) through (v) of the definition of “developmental disability” in this section if the individual, without services and supports, has a high probability of meeting these criteria later in life.

Homeless (24 CFR 578.3)

Literally Homeless (Category 1):

Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:

(1) Has a primary nighttime residence that is a public or private place not meant for human habitation;

(2) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or

(3) Is exiting an institution where or she has resided for 0 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution; or

At imminent risk of homelessness (Category 2)

Individual or family who will imminently lose their primary nighttime residence, provided that:

(1) Residence will be lost within 14 days of the date of application for homeless assistance;

(2) No subsequent residence has been identified; and

(3) The individual or family lacks the resources or support networks needed to obtain other permanent housing; or

Homeless under other Federal statutes (Category 3)

Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who:

(1) Are defined as homeless under section 387 of the Runaway and Homeless Youth Act (42 U.S.C. 5732a), section 637 of the Head Start Act (42 U.S.C. 9832), section 41403 of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2), section 330(h) of the Public Health Service Act (42 U.S.C. 254b(h)), section 3 of the Food and Nutrition Act of 2008 (7 U.S.C. 2012), section 17(b) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)), or section 725 of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a);

(2) Have not had a lease, ownership interest, or occupancy agreement in permanent housing at any time during the 60 days immediately preceding the date of application for homeless assistance;

(3) Have experienced persistent instability as measured by two moves or more during the 60-day period immediately preceding the date of applying for homeless assistance; and

(4) Can be expected to continue in such status for an extended period of time because of chronic disabilities; chronic physical health or mental health conditions; substance addiction; histories of domestic violence or childhood abuse (including neglect); the

presence of a child or youth with a disability; or two or more barriers to employment, which include the lack of a high school degree or General Education Development (GED), illiteracy, low English proficiency, a history of incarceration or detention for criminal activity, and a history of unstable employment; or

Fleeing domestic abuse or violence (Category 4)

Any individual or family who:

(1) Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence;
(2) Has no other residence; and
(3) Lacks the resources or support networks, e.g., family, friends, and faith-based or other social networks, to obtain other permanent housing.

Assessment

A process that reveals the past and current details of a individual's/household's strength, and needs, in order to match the client to appropriate services and housing. For the purpose of this document, assessment will refer to a process (whether at primary screening and intake or at entry to a housing program) that reveals a client's eligibility, needs, barriers and strengths.

Assessor

An intake worker, whose responsibility is to provide coordinated intake and assessment for individuals or families seeking housing services.

Front Doors

Agencies that serve as Front Door sites are responsible for ensuring that all households experiencing homelessness and at-risk of homelessness have prompt access to Intake and Assessments and that Assessments are administered in a safe, welcoming environment. Front Door agencies are responsible for adhering to the guiding principles listed in the document including (but not limited to) providing fair and equal access to persons that are disabled and persons who are limited English proficient.

Diversion- is a strategy that prevents homelessness for people seeking shelter by helping them identify immediate alternate housing arrangements and, if necessary, connecting them with services and financial assistance to help them return to permanent housing. The main difference between diversion and other permanent housing-focused interventions centers on the point at which intervention occurs. Prevention targets people at imminent risk of homelessness, diversion targets people as they are applying for entry into shelter, and rapid re-housing targets people who are already homeless.

HEARTH ACT – The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) act of 2009 that includes Emergency Solutions Grant (ESG) and Continuum of Care (CoC) grants

Coordinated Assessment –Relates to the utilization of the same assessment tool to connect clients to services as a means for a Coordinated Entry system. For the purpose of this document, that tool is the VI-SPDAT (Vulnerability Index & Service Prioritization Decision Assistance Tool)

VI-SPDAT (Vulnerability Index & Service Prioritization Decision Assistance Tool)
The VI-SPDAT is an assessment tool that helps identify who should be recommended for each housing and support intervention, moving the discussion from simply who is eligible for a service intervention to who is eligible and in greatest need of that intervention. While the SPDAT is an assessment tool, the VI-SPDAT is a survey that anyone could complete, to help prioritize clients.

Singles VI-SPDAT
The scoring matrix for single households:

0-3: no housing intervention (Diversion may be offered)
4-7: an assessment for Rapid Re-Housing
8+: an assessment for Permanent Supportive Housing/Housing First

Family VI-SPDAT
Scoring matrix for family households:

0-3: no housing intervention
4-8: an assessment for Rapid Re-Housing or Transitional Housing
9+: an assessment for Permanent Supportive Housing/Housing First

TAY VI-SPDAT (when available)
Scoring matrix for TAY households:

0-3: no housing intervention
4-7: an assessment for Rapid Re-Housing or Transitional Housing
8+: an assessment for Permanent Supportive Housing/Housing First

Note: the VISPDAT scores listed above, do not mean a household cannot be referred to a different housing intervention. For example: if a household scores 10 on the Family VI-SPDAT, but there are no Permanent Supportive Housing slots available, the household may be referred to Transitional housing as a temporary measure if space is available.

A VI-SPDAT score may only be changed after a case conference is conducted about the particular client and their self-reporting during the assessment. The case conference must be documented with a sign in sheet identifying participants and

their respective agencies and MUST include a clinician. A written recommendation must be placed in the client's file. The HMIS lead may be requested to update/change the VI-SPDAT score upon submission of the written recommendation for that client. Case conference can be held telephonically.

Homeless Management Information System

A Homeless Management Information System (HMIS) is a data base used to record and track client-level information on the characteristics and service needs of homeless persons. HMIS ties together homeless service providers within a community to help create a more coordinated and effective housing and service delivery system.

The U.S. Department of Housing and Urban Development (HUD) and other planners and policy makers at the federal, state, and local levels use aggregate HMIS data to obtain better information about the extent and nature of homelessness overtime. Specifically, HMIS can be used to produce an unduplicated count of homeless persons, understand patterns of service use, and measure the effectiveness of homeless programs.

Mendocino County's HMIS is staffed at the Mendocino County Health and Human Services agency. The software provider is ClientTrack. The HMIS staff is responsible for the administration of the HMIS software and providing technical assistance to participating agencies and end-users. Agencies that participate in Mendocino County's HMIS are referred to as "participating agencies." Each participating agency needs to follow certain guidelines to help maintain data privacy and accuracy.

As the HMIS Lead Agency, the Mendocino County Health and Human Services, Is responsible for the day-to-day administration of the *Coordinated Entry Process*, including but not limited to the following:

(1) Monitoring data quality of HMIS data and provide training as necessary to ensure continued quality of data gathered.
(2) Maintaining the BNL and disseminating the list to the Receiving Programs and the Coordinated Entry Review Team.

Authorized User Agencies

Housing providers who wish to, or are required to, participate in the *Coordinated Entry Process* are Authorized User Agencies. Authorized User Agencies must sign and agree to the HMIS Privacy and Security Policies for HMIS data base use.

Receiving Program –

All Transitional Housing, Rapid Re-housing, and Permanent Supportive Housing programs are Receiving Programs and are responsible for reporting pulling referrals from the BNL in compliance with the protocols described in this manual. All programs that receive a referral from the Coordinated Entry Process are responsible for responding to that referral.

Process Overview and Workflow

To illustrate how the *Coordinated Entry Process* functions, the following overview provides a brief description of the path a household would follow from an initial request for housing through permanent housing placement. The overview also describes roles and expectations of the key partner organizations that play a critical role in the system. Additional details can be found in the subsequent sections of this manual and the Coordinated Entry workflow.

From Initial Request for Services to Permanent Housing Placement–Pathway through the Coordinated Entry Process

Step1: Connecting to the Coordinated Entry Process/Initial Request for Services - To ensure accessibility to households in need, the Coordinated Entry Process provides access to services from multiple, convenient physical locations. Households in need may initiate a request for services in person through any of the designated Front Doors, by phone to the Front Doors, and/or through participating community based service providers.

Step 2: Pre-screening Assessment – The pre-screening with households in need. That assessment consists of several questions meant to determine whether administering a VI-SPDAT is appropriate, or if some other alternative action is appropriate.

Step 3: Coordinated Entry Assessment – Assessors will complete the Coordinated Entry Assessment with the household. The assessment includes the collection of HMIS universal data elements as well as administering the appropriate VI-SDAT version. Front Doors have the option of completing the assessment directly into the HMIS system (which is strongly encouraged) or administering a paper version to be entered into HMIS at a later time – depending on the logistics of the Front Door's operation. Data collected on paper should be entered into HMIS within 72 hours of collection. Entry into HMIS automatically enters the household onto the BNL.

Step 4: Housing Match- Information gathered from the assessment is used to determine which housing intervention is best suited to end the household's homelessness (Permanent Supportive Housing, Transitional Housing, Rapid Re-housing, Emergency Shelter, or Diversion). Scoring from the VI-SPDAT matches households to a particular housing intervention and will be reflected by the household's positioning on the BNL. Housing Match will be offered, however services are person centered. It is recognized that the initial housing match may not be appropriate for the household.

Step 5: Housing Referral – Completion of the Coordinated Entry Assessment results in the household being placed on the BNL. Upon identifying a program opening, Receiving Programs will pull referrals from the BNL for the next household they will serve within their eligibility criteria.

Step 6: Housing Navigation - **Various programs provide housing search assistance. Appropriate referrals may be made by the receiving program or by Coordinated Entry assessors.**

Below is an illustration of the CE Workflow:

Coordinated Entry Policies and Procedures

1. Connecting to the Coordinated Entry Process

1.1. Locations & Hours – Assessments are conducted at designated Coordinated Entry Front Door Sites. Current Front Door locations and assessment hours include:

Agency	Location	Telephone	Hours
MCAVHN	148 Clara Avenue Ukiah, CA 95482	(707) 462-1932	9AM -5PM Monday, Wednesday, Thursday and Friday and 1PM-5 PM on Tuesday
The Arbor	810 N. State Street, Ukiah, CA	(707) 462-7267	9 AM-6:30 PM Mon - Fri
Mendocino Coast Hospitality Center	101 N Franklin St. Fort Bragg, CA	(707) 961-0172	9AM to Noon and 1 PM–5PM M-F

1.2. Eligibility – Coordinated Entry is intended to facilitate access to the most appropriate housing intervention for each household's immediate and long-term housing needs and ensure that scarce permanent housing resources are targeted to those who are most vulnerable and/or have been homeless the longest. The Coordinated Entry Process uses the following criteria to accurately match needs to resources:

Housing Model	Population	Priority Populations
Permanent Supportive Housing	• Any high needs individual with multiple barriers to housing that is literally homeless (lease-based program) • Specialized eligibility requirements for subsidies including veterans, disabled, long term homeless, or domestic violence • **Unique Populations:** Families with Children (not typically chronic; complete Family VI-SPDAT)	• Individuals with a disability and long-term, multiple episodes of homelessness (Vulnerability Index score of 10 or higher; chronically homeless) • Veterans who are not eligible for VA housing subsidies
Rapid Re-Housing	• Literally homeless households are those residing in a place not meant for human habitation, living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or exiting an institution where (s)he has resided for90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution • Households that have reasonable potential for personal sustainability post-assistance	• Households with children residing on streets or in emergency shelters • Veteran households with children residing on streets or in emergency shelters who are not eligible for VA-funded RRH or HUD/VASH

Transitional Housing	• Singles • Families • Youth (18-24) • Domestic violence • Pregnant Head of Household • Households with a recent change in composition (Family Reunification) • Those interested in substance use treatment • Those interested in Mental Health Recovery Treatment	Single adults with mental illness and families where the adult has mental illness For Mendocino Coast Hospitality Center Transitional Housing: the above, plus singles and families who are current or prior coastal residents.

1.3 Marketing/Advertising – The MCHS*CoC Governing Board* will conduct marketing to promote access and availability of the information regarding the Coordinated Entry Process.

2 The Housing Assessment Process

2.1 Assessors

2.1.3 Roles and Responsibilities - Assessors are generally trained staff at Front Door agencies. *Assessors may* collect universal data and administer the VI-SDAT. Assessors may also be trained in diversion services. The *Assessor may connect a consumer/household with* a Case Manager.

Case managers, when available may provide the following:

- Operate as the initial contact for the *Coordinated Entry Process*
- Collect universal data and administer the VI-SDAT
- Client notification of *Eligibility and Referral Decisions*
- Provide or refer to diversion services where appropriate

2.1.4 Training Requirements – *Assessors* are trained on the coordinated Entry process, HMIS data entry, and VI-SPDAT tool by their respective employing agency with the support of the CoC. Trainings occur initially and annually thereafter.The HMIS lead will provide training for HMIS data entry requirements.

Cultural competency, motivational interviewing, and trauma informed trainings will be offered to providers annually.

.. Release of Information – *All clie*nts must sign a release of information prior to the assessment process.

2.1.5 Client Photos – Photos may be taken at the time of assessment but are not required. If a photo is taken and uploaded into HMIS, a photo release must be signed by the client prior to the photo being taken.

2.1.6 Timeline - The *Assessor* notifies the client of his/her placement on the BNL within 24 business hours.

2.1.7 Nondisclosure of disability: Failure of a participant to disclose a disability, or the specific nature of a disability does not preclude participation in the coordinated entry process.

3 Housing Matching

3.1 HMIS Lead Agency – HMIS Staff at the Mendocino County HHSA is responsible for the daily administration of the HMIS software and providing technical assistance to participating agencies and end-users. Additionally, they maintain the BNL and provide the list to all receiving programs weekly. VI-SPDAT assessments that are older than 6 months result in the client being removed from the By Name List.

3.2 Timeline - Once the Assessor has made contact with the client and/or the client's Case Manager that worker will attempt to contact the client within 2 business days and begins the process of scheduling intake appointments.

3.3 Unit Availability/Vacancy Notification – All Transitional Housing, Rapid Re-housing, and Permanent Supportive Housing Programs will make known availability and vacancies via email to partnering agencies. All receiving programs pull names as vacancies in programs arise.

4 Housing Referral

4.1 By Name Only List (BNL) – The BNL consists of the following:

4.2.1 Clients are prioritized based on their VI-SPDAT score.

4.2.2 The BNL is sorted by the VI-SPDAT score, length of time homeless, and veterans' status.

4.2.3 The Receiving Programs receive the BNL from the HMIS lead wekly.. When a VI-SPDAT is older than 6 months, the client falls off of the By Name List.

4.2.4 Case Managers will be requested to make contact with the client within ten (10) business days.

4.2.5 If the client cannot be contacted within that time frame, the next client on the list will begin to be processed.

4.2.6 Once staff makes contact with the client, the client must decide within 5 business days whether to accept or decline the unit or program slot.

4.2.7 If the client accepts the unit/program slot, he/she moves forward in the next steps towards move-in/program enrollment.

4.2.8 If the client declines the unit, then the next client on the list is contacted and the client that refused is skipped.

4.2.9 A client may refuse a unit/placement 3 times before being removed from the BNL. At that time the client must go through the Coordinated Entry process again.

4.2.10 Receiving Program Responsibilities – The Receiving Program makes contact with the client, or case manager within 10 business days of pulling the client's name from the by name list. If the client misses the first appointment, Receiving Programs will schedule a new intake appointment within 3 business days and should hold the vacancy until the intake appointment is concluded. Clients may be denied entrance into the receiving program if they miss two appointments. In this case the client must go through the Coordinated Entry process again.

4.2.11 Document Requirement Updates - Receiving Programs make eligibility determination decisions within 10 business days of the intake interview (or when all required application materials are complete). If a client is denied, the client must be notified in writing of the denial, the reason for the denial, and of their right to appeal, and how to do so.

4.2.12 Reasons for denial – Receiving Programs must follow their written policies regarding denial into their programs. These policies must be designed to screen in rather than screen out participants. Receiving Programs must have an appeal process for those applicants who have been denied service or entry into a program. Some reasons for denial may be:

- there is no actual vacancy available;

- the individual or family missed two intake appointments without good cause;
- the household presents with more people than referred by the Housing Assessor and the Receiving Program cannot accommodate the increase;
- certain criminal behaviors; or
- Program policies and procedures of the Receiving Program has determined that the individual or family cannot be safely accommodated or cannot meet tenancy obligations with the supports provided by the program.

Programs may not deny persons with psychiatric disabilities for refusal to participate in mental health services. The *Receiving Program* must enter the reason for any decisions to reject a client in HMIS. If the ineligible client has not otherwise been accommodated for the night, e.g. via an intervention by emergency services, the *Receiving Program* must notify the *Housing Navigator*, refer the client back, and document that outcome in HMIS. Reason for denial forms must be submitted to the client the within 5 business days of the day the decision was made.

4.2.13 Client Choice – Clients may decline a referral because of program requirements that are inconsistent with their needs or preferences. There are no limitations on this decision. For example, clients may decline participation in programs requiring sobriety.

4.2.14 Client Appeal – All clients have the right to appeal eligibility determinations issued by any *Receiving Program.* Each program is required to have an appeal process and must educate clients on this process.

4.3 Move In – If the homeless individual or family is accepted, the *Receiving Program* must document that acceptance in HMIS.

4.4 Referrals to and from other systems not using HMIS – The *Coordinated Entry Process* appropriately addresses the needs of Veterans and individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking.

4.4.1 Domestic Violence (DV) – When a homeless or at-risk individual/household is identified by the *Coordinated Entry Process* to be in need of domestic violence services, that individual/household is referred to the domestic violence hotline or agency immediately. If the individual/household does not wish to seek DV specific services, the individual/household will have full access to the *Coordinated Entry*

Process, in accordance with all protocols described in this manual. If the DV helpline/agency determines that the individual/household seeking DV specific services is either not eligible for or cannot be accommodated by the DV specific system, the helpline/agency will refer the client to a *Front Door* for assessment and referral in accordance with all protocols described in this manual.

4.4.1..1 Domestic Violence service provider's participate in the Continuum of Care and are updated regularly about the coordinated entry process. When a Domestic Violence provider admits a client during a period when Coordinated Entry assessors are not available, the Domestic Violence provider will assist the client with accessing the Coordinated Entry system during normal coordinated entry business hours.

4.4.2 Crisis & Emergency - When a homeless or at-risk individual/household is identified by the Coordinated Entry Process to be experiencing a mental health crisis or medical emergency, staff are to provide the appropriate response immediately by calling 911 or crisis. The individual/household may be referred back to the Front Door for assessment and referral in accordance with all protocols described in this manual, at such time as the crisis/emergency has been rectified.

4.4.2..1 When a Crisis service provider, such as the Emergency Inland Winter Shelter, the Cold Weather Shelter, Youth victim assistance housing providers, Mental Health Service providers, or others with in the homeless system of care, receive a client outside of normal coordinated entry service hours, that crisis/emergency service provider will coordinate with the client to connect with the Coordinated Entry process as soon as normal Coordinated Entry hours are open. It should be noted that these crisis (mental health, emergency winter shelter, youth crime victim witness or victim and others) are active in the continuum of Care and have been educated on the Coordinated Entry system.

4.4.2..2 If an individual presents as homeless outside of the normal coordinated entry access hours and needs immediate shelter, shelters can be accessed via direct calls to the appropriate shelter by crisis workers.

4.5 Veterans–When a homeless or at-risk individual is identified by the *Coordinated Entry Process* to be a Veteran, additional questions concerning service era, length of service, and discharge status will be asked. If eligible for VA services, the Veteran will be given the option of being referred to the VA Office. If the Veteran chooses that option, then that individual is referred to the VA Office immediately. If the VA Drop-In

Center determines that the individual seeking veteran specific services is not eligible for such services or if the individual has been dishonorably discharged, the client will be referred to a Front Door for assessment and referral in accordance with all protocols described in this manual.

4.5.1 When Veterans Service providers accept clients after normal coordinated entry service hours, the Veterans service provider will coordinate client access to the coordinated entry system as soon as normal coordinated entry services resume.

Fair Housing, Tenant Selection Plan, and Other Statutory and Regulatory Requirements

The *Coordinated Entry Process* complies with the non-discrimination requirements of the Fair Housing Act, which prohibits discrimination in all housing transactions on the basis of race, national origin, sex, color, religion, disability status and familial status. This also includes protection from housing discrimination based on source of income. Additional protected classes under state law include sexual orientation (including gender identity), marital status, military discharge status, age (40+). Agencies cannot preference any protected class unless allowed by statute/regulation, or written waiver from their funding or regulatory body (i.e. U.S. Department of Housing and Urban Development).

All Authorized User Agencies who enter into an MOU for the *Coordinated Entry Process* agree to take full accountability for complying with Fair Housing and all other funding and program requirements. The MOU requires User Agencies to use the *Coordinated Entry Process* in a consistent manner with the statutes and regulations that govern their housing programs.

The *MCHSCoC* will request from each Authorized User Agency their tenant selection plan and any funding contract that requires or allows a specific subpopulation of persons to be served. For instance, Housing Opportunities for Persons with AIDS (HOPWA) programs will show funding contract, a single-gender program must produce its HUD waiver. The MCHSCoC in accordance with the Fair Housing Act also recognizes that a housing provider may seek to fulfill its “business necessity” by narrowing focus on a subpopulation within the homeless population. The *Coordinated Entry Process* may allow filtered searches for subpopulations while preventing discrimination *against* protected classes.

Evaluating and Updating the Coordinated Entry Process

The implementation of the *Coordinated Entry Process* necessitates significant, community-wide change. To help ensure that the Process will be effective and manageable for homeless and at-risk households and for the housing and service providers tasked with meeting their needs, particularly during the early stages of implementation, the MCHSCoC anticipates adjustments to the processes described in this manual. To inform those adjustments, the *Coordinated Entry Process* will be periodically evaluated, but not less than annually, and there will be ongoing opportunities for stakeholder feedback, including but not limited to Referral and Receiving Program workgroups convened and managed by the MCHS*CoC Governing Board*. Specifically, the *Governing Board* is responsible for:

- Leading periodic evaluation efforts to ensure that the Coordinated Entry Process is functioning as intended; such evaluation efforts shall happen at least annually.
- Leading efforts to make periodic adjustments to the Coordinated Entry Process as determined necessary; such adjustments shall be made at least annually based on findings from evaluation efforts.
- Ensuring that evaluation and adjustment processes are informed by a broad and a representative group of stakeholders.
- Ensuring that the Coordinated Entry Process is updated as necessary to maintain compliance with all state and federal statutory and regulatory requirements

Evaluation efforts shall be informed by metrics established annually by the *CoC Governing Board*, in conjunction with the *CoC Strategic Planning Committee* and *Coordinated Entry Review Team***.**
These metrics shall include indicators of the effectiveness of the functioning of the *Coordinated Entry Process* itself, such as:

- Wait times for initial contact
- Extent to which expected timelines described in this manual are met
- Number/Percentage of referrals that are accepted by receiving programs
- Rate of missed appointments for scheduled assessments
- Number/Percentage of persons declined by more than one (1) provider
- Number/Percentages of Eligibility and Referral Decision appeals
- # of program intakes not conducted through Coordinated Entry Process

- Completeness of data on assessment and intake forms

These metrics shall also include indicators of the impact of the *Coordinated Entry Process* on system-wide Continuum of Care outcomes, such as:

- Persons referred have length of stays consistent with system guidelines
- Waiting lists are reduced for all services; eliminated for shelter
- Program components meet outcome targets
- Reductions in long term chronic homeless
- Reduction in family homelessness
- Reductions in returns to homelessness
- Reduced rate of people becoming homeless for first time

Termination

Any Authorized User Agency may terminate their participation in the *Coordinated Entry Process* by giving written notice. Housing programs that are required to participate due to HUD guidelines will need HUD approval to terminate participation.

How do people access Shelter?

Coast:

24 beds year round shelter – year round Hospitality Center

Extreme weather shelter – 20 max

25 Transitional beds

Cold weather shelter

(no way to get into hospitality house if emergency)- Occasionally Police or Emergency Services will bring people by and if room will take them- if clients come to the front door will likely tell them to come back in the morning

Inland:

If police or emergency services brought to door (if beds available), would take them in, but if they come to the door in the middle of the night would likely be told to come back next day