

Mendocino County
Homeless Services Continuum of Care
Coordinated Entry
Policies and Procedures Manual

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Mendocino County Homeless Services Continuum of Care Coordinated Entry Policies and Procedures Manual

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PURPOSE AND BACKGROUND

The Mendocino County Homeless Services Continuum of Care (MCHSCoC) has developed the following Coordinated Entry (CE) process for the geographic area of Mendocino County to meet federal and state regulations. The primary goal of CE is that assistance be allocated as effectively as possible and be easily accessible no matter where or how people present. CE 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 implemented regulations. This Manual has been developed in conjunction with MCHSCoC partner agencies and other homeless service providers.

Coordinated Entry processes help communities prioritize assistance based on vulnerability and severity of service needs to ensure that people who need assistance the 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 CE processes described in this manual cover the entire geographic area of Mendocino County.

Guiding Principles

Prioritization: CE 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. CE utilizes the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) as a screening tool for initial prioritization. For those identified for housing assistance, the most vulnerable (as identified by the VI-SPDAT) will be assisted first. Assistance is prioritized by VI-SPDAT Score. In the case of identical or equal VI-SPDAT scores, the earliest date of current enrollment in CE will be prioritized.

Low Barrier: CE 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 CE.

Housing First Orientation: CE is Housing First oriented, in such that people are housed quickly without preconditions or service participation requirements.

Homelessness Prevention: Under revision by the Coordinated Entry/Discharge Planning (CEDP) committee. Will be presented to the Governing Board by the March 2019

meeting.

Person-Centered: CE incorporates participant choice, which can include location and type of housing, and the type, frequency, and level of services in which the household participates.

Fair and Equal Access: All people in the MCHSCoC's geographic area have fair and equal access to CE, regardless of where or how they present for services. Fair and equal access means that people can easily access CE, whether in person or by phone, 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. CE can serve people who speak languages commonly spoken in the community.

Emergency Services: CE does not delay access to emergency services such as shelter.

Standardized Access and Assessment: CE locations and methods offer the same assessment approach and referrals using uniform decision-making processes. A person presenting at one CE location is not steered towards a specific program or provider simply because they presented at that location.

Inclusiveness: CE is open to all subpopulations. This includes people experiencing chronic homelessness, veterans, families, youth, and survivors of domestic violence. 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.

Outreach: CE 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 CE.

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

Inform Local Planning: Information gathered through CE 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 CE implementation.

Safety Planning: CE 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 CE and domestic violence services, and that any data collection adheres to the Violence Against Women Act (VAWA).

Accurate Data: The MCHSCoC uses a Homeless Management Information System (HMIS – web-based database) to collect and manage data associated with Coordinated Entry.

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 Emergency Solutions Grant (ESG) or Continuum of Care (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 AND KEY TERMS

Terms used throughout this manual are defined below:

Authorized User Agencies

Authorized User Agencies are housing providers who participate in CE. These agencies must sign and agree to the HMIS Privacy and Security Policies for HMIS database use. Any Authorized User Agency may terminate their participation in CE by giving written notice. Housing programs that are required to participate due to HUD guidelines will need HUD approval to terminate participation.

By-Name List

The By-Name List (BNL) is the MCHSCoC-wide “waitlist” for housing programs participating in CE.

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—
 - a. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
 - b. Is manifested before the individual attains age 22;
 - c. Is likely to continue indefinitely;
 - d. Results in substantial functional limitations in three or more of the following areas of major life activity:
 - i. Self-care;
 - ii. Receptive and expressive language;
 - iii. Learning;
 - iv. Mobility;
 - v. Self-direction;
 - vi. Capacity for independent living;
 - vii. Economic self-sufficiency.
 - e. 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.

Disability (24 CFR §583.5)

- 1) A condition that:
 - a. Is expected to be long-continuing or of indefinite duration;
 - b. Substantially impedes the individual’s ability to live independently;
 - c. Could be improved by the provision of more suitable housing conditions; and
 - d. 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).

Diversion

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, while diversion targets people as they are applying for entry into CE.

Front Door

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 CE and the screening for CE is administered in a safe, welcoming environment. Front Door agencies are responsible for adhering to the guiding principles listed in this document, including (but not limited to) providing fair and equal access to persons who are disabled and persons who are limited English proficient.

HEARTH Act

The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) act of 2009 that provides regulatory and financial guidance over the ESG and COC grants

Homeless (24 CFR 578.3)

Chronically Homeless:

- a. 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 homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1)(i).
 - iii. 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;
- b. 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
- c. 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.

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 they have resided for 90 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 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 on other social networks, to obtain other permanent housing.

Homeless Management Information System

A Homeless Management Information System (HMIS) is a database used to record and track client-level information on the characteristics and service needs of homeless persons. HMIS ties together homeless service providers within the community to help create a more coordinated and effective housing and service delivery system. Mendocino County's HMIS is operated by the Mendocino County Health and Human Services Agency (HHSA).

Receiving Program

All Transitional Housing, Rapid Re-housing, and Permanent Supportive Housing programs are Receiving Programs and are responsible for reporting and pulling referrals from the BNL in compliance with the protocols described in this manual. Programs receiving referrals from CE are responsible for responding to those referrals.

Screeener

A specially trained intake worker, whose responsibility is to provide coordinated intake and screening for individuals or families seeking housing services.

Screening

A process that reveals the past and current details of an individual's/household's strengths and needs, in order to match the client to appropriate services and housing. For the purpose of this document, screening 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.

VI-SPDAT

The VI-SPDAT (Vulnerability Index and Service Prioritization Decision Assistance Tool) is a screening 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.

PROCESS OVERVIEW AND WORKFLOW

To illustrate how CE 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.

Summary of Coordinated Entry Steps

Step 1: Connecting to Coordinated Entry

To ensure accessibility to households in need, CE 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

The pre-screening consists of several questions meant to determine whether administering a screening for CE is appropriate or if some other alternative action is appropriate, such as a screening for Homeless Prevention.

Step 3: Coordinated Entry Screening

The CE screening includes the collection of HMIS universal data elements, as well as the use of the most appropriate VI-SDAT screening tool. All screeners must use the MCHSCoC CE Screening Packet for either single adults or families to gather the household information necessary to enroll them in CE.

Step 4: Coordinated Entry Enrollment in HMIS

The household screening packet information is entered in HMIS by the screening agency and enrolled in the CE program. This enters them on to the BNL.

The BNL is sent to all Receiving Programs.

Step 5: Housing Match

When Receiving Programs identify a program opening, they will pull referrals from the BNL for the next household they will serve within their eligibility criteria.

Step 6: Exiting Households from Coordinated Entry

Households are exited from CE for a number of reasons, such as acquiring permanent housing or lack of contact with CE for an extended time.

Coordinate Entry: In Depth Steps

1) Connecting to Coordinated Entry

- a) Locations & Hours – Screening for CE is conducted at designated Front Door sites. Current Front Door locations and screening hours include:

Agency	Location	Telephone	Hours
MCAVHN	148 Clara Ave Ukiah, CA 95482	(707) 462-1932	Drop In Hours: 9AM-12PM M-F; Appointment Only 1PM-5PM M-F
The Arbor	810 N State St Ukiah, CA	(707) 462-7267	10 AM-6 PM M-F
Mendocino Coast Hospitality Center	101 N Franklin St Fort Bragg, CA	(707) 961-0172	Drop In Hours: 9AM-12PM M-F & 1 PM–3 PM M-F

- b) Veterans–When a homeless or at-risk individual is identified by CE 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.
- c) Domestic Violence (DV) – When a homeless or at-risk individual/household is identified by CE 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 CE, 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.
- d) Crisis & Emergency – When a homeless or at-risk individual/household is identified by CE to be experiencing a mental health crisis or medical emergency, staff are to provide the appropriate response immediately by

calling 911 or the Crisis Line. The individual/household may be referred back to the Front Door for screening and referral in accordance with all protocols described in this manual, when the crisis/emergency has been rectified.

- e) Accessing CE After Hours – When a service provider encounters a household experiencing homelessness outside of normal CE service hours, that service provider should refer the client to CE Front Door during their normal service hours.
 - i) 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 service providers.
- f) Marketing/Advertising – The MCHSCoC Coordinated Entry and Discharge Planning (CEDP) Committee will conduct marketing to promote access and availability of the information regarding CE. Marketing materials will be provided to the Governing Board annually.

2) Pre-Screening

- a) Pre-Screening Facesheet – Household who present at Front Doors or screening agencies reporting need for housing assistance will be pre-screened using a standard tool. This tool asks for information such as:
 - i) Name;
 - ii) Contact information;
 - iii) Age
 - iv) Household composition;
 - v) Immediate safety status;
 - (1) Domestic violence
 - (2) Mental health crisis
 - (3) Medical emergency
 - vi) Housing status
- b) Next Steps - Responses to the Pre-Screening Tool determines the next steps for the household.
 - i) Households who are not currently experiencing homelessness will be referred to mainstream resources and diverted from CE.
 - ii) Households who are currently experiencing homelessness will be referred to Step 3 of CE.
 - (1) However, even households who are homeless may be diverted from accessing CE and system resources if they are able to access their own resources to address their housing crisis. Screeners should utilize diversion tactics throughout the entire CE process.

3) Coordinated Entry Screening

- a) Opening Script – Every screener conducting a CE screening interview must use the standardized CE opening script. As part of this opening script the household is asked if they consent to going through the screening interview. If they do not consent to completing the interview, they will not be enrolled in CE.
- b) CE Screening Packet – There are standardized screening packets for single adults and one for families with children. The CE Screening Packet includes:
 - i) Pre-Screening Tool;
 - ii) HMIS Informed Consent and Release of Information: in order for client data to be shared with other organizations on HMIS and in Housing Navigation meetings or during case conferencing, this form must be signed for each member of the household. The household may refuse to sign it, in which case the screening organization enrolling them in CE would need to restrict access on HMIS to only their organization.
 - iii) VI-SPDAT (single adult or family): these screening questions are worked in with the Universal and MCHSCoC data points. The VI-SPDAT was created by OrgCode, an organization that has requirements for how the tool may be used.
 - (1) OrgCode requirements and tips include:
 - (a) The tool must be administered the same way by every screener to be reliable.
 - (b) The scored questions must be asked the way they are written. However, additional questions can also be asked to clarify or explore for more information. And additional information known by the screener and other service providers can be used to inform the screening. Please see below under MCHSCoC requirements for more details.
 - (c) Do not refer to people as a score. Do not tell people their score. The score that comes out of the VI-SPDAT is for a moment in time and is used to start the process of matching them with available resources.
 - (2) MCHSCoC requirements and tips include:
 - (a) A VI-SPDAT score may only be changed after a case conference is conducted about the particular household 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 conferences can be held telephonically.

- iv) HMIS Universal Data: specific data required for HMIS
- v) MCHSCoC data: additional data points gathered by the MCHSCoC. These could be additional questions to determine eligibility for specific programs or if the household is established in Mendocino County.
- c) Enrolling in CE on HMIS – Data collected during the screening interview should be entered into HMIS within 72 hours of collection. Entry into HMIS, enrollment into the Coordinated Entry program on HMIS, and a recent (no older than 6 months) VI-SPDAT screening puts the household on the BNL.
- d) Staying enrolled in CE – the household will need to be re-screened at least every six (6) months to stay enrolled in CE.
- e) Training Requirements – Screeners are trained on the CE process, HMIS data entry, and VI-SPDAT screening by trainers designated by the CEDP Committee and MCHSCoC. Screening staff will be trained on CE and VI-SPDAT by the CEDP Committee designated trainer prior to conducting a CE Screening Interview and then attend annual training refreshers. 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. Screeners who are not following CE policies will be required to receive additional training. The CEDP Committee will track these trainings. Screeners who do not complete the required trainings may lose access to enrolling households in CE. Service Referral – As appropriate, screeners may provide the household with referrals to services and resources to address their housing crisis.

4) Coordinated Entry Enrollment in HMIS

- a) HMIS Entry - The household screening packet information is entered in HMIS by the screening agency.
- b) Coordinated Entry Program Enrollment – The screening agency enrolls the client in the HMIS CE program. This enters them on to the BNL. The BNL is sent to all Receiving Programs. Clients are prioritized first based on their VI-SPDAT score, second by their date of enrollment in CE, and third by veteran status.
- c) HMIS Lead Agency – HMIS Staff at Mendocino County HHSA are responsible for the daily administration of 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 every other week.

5) Housing Match

- a) Housing Match –Information gathered from the screening is used to determine which housing intervention is best suited to address the household's homelessness (permanent supportive housing, rapid re-housing, diversion, or another option). Scoring from the VI-SPDAT matches households to a particular

housing intervention and will be reflected by the household's positioning on the BNL.

b) 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. CE uses the following criteria to accurately match needs to resources:

- i) Singles VI-SPDAT scoring matrix:
 - (1) 0-3: no housing intervention – Diversion
 - (2) 4-7: an assessment for Rapid Re-Housing
 - (3) 8+: an assessment for Permanent Supportive Housing/Housing First
- ii) Family VI-SPDAT scoring matrix:
 - (1) 0-3: no housing intervention – Diversion
 - (2) 4-8: an assessment for Rapid Re-Housing or Transitional Housing
 - (3) 9+: an assessment for Permanent Supportive Housing/Housing First
- iii) 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.

c) Housing Types

Housing Models	Populations	Priority Populations
Permanent Supportive Housing	<ul style="list-style-type: none"> • 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) 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Literally homeless households are those residing in a place not meant for human habitation, living in a publicly or privately operated shelter 	<ul style="list-style-type: none"> • Households with children residing on streets or in emergency shelters

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Housing Models	Populations	Priority Populations
	<p>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 for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution</p> <ul style="list-style-type: none"> • Households that have reasonable potential for personal sustainability post- assistance 	<ul style="list-style-type: none"> • Veteran households with children residing on streets or in emergency shelters who are not eligible for VA-funded RRH or HUD/VASH
<p>Transitional Housing</p>	<ul style="list-style-type: none"> • 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 	<p>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</p>

- a) Unit Availability/Vacancy Notification – When Receiving Programs identify a program opening, they will pull referrals from the BNL for the next household they will serve within their eligibility criteria.
- b) Using BNL to Match - The Receiving Programs receive the BNL from the HMIS lead every other week. When they have an opening in their program, they will use the most recently released BNL to identify the next household within their program criteria, using the VI-SPDAT as the primary source of prioritization, length of time enrolled in CE as the secondary prioritization source, and any program specific eligibility criteria as the third method for prioritization. Once a household has been identified for potential intake into the program, the following will occur:
 - i) Receiving Program staff will attempt to make contact with the client

- within ten (10) business days. These attempts must be documented. As people experiencing homelessness can sometimes be difficult to contact, Receiving Programs should utilize partner service organizations to make contact with the household, especially the organization that enrolled the household in CE. If the client cannot be contacted within ten (10) business days, the next client on the BNL will begin to be processed.
- ii) Once staff contacts the household, a program intake appointment will be scheduled and completed. If the client misses the first appointment, Receiving Programs will schedule a new intake appointment within three (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.
 - c) Denial and Appeal - Receiving Programs must make eligibility determination decisions within ten (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.
 - i) 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. Reasons for denial may include:
 - (1) there is no actual vacancy available;
 - (2) the individual or family missed two intake appointments without good cause;
 - (3) the household presents with more people than referred by CE Screener and the Receiving Program cannot accommodate the increase;
 - (4) certain criminal behaviors, as specified by the Receiving Program's policies; or
 - (5) Policies and procedures of the Receiving Program have 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.
 - (6) The Receiving Program must enter the reason for any decision to reject a client into HMIS. Reason for denial forms must be submitted to the client the within five (5) business days.
 - (7) 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.

- d) Program Acceptance - Once the household is offered a slot in the Receiving Program, they have five (5) business days to accept or decline program enrollment. If the client accepts the unit/program slot, they move forward towards move-in/program enrollment. If the client declines the unit, then the next client on the list will begin to be processed.
 - (1) 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.
 - (2) A client may refuse a housing unit/placement three (3) times before being removed from the BNL. At that time, the client must go through CE again.
- e) Receiving Program Enrollment – If the homeless individual or family is accepted, the Receiving Program must document that acceptance in HMIS.

6) **Exiting Households from Coordinated Entry**

- a) Exiting CE - Households are exited from CE enrollment when any of the following occur:
 - i) Households must have an updated screening completed every six (6) months or they must be exited from CE enrollment.
 - ii) When a household has acquired permanent housing through any means (program or personal resource, they must be exited from CE enrollment with an exit interview completed.
 - iii) When a household is enrolled in a housing program, they may need to remain enrolled in CE. For example, if a household is enrolled in Rapid Re-Housing, they would still be homeless until they acquired housing with the RRH assistance. Once the household has acquired permanent housing, CE enrollment must be exited with an exit interview conducted.
 - iv) The household is known to have left Mendocino County and will not be returning for an extended time.
 - v) The client no longer meets the definition of homeless as established by the MCHSCoC. For example, they will be incarcerated or in an institution for ninety (90) days or longer.
 - vi) The client is deceased.
- b) Exiting in HMIS - When a household is exited from CE, they must be disenrolled through HMIS by the organization that enrolled them. An exit interview should be completed with every household, unless it is not possible to contact them. This exit interview should gather data, such as where they are leaving to (housing situation, rent/own, subsidy, etc.) and other data required by the MCHSCoC.

FAIR HOUSING AND TENANT SELECTION

CE 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 CE agree to take full accountability for complying with Fair Housing and all other funding and program requirements. The MOU requires User Agencies to use CE 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. CE may allow filtered searches for subpopulations while preventing discrimination against protected classes.

Nondisclosure of disability: Failure of a participant to disclose a disability or the specific nature of a disability does not preclude participation in CE.

EVALUATING AND UPDATING COORDINATED ENTRY

The implementation of CE 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 MCHSCoC Governing Board. Specifically, the Governing Board is responsible for:

- Leading periodic evaluation efforts to ensure that CE is functioning as intended; such evaluation efforts shall happen at least annually.
- Leading efforts to make periodic adjustments to CE 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 CE 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 CE 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 CE
- Completeness of data on assessment and intake forms

These metrics shall also include indicators of the impact of CE 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