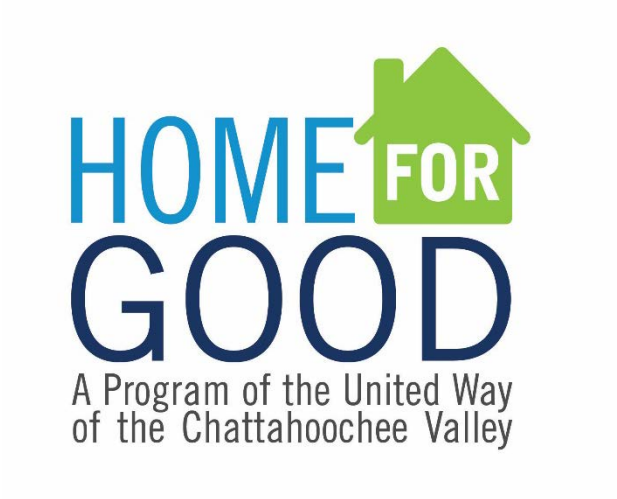

Muscogee/Russell Continuum of Care

Coordinated Entry Policies and Procedures

Prepared by the Home For Good, a program of United Way of the Chattahoochee Valley, serving as Lead Agency to the Muscogee/Russell continuum of Care, and Untied Way 2-1-1

Disclaimer: *The Coordinated Entry System* uses a two-step phased assessment process to first triage for the best housing intervention (Permanent Supportive Housing [PSH] or Rapid Re Housing [RRH], and then to determine prioritization based on vulnerability. It is not a guarantee that the individual or family will meet the final eligibility requirements for – or receive a referral to – a particular housing option.

The materials within this Coordinated Entry-System Policies and Procedures Manual have been developed locally for the Muscogee/Russell Continuum of Care and are not evidence based. They are intended to offer an example of how tools can be simplified and tailored to meet the objectives of a system that coordinates access to housing for homeless individuals, youth, and families. These tools, assessments, policies and procedures will continue to be refined locally based on feedback from assessors, providers and clients.

Muscogee/Russell Continuum of Care

Coordinated Entry System Policies and Procedures manual

Table of Contents

I. Purpose and Background

Under the requirements of the Homeless Emergency Assistance and Rapid Transition to Housing: Continuum of Care program (HEARTH Act,) The Muscogee/Russell Continuum of Care has implemented a Coordinated Entry System. Coordinated Entry is a powerful tool designed to ensure that homeless persons and persons at risk of homelessness are matched, as quickly as possible, with the intervention that will most efficiently and effectively end their homelessness. The *Coordinated Entry System* described in this manual is designed to meet the requirements of the HEARTH Act, under which, at a minimum, Continuum of Care must adopt written standards that include:

i. Policies and procedures for providing an initial housing assessment to determine the best housing and services intervention for individuals and families;

ii. A specific policy to guide the operation of the centralized or coordinated assessment system on how its system will address the needs of individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or staling, but who are seeking shelter or services from non-victim service providers;

iii. Policies and procedures for evaluating individuals' and families' eligibility for assistance;

iv. Policies and procedures for determining and prioritizing which eligible individuals and families will receive transitional housing assistance;

v. Policies and procedures for determining and prioritizing which eligible individuals and families will receive rapid rehousing assistance;

vi. Policies and procedures for determining and prioritizing which eligible individuals and families will receive permanent supportive housing assistance;

The Muscogee/Russell Continuum of Care has designed the Coordinated Entry System described in this manual to coordinate and strengthen access to housing for families and individuals who are homeless or at risk of homelessness throughout the geographical region served by the Muscogee/Russell Continuum of Care. The Coordinated Entry System institutes consistent and uniform assessment and referral processes to determine and secure the most appropriate response to each individual or family's immediate and long-term housing needs.

The *Coordinated Entry System* is designed to:

- Allow anyone who needs assistance to know where to go to get that assistance, to be assessed in a standard and consistent way, and to connect with the housing programs and services that best meet their needs;

- Ensure clarity, transparency, consistency and accountability for homeless clients, referral sources and homeless service providers throughout the assessment and referral process;

- Facilitate exits from homelessness to stable housing in the most rapid manner possible given available resources;

- Ensure that clients gain access as efficiently and effectively as possible to the type of intervention most appropriate to their immediate and long-term housing needs;

- Ensure that people who have been homeless the longest and/or are the most vulnerable have priority access to scarce permanent supportive housing resources.

To achieve these objective the *Coordinated Entry System* includes:

- A **uniform and standard assessment process,** including initial triage followed by detailed assessment tools**,** to be used for all those seeking assistance, and procedures for determining the appropriate next level of assistance to resolve the homelessness of those living in shelters, on the streets, or places not meant for human habitation;

- Establishment of **uniform guidelines** among components of homelessness assistance (Emergency Shelter, Transitional Housing, Rapid Re-housing , and Permanent Supportive Housing) regarding eligibility for services, priority populations, expected outcomes, and targets for length of stay;

- Agreed upon **priorities for accessing homeless assistance;**

- **Referral policies and procedures** from the system of Coordinated Entry to homeless services providers to facilitate access to services

- The **policies and procedure manual** contained herein and detailing the operations of the *Coordinated Entry System.*

The implementation of the *Coordinated Entry System* necessitates significant, community-wide change. To help ensure that the system will be effective and manageable for those who are experiencing homelessness or at-risk of becoming homeless and for the housing and service providers tasked with meeting their needs, a comprehensive group of stakeholders was involved

in its design. In addition, particularly during the early stages of implantation, the Muscogee/Russell County Continuum of Care anticipates adjustments to the processes described in this manual. A periodic evaluation of the *Coordinated Entry System* will provide ongoing opportunities for stakeholder feedback. Home for Good as the *Coordinating Entity* will be responsible for monitoring the *Coordinated Entry Syste*m.

II. Definitions

Terms used throughout this manual are defined below:

Chronically Homeless (HUD Definition):

1) An individual who:

   i. Is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

   ii. Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions in the last 3 years; and

   iii. Can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000 (42 U.S.C. 15002)), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability;

2) An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all 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 paragraph (1) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Disability (HUD Definition):

A Physical, Mental or Emotional Impairment, including impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury that is expected to be long-continuing or of indefinite duration, sustainability impedes the individual ability to independently, and could be improved by the provision of more suitable housing conditions; includes:

Developmental Disability as defined in §of the Developmental Disabilities Assistance and Bill of Rights **Act of 2000 (42 USC 15002)**. Means a severe, chronic disability that is attributable to a mental or physical impairment or combination AND is manifested before age 22 AND is likely to continue indefinitely AND reflects need for a combination and sequence of special, interdisciplinary or generic services, individualized supports, or other forms of assistance that are lifelong or extended duration and are individually planned and coordinated. An individual may be considered to have a developmental disability without meeting three or more of the criterial listed previously, if the individual is 9 years old or younger AND has a substantial developmental delay or specific congenital or acquired condition AND without services and supports, has a high probability of meeting those criteria later in life.

HIV/AIDS Criteria includes 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).

Homeless Definitions:
https://www.hudexchange.info/resources/documents/HomelessDefinition_RecordkeepingRequirementsandCriteria.pdf

Literally Homeless (HUD Homeless Definition Category 1):

Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) Has a primary nighttime residence that is a public or private place not meant for habitation; (ii) 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 organization or by federal, state and local government programs); (iii) is 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 intuition.

At Imminent Risk of Homelessness (HUD Homeless Definition Category 2)

Individual or family who will imminently lose their primary nighttime residence, provided that: (i) Residence will be lost within 14 days of the date of application for homeless assistance, (ii) No subsequent residence has been identified; and (iii) The individual or family lacks the resources or support networks needed to obtain other permanent housing.

Homeless under other Federal statutes (HUD Homeless Definition 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: (i) Are defined as homeless under the other listed federal statues; (ii) 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; (iii) 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 (iv) can be expected to continue in such status for an extended period of time due to special needs or barriers.

Fleeing Domestic Abuse or Violence (HUD Homeless Definition Category 4)

Any individual or family who; (i) Is fleeing, or is attempting to flee, domestic violence; (ii) Has no other residence; and (iii) Lacks the resources or support networks to obtain other permanent housing.

2017 Area Median Income limits (Columbus, GA Metro Area). These figures may or may not change depending on HUD guidelines.

ALABAMA Area Median Income Limits HUD 4.11.2017

GEORGIA Area Median Income Limits HUD 4.11.17

Household Size	30% AMI Extremely Low	50% AMI Very Low	80% AMI Low
1 Person	$12,060	$18,700	$29,900
2 Persons	$16,240	$21,400	$34,200
3 Persons	$20,420	$24,050	$38,450
4 Persons	$24,600	$26,700	$42,700
5 Persons	$28,780	$28,850	$46,150
6 Persons	$31,000	$31,000	$49,550
7 Persons	$33,150	$33,150	$52,950
8 Persons	$35,250	$35,250	$56,400

Vulnerability Index

The Vulnerability Index™ (VI) is an assessment tool used to identify members of the homeless population who are considered medically vulnerable and who will face an increased risk of mortality if homelessness persists.

Single VI

The baseline for vulnerability for single adults is six (6) months of homelessness. Vulnerability scores for single adults range from 0 to 9. Applicants who receive a score of 0 are considered non-vulnerable: however, they may still be eligible for PSH. Six months or more homelessness in combination with one or more of the markers detailed below will give someone a vulnerability score (1 or greater):

1. Three or more hospitalizations or emergency room visits in a year.
2. Three or more emergency room visits in the previous three months.
3. Aged 60 or older.
4. Cirrhosis of the liver.
5. End-stage renal disease.
6. History of frostbite, immersion foot, or hypothermia.
7. HIV+/AIDS
8. Tri-morbidity: co-occurring psychiatric, substance abuse, and chronic medical condition (asthma, cancer diabetes, etc.).
9. Is fleeing or is attempting to flee Domestic Violence and has no other resources or support networks to obtain other permanent housing.

A vulnerability score (e.g. 0) is not assigned to persons who are homeless for six months but have none of the markers listed above. Additionally, homeless persons who have less than six months of homelessness but who have the above medical risks are assigned a score of zero.

Rapid Re-Housing Next Step Assessment

Two separate assessment tools will be used to prioritize non-chronically homeless households for entry into a Rapid Re-housing program. The assessment tools target youth, families, and single individuals. The first assessment tool (completed via 2-1-1) offers a high-level overview of the individual or family experiencing homelessness. The second more in-depth tool (Vulnerability Index - Service Prioritization Decision Assistance Tool or VI-SPDAT) focuses on length of literal homelessness and residential instability, involvement with child welfare and/or informal separation from children, number of children, trauma history, substance abuse history, and employment history. The assessments ask questions tailored to each population and include the following:

1. Homeless history
2. Involvement with child protective services
3. Parental risk factors
4. Child risk factors
5. Job loss
6. Criminal background history
7. Mental health history
8. Substance abuse history

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 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 policymakers at the federal, state, and local levels use aggregated HMIS data to obtain better information about the extent and nature of homelessness over time. 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.

The Muscogee/Russell CoC's HMIS is staffed at Home For Good. The software provider is Client Track. 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 Muscogee/Russell CoC's HMIS are referred to as "participating agencies". Each participating agency needs to follow certain guidelines to help maintain data and privacy and accuracy.

Those who are experiencing homelessness due to domestic violence or abuse may be excluded from the HMIS for their protection and to keep their location/location of accessed services confidential. Domestic violence shelters report through a separate state-wide database.

III. Staffing Roles and Expectations

Continuum of Care (CoC) – Recognizing the need to stimulate community-wide planning and coordination of programs for individuals and families who are homeless, the U.S. Department of Housing and Urban Development (HUD) in 1994 instituted a requirement of communities to come together to submit a single, comprehensive application for HUD funds for housing and support services for people who have experienced homelessness. The organizational concept to embody this effort is the Continuum of Care (CoC), which is governed by a Board of Directors, composed of representatives from across the community. As a result of its strong leadership, access to resources and high visibility in the community, Home For Good, a program of United Way of the Chattahoochee Valley (HFG), serves as this region's lead agency for the CoC. The CoC encompasses Muscogee County in Georgia and Russell County in Alabama, and its purpose is to:

- Help create integrated, community-wide strategies and plans to make homelessness atypical and nonrecurring;
- Provide coordination among the numerous regional organizations and initiatives that serve the homeless population, and

- Create the region's single, comprehensive grant application to HUD for McKinney-Vento funding.

Coordinating Entity – Home For Good is the designated Coordinating Entity. The Coordinating Entity is responsible for the day-to-day administration of the Coordinated Entry System, including but not limited to the following:

- Creating and widely disseminating material regarding services available through the Coordinated Entry System and how to access those services;
- Designing and delivering training at least annually to all key stakeholder organizations, including but not limited to the required training for Coordinated Entry Staff;
- Ensuring that pertinent information is entered into HMIS for monitoring and tracking the process of referrals including vacancy reporting and completion of assessments;
- Managing case conferences to review and resolve rejection decisions by receiving programs and refusals by clients to engage in a housing plan in compliance with receiving program guidelines;
- Managing an eligibility determination appeals process in compliance with the protocols described in this manual;
- Managing manual processes as necessary to enable participation in the Coordinated Entry System by providers not participating in HMIS;
- Designing and executing ongoing quality control activities to ensure clarity, transparency, and consistency in order to remain accountable to clients, referral sources, and homeless service providers throughout the Coordinated Entry process;
- Periodically evaluating efforts to ensure that the Coordinated Entry System is functioning as intended and making periodic adjustments as deemed necessary;
- Ensuring that evaluation and adjustment processes are informed by a broad and representative group of stakeholders;
- Updating policies and procedures as needed;
- Managing all public relations requests related to the Coordinated Entry System.

Coordinated Entry Administrator – The Coordinating Entity staffs the Coordinated Entry Administrator (CEA) position. This role includes the day-to-day management of the Coordinated Entry System (CES) once intakes are received from the 2-1-1 Information and Referral line, including but not limited to the following:

- Serving as point person for initial outreach to clients
- Administering the VI-SPDAT, recording results in HMIS and making initial determination for program eligibility based on program mapping

- Maintaining the Prioritization (formerly “By Name”) List
- *Report generating (as of this revision, reports are unavailable)*
- Confirming agency follow-up with clients within the agreed time frame
- Communicating to user agencies and outreach coordinators
- Deactivating/reactivating client records
- Responding to email generated questions

United Way of the Chattahoochee Valley’s 2-1-1 Information and Referral line (2-1-1) – The 24 hour a day information and Referral Line was selected to serve as the agreed initial access point responsible for ensuring that all households experiencing homelessness and are at-risk of homelessness have immediate access to intake, assessments and shelters/services to meet their immediate needs. Callers who identify themselves as victims of domestic violence will be given referrals to domestic violence shelters immediately with no need for further assessment.

Receiving Program – All Rapid Re-housing RRH, Permanent Supportive Housing PSH programs, and Emergency Shelters are Receiving Programs. All programs that receive a referral from the Coordinated Entry System are responsible for responding to that referral and participating in case conferences, in compliance with the protocols described in this manual.

Receiving Program Staff – Designated individuals who represent agencies that provide housing related programs and services. These representatives may come from agencies who participate in HMIS and who receive CoC funding and those who do not.

Authorized User Agencies – Agencies are Housing Providers who wish to, or are required to, participate in the Coordinated Entry System. Authorized user Agencies sign a Memorandum of Understanding to have access to the HMIS database.

IV. Target Population

The Coordinated Entry System is open to all households who meet the HUD definition of homeless, as outlined in the new HEARTH Act regulations, and have incomes below 50% of the Area Median Income. The system uses vulnerability indices (descried in Definitions) to rank applicants in order of vulnerability, with the most vulnerable households ranked at the top. More directly, applicants may be offered housing regardless of vulnerability score, but the more vulnerable persons will likely be offered housing before non-vulnerable.

V. System Overview and Workflow

To illustrate how the Coordinated Entry System 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 in the appendices. **From initial Request for Services to Permanent Housing Placement – Pathway through the coordinated Entry System (See Appendix F)**

- **Step 1: Connecting to the Coordinated Entry System/Initial Request for Services** – To ensure accessibility to households in need, the CES provides access to services 24 hours a day through the 2-1-1 Information and Referral line. Those experiencing homelessness can simply 2-1-1 or call directly at 706-405-4775 (ten digit number is preferred method if using a pre-paid cellphone). Households who are requesting services in person through any of the designated Receiving Programs will be directed to do an initial assessment through the 2-1-1 line.

- **Step 2: Triage and Initial Housing Assessment –** The initial assessment is done through a series of questions asked by the 24/7 call center, based on the question "where did you sleep last night?" the assessment is reviewed by 2-1-1 Manager and the CEA to determine primary program eligibility based on agency provided program mapping; decisions based on this assessment and referral actions are completed using HMIS. The CEA will call the client within 3 business days to schedule and/or complete the in-depth VI-SPDAT assessment. If Domestic Violence, Please refer to process outlined in **Appendix D.**

- **Step 3: Housing Referral –** Once the VI-SPDAT is completed in HMIS, eligible programs have been identified through program mapping and the household/individual have decided which programs they are interested in, an electronic referral to the Receiving Program is completed and the individual/family is placed on the Prioritization/By Name List according to Vulnerability Index score/Prioritization

- **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 or Rapid-Re-housing). Receiving Program staff matches households to a particular housing intervention and then a specific housing program based on program eligibility and notates in HMIS. Note that the Receiving Program that received the initial referral may determine after further assessment that another program is more suitable

- **Step 5: Housing Navigation –** Once referred to a Receiving Program the program is responsible for navigation through the process to insure client's housing needs are

met. **The goal is to move from homelessness to housed in 30 days, but due to program resources clients may be wait-listed.**

VI. Coordinated Entry Policies and Procedures

1. Connection to the Coordinated Entry System

1.1 Locations & Hours – Initial Intake and Assessment are conducted through the 2-1-1 call center 24 hours a day, seven days a week

1.2 Eligibility – the Coordinated Entry System is intend 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 according to the agreed prioritization standards (see Appendix) The Coordinated Entry System uses Program Mapping/Project Eligibility Matrix to accurately match needs to the appropriate housing intervention.

1.3 Marketing/Advertising – As needed, the Coordinating Entity will send information & updates regarding the CES to stakeholders, agencies, government bodies, and the general public via email, newspapers, radio and/or television. The coordinating Entity also distributes flyers and brochures and maintains information available on its website: www.homeforgoodcv.org.

2. The Housing Assessment Process

2.1 Roles and responsibilities: 2-1-1 Call Agents and Coordinated Entry Administrator – 2-1-1 Call Agents are responsible for completing the initial intake. The 2-1-1 Manager pulls all intakes on the next business day and forwards qualifying callers' information to the Coordinated Entry Administrator for further assessment through the VI-SPDAT. Once the CEA has completed the VI-SPDAT, uploaded the information into the HMIS and made and informed client of an initial referral decision, they then send the referral to the Receiving Program's designated staff member. The CEA's responsibilities include, but are not limited to the following:

- Scheduling and completing a VI-SPDAT with all qualified callers
- Client notification of Eligibility and Referral Decisions along with program expectations and processes
- Submission of referrals to the Receiving Program through HMIS
- Collecting and uploading all documents available at assessment
- Participation in case conferences
- Responding to requests by the Coordinating Entity
- Reassessing clients after they have been on the Prioritization (by-name list) list for more than 90 days

2.2 Training Requirements – the 2-1-1 Manager, Coordinated Entry Administrator, and appropriate Receiving Program staff members are trained annually by the Coordinating Entity.

2.3 HMIS Workflow – The workflow below outlines the Coordinated Entry steps in HMIS:

2.4. Release of Information – All clients must agree verbally to information sharing during the limited 2-1-1 telephone assessment and before initial referrals are sent to Receiving Programs. Once the client is being processed for possible enrollment by the Receiving Program, a signed HMIS consent form must be obtained. Additional program specific ROI's may be required and may or may not be uploaded into HMIS.

2.5. Client Photos – Photos can be taken at the time of the agency-level Vulnerability 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.

2.6. Timeline – The 2-1-1 Call Agent notifies the client that their needs and barriers will be reviewed within 24 business hours of the intake. Once the Coordinated Entry Administrator conducts the VI-SPDAT and reviews the data the referral is made, the Receiving Program has three (3) business days to acknowledge receipt of the referral and make initial contact with the client. The Receiving Program can reject or deny the referral if the assigned case manager has been unable to contact the household after three (3) business days. If a household shows up at the Receiving Program after the three (3) business days have expired, the program staff will assist the household in reentering the system by contacting the CEA on their behalf. All of this information is documented in HMIS.

3. Housing Matching

3**.1. HMIS Responsibilities** – HMIS Staff at Home For Good is responsible for the daily administration of the HMIS software, providing technical assistance, and user training to participating agencies and end-users.

3.2. Receiving Program Staff

3.2.1. Roles and Responsibilities – Program Staff work out of their home agencies, or in the field. All Program Staff work with

individuals in navigating the process of securing housing from housing referral to "lease up." All Program Staff, Community Outreach Teams, and Case Managers operating as "Housing Navigators" carry the following responsibilities:

- Assisting client in obtaining necessary documentation required for housing
- Collecting and uploading necessary documentation, securing additional financial assistance if needed, providing transportation, accompaniment to potential housing options, etc.
- Assisting clients in navigating any challenges related to the housing process (application and/or inspection process, etc.)
- Participation in case conferences
- Responding to requests by the Coordinating Entity, as appropriate.

3.2.2. Training Requirements – Program Staff are trained by the Coordinating Entity. The training consists annual training and ad hoc meetings as necessary.

3.3. Timeline – Once the Coordinated Entry Administrator has made contact with the client's Program Staff, that worker contacts the client within three (3) business days and begins the process of scheduling enrollment appointments. This information is tracked in HMIS.

3.4. Unit Availability/Vacancy Posting *– All Rapid Re-housing, and Permanent Supportive Housing Programs are required to post vacancies in HMIS within twenty-four (24) business hours of unit/bed availability. If providers know of an impending vacancy, they are required to post the anticipated availability date up to fourteen (14) days before unit vacancy. Programs must update vacancy information in HMIS within twenty-four (24) business hours of unit/bed being filled. This information is crucial in determining what resources are available and where to send a client needing housing. (At the time of this revision, unit availability/vacancy information is not available. The CoC intends to implement this section as soon as feasibly possible.)*

4. Housing Referral

4.1. Waitlist – There are separate waitlists for Permanent Supportive Housing and Rapid Re-housing. The By Name/Prioritization List (waitlist) consists of the following:

4.1.1. Permanent Supportive Housing clients are prioritized based on their VI-SPDAT score.

4.1.2. Rapid Re-housing clients are prioritized by their household type (veterans, youth, families, singles) followed by their next step assessment score in each.

4.1.3. Housing Navigators will pull the By Name/Prioritization List daily. (At the time of this revision, unit availability/vacancy information is not available. The CoC intends to implement this section as soon as feasibly possible.)

4.1.4. If the By Name/Prioritization List indicates an opening for either Permanent Supportive Housing or Rapid Re-housing, the Assessors create a referral to the program with the opening. (At the time of this revision, unit availability/vacancy information is not available. The CoC intends to implement this section as soon as feasibly possible.)

4.1.5. If the referral was made to a Permanent Supportive Housing program, then the Assessors will also create a reservation for the open unit to remove it from that program's inventory. (At the time of this revision, unit availability/vacancy information is not available. The CoC intends to implement this section as soon as feasibly possible.)

4.1.6. Program Staff or Case Managers Attempt to make contact with the client for three (3) business days.

4.1.7. If the client cannot be contacted within that time frame, the CEA is contacted and then staff moves on to the next client on the list.

4.1.8. Once staff meets with the client, the client must decide immediately whether to accept or decline the services provided by the Receiving Program.

4.1.9. If the client accepts services, he/she moves forward in the next steps toward move in.

4.1.10. If the client declines services, the Receiving Program Staff sends the referral back to the Coordinated Entry Administrator for re-assignment and the client that refused is moved down to the

bottom of the By-Name/Prioritization waitlist based on their VI-SPDAT score or advised that there are no other community resources.

4.2. Receiving Program Responsibilities – Once a referral is made, the Receiving Program has twenty-four (24) business hours to acknowledge receipt of the referral. The Receiving Program must then enroll or deny the referral within three (3) days. The Receiving Program can reject or deny the referral if the assigned Program Staff has been unable to contact the house hold after three (3) days. If a household shows up at the Receiving Program after the three (3) days have expired, the Program Staff will assist the household in reentering the system through the Coordinated Entry System via the CEA. **All of this information is tracked and documented in HMIS.**

4.2.1. Document Requirement Updates – Receiving Programs make eligibility determination decisions within one (1) business day of the enrollment interview (or when all required application materials are complete). The Receiving Program orally reviews the intake decision notification with the client to ensure that the client understands the decision, and applicable next steps, including the client's right to appeal the decision. An enrollment decision notification includes at a minimum:

- First available move-in date, if possible; and
- Reason the client cannot enter the program, including reason for rejection by client or program (which includes redirection to the Coordinated Entry Administrator), if applicable
- Instruction for appealing the decision

4.2.2. Reasons for Denial – Receiving Programs may only decline households found eligible for and referred by the Coordinated Entry Administrator under limited circumstances including: **(See Appendix J)**

- there is no actual vacancy available;
- the household cannot be physically located by the CoC Outreach team;
- the Receiving Program has been unable to make contact with the household for three (3) consecutive business days;
- the household presents with more people than referred by the Coordinated Entry Administrator and the Receiving Program cannot accommodate the increase;
- the household was denied by independent property owner/landlord due to certain criminal behaviors

- based on their individual program policies and procedures as outlined in program mapping, the Receiving Program has determined that the household cannot be safely accommodated or cannot meet tenancy obligations with the supports provided by the program.

Programs may not decline persons with psychiatric disabilities for refusal to participate in mental health services. The Receiving Program must update the referral outcome in HMIS for any decisions to accept or reject a client. If the ineligible client has not otherwise been accommodated for the night, e.g. via an intervention by emergency services/community shelters, the Receiving Program must notify the Coordinated Entry Administrator, refer the client back, and document the outcome in HMIS. Reason for denial forms must be submitted to the client on the same day as the decision was made if possible.

4.2.3. Client Choices – 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. **(See Appendix I)**

4.2.4. Client Appeal – All clients have the right to appeal eligibility determinations issued by either the Coordinating Entity or any Receiving Program. Instructions for submitting an appeal are provided to clients at the time that an intake decision is made by the Receiving Program. The Coordinated Entry Administrator and Receiving Program Housing Navigators are responsible for assisting clients in filing eligibility determination appeals, including but not limited to drafting a written appeal on behalf of the client. All appeals of decision by Receiving Programs should be made in writing and submitted to the Coordinating Entity within thirty (30) days. **(see Appendix K)**

4.3. Move-In – If the household is accepted, the Receiving Program must document that acceptance in HMIS and arrange for move-in as soon as possible. If the client does not move-in as scheduled or within three (3) business days of the mutually agreed move-in date, the Receiving Program must notify the Coordinated Entry Administrator so that the outcome is documented in HMIS. To the extent feasible, given available funding and as necessary, the Receiving Program will provide the individual or family with move-in assistance including transportation of household members and personal belongings.

4.4. PSH to PSH – under the CoC Program, Permanent Supportive Housing (PSH) projects may serve individuals and families from other PSH projects who

originally met the eligibility requirements for PSH so long as the program participants were eligible for the original PSH (Section 423(f) of the McKinney-Vento Act, as amended by the HEARTH Act). **This means that an individual or family may transfer from one PSH program to another under the CoC Program**. This could occur under the following circumstances:

- if there were another PSH program that better met the services needs of the program participant;
- the program participant is evicted by the landlord or housing program and the participant is still eligible for case management services; or
- the current PSH program in which the individual or family is enrolled in has lost their funding
- The Program Staff of both programs must be in agreement that the transfer better meets the needs of the individual and all original program eligibility documentation needs to be included in the transfer paperwork

4.4.1. PSH to PSH Referral – if any of the above scenarios apply, a staff member from the current PSH must notify the Coordinated Entry Administrator in writing via email to initiate the process of transferring the client. The CEA will verify that the request falls within the guidelines for the transfer as outlined in this manual. The Coordinated Entry Project Manager will determine if a PSH unit is available, create the referral in HMIS, and notify the current PSH program. The current PSH program will then be responsible for assisting the program participant in completing the documentation necessary for the new PSH program. Transfer requests outside of the ones outlined in this manual will not be approved. If no PSH unit is available, then the current PSH program will have to continue to work with the program participant in securing alternate housing options.

4.5. Referrals to and from other systems not using HMIS or systems that utilize HMIS for protected populations – The Coordinated Entry System appropriately addresses the needs of Veterans, individuals who are HIV/AIDS+, and individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking.

4.5.1. Domestic Violence (DV) – When a homeless or at-risk household is identified by the Coordinated Entry System to be in need of domestic violence services, that household is referred to the domestic violence hotline immediately.

If the household does not wish to seek DV specific services, the household will have full access to the CES, in accordance with all protocols described in this manual If the DV helpline determines that the household seeking DV specific services is either not eligible for or cannot be accommodated by the DV specific system, the helpline will refer the client to the Coordinated Entry Administrator for assessment and referral in accordance with all protocols described in the manual. The client can request DV services at any time in the process. **(See Appendix D)**

4.5.2. Veterans – When a homeless or at-risk individual is identified by the Coordinated Entry System to be a Veteran, additional questions concerning service era, length of service, and discharge status may be asked. If eligible for VA services, the Veteran will be given the option of being referred to the VA and/or SSVF service providers. If the Veteran chooses that option, then that individual is referred to the VA and/or SSVF service providers immediately. If the VA and/or SSVF service provider determines that the individual seeking veteran specific services is not eligible for VA and/or SSVF services, the Housing Assessor at the VA and/or SSVF Service provider will notify the Coordinated Entry Administrator immediately and offer an alternate referral in accordance with the process outlined in this manual.

5. Case Conferences

5.1. The Coordinating Entity (Home For Good) will require a case conference to review and resolve rejection decisions by Receiving Programs. The purpose of the case conference will be to resolve barriers to the household receiving the indicated level of service. Such a case conference will be held in all instances in which a household is declined by a Receiving Program. Case conferences will be held in all instances in which a household has declined more than two placements.

Receiving Programs may also request a case conference, at their discretion, in other circumstances in which a household is insufficiently engaged in actions necessary to secure a permanent placement.

In cases in which a household is facing program termination/discharge for program non-compliance, the Receiving Program will notify the Coordinating Entity. The Coordinating Entity may require a case conference to review and determine next steps. The purpose of the case conference will be to discuss interventions used to date and resolve barriers to securing permanent housing including plans to have the household re-assessed for a more suitable housing program.

The Coordinating Entity will determine which parties will attend a case conference, including but not limited to the Coordinated Entry Administrator, the

Receiving Program's Staff Member, the client, and other contacts as determined necessary. The Coordinating Entity will make all logistical arrangements for the case conference, including but not limited to notifying all parties.

Case Conferences may take place in a group setting such as the bi-monthly Housing Navigator meeting if agreed to by all parties.

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

The Coordinating Entity takes all necessary steps to ensure that the Coordinated Entry System is administered in accordance with the Fair Housing Act by promoting housing that is accessible to and usable by persons with disabilities. The Coordinated Entry System complies with the non-discrimination requirements of the Fair Housing Act including 24 CFR Part 5 [Docket No. FR 5863–F–02] RIN 2506–AC40. Discrimination is prohibited in all housing transactions on the basis of race, national origin, sex, color, religion, disability status, sexual orientation, gender identity 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 statue/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 System 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 System in a consistent manner with the statues and regulations that govern their housing programs.

The Coordinating Entity 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 its funding contract or a single-gender program must produce its HUD waiver. It is further recognized that the Fair Housing Act 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 System may allow filtered searches for subpopulations while preventing discrimination against protected classes.

VIII. Evaluating and Updating Coordinated Entry System Policies and Procedures

The implementation of the Coordinated Entry System necessitates significant, community-wide change. To help ensure that the system 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 implantation, the Muscogee/Russell Continuum of Care anticipates adjustments to the process described in the manual. To inform those adjustments, the Coordinated Entry System will be periodically evaluated, and there will be ongoing opportunities for stakeholder feedback, including but not limited to referral and Receiving Program work groups convened and managed by the Coordinating Entity. Specifically, the Coordinating Entity is responsible for:

- Leading periodic evaluation efforts to ensure that the Coordinated Entry System is functioning as intended; such evaluation efforts shall happen at least annually

- Leading efforts to make periodic adjustments to the Coordinated Entry System as determined necessary; such adjustments hall be made at least annually based on findings from evaluation efforts.

- Ensuring that evaluation and adjustment processes are informed by a broad and representative group of stakeholders

- Ensuring that the Coordinated Entry System 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 Coordinating Entity, in conjunction with the CoC Steering committee (a committee of the CoC Board of Directors) and Coordinated Entry Workgroup. These metrics will be displayed on dashboards located on the Coordinating Entity's website and shall include indicators of the effectiveness of the functioning of the Coordinated Entry System itself, such as:

- *Wait times for initial contact*
- *Extent to which expected timelines described in the manual are met*
- *Number/percentage of referrals that are accepted by receiving program*
- *Rate of missed appointment for schedule assessments*
- *Number/percentage of persons declined by more than one(1) provider*
- *Number/percentages of Eligibility and Referral Decision appeals*
- *Number of program intakes not conducted through Coordinated Entry system*

- *Completeness of data on assessment and intake forms*

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

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

(At the time of this revision, unit availability/vacancy information is not available. The CoC intends to implement this section as soon as feasibly possible.)

IX. Termination

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

X. Appendices

Appendices

A. Proposed Community-Wide Prioritization Standards
B. Coordinated Entry Housing Initial Assessment
C. Vulnerability Index Survey
D. Domestic Violence Protocols
E. Coordinated Entry User Agency MOU
F. Coordinated Entry System Workflow
G. HMIS Workflow
H. Program Eligibility Matrix (Program Mapping)
I. Coordinated Entry Referral Denial Form Client
J. Coordinated Entry Referral Denial Form Program
K. Coordinated Entry Referral Denial Appeal (Client)
L. Case Conferencing/Housing Navigation Standing Meetings
M. Statement of Confidentiality