Coordinated Entry System Operations Manual
IL-500 McHenry County Continuum of Care to End Homelessness

TABLE OF CONTENTS

I. PURPOSE AND BACKGROUND **2**

A. DISCLAIMER

B. DEFINITIONS

II. STAFFING ROLES AND EXPECTATIONS 6

III. TARGET POPULATION..6

IV. SYSTEM OVERVIEW AND WORKFLOW..7

V. COORDINATED ENTRY POLICIES AND PROCEDURES..7

A. Connecting to the Coordinated Entry System

B. Housing Models

C. Housing Assessing

D. Housing Match & Preparation

E. Prioritization & Referral

F. Case Conferences

VI. FAIR HOUSING, TENANT SELECTION PLANS, AND OTHER STATUTORY AND REGULATORY REQUIREMENTS…13

VII. EVALUATING AND UPDATING COORDINATED ENTRY SYSTEM POLICIES AND PROCEDURES........................14

VIII. Termination..15

Appendix. Participant Rights and Responsibilities..18

I. Purpose and Background

In accordance with the requirements provided in the Interim Rule for the Continuum of Care (CoC) Program recorded in 24 CFR 578.7(a)(8) to fulfill the goals of the Opening Doors: Federal Strategic Plan to Prevent and End Homelessness, the McHenry County Continuum of Care to End Homelessness (McHenry County CoC) has designed a Coordinated Entry System. The Coordinated Entry System is designed to meet the following requirements of the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH Act):

- Establish and operate a coordinated assessment system that provides an initial, comprehensive assessment of the needs of individuals and families for housing and services;
- A specific policy to guide the operation of the 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 stalking, but who are seeking shelter or services from non-victim service providers;
- Policies and procedures for evaluating individuals' and families' eligibility for assistance;
- Policies and procedures for determining and prioritizing which eligible individuals and families will receive transitional housing assistance;
- Policies and procedures for determining and prioritizing which eligible individuals and families will receive rapid rehousing assistance;
- Policies and procedures for determining and prioritizing which eligible individuals and families will receive permanent supportive housing assistance.

The Coordinated Entry System improves service delivery for individuals and families experiencing homelessness and increases the efficiency of the homeless response system by simplifying access to housing and services for people experiencing homelessness; prioritizing housing assistance based on need; and quickly connecting households to the appropriate housing intervention.

To help ensure the system would efficiently and effectively respond to the needs of households experiencing homelessness and those at risk of homelessness and support the work of the service providers, a comprehensive group of stakeholders were involved in the design. A periodic review by stakeholders will be conducted to ensure the systems functionality with the ability to adjust processes as needed. **The Pioneer Center for Human Services**, as the CE Lead Agency, is responsible for management of the Coordinated Entry System and the Coordinated Entry Workgroup is responsible for its oversight.

A. Disclaimer

The Coordinated Entry System is designed to ensure households experiencing homelessness have fair and equal access to housing programs and services within the Continuum of Care. It is not a guarantee that the household will receive a referral to or meet the final eligibility requirements for a housing program.

B. Definitions

Terms used throughout this manual are defined below:

Community Hub locations:
Agencies that provide entry into the system for any household requesting homeless services and are not limited to households enrolled in their agency specific programs.

Program Access points:
Homeless service providers that provide entry into the system ONLY for households they serve in their agency emergency shelter program, case management, or other assistance.

Chronically Homeless:
A "chronically homeless individual" is defined to mean a homeless individual with a disability who lives either in a place not meant for human habitation, a safe haven, or in an emergency shelter, or in an institutional care facility (including a jail) if the individual has been living in the facility for fewer than 90 days and had been living in a place not meant for human habitation, a safe haven, or in an emergency shelter immediately before entering the institutional care facility.

In addition, the individual must meet one of the following criteria:

- Homeless continuously for at least 12 months **or**
- At least 4 separate occasions in the last 3 years where the combined occasions must total at least 12 months.
    - Each period separating the occasions must include at least 7 nights of living in a situation other than a place not meant for human habitation, in an emergency shelter, or in a safe haven.
  - A "chronically homeless family" is defined to mean a family with an adult or minor head of household that meets the definition of a chronically homeless individual. A chronically homeless family includes those whose compositions has fluctuated while the head of household has been homeless.

Disability:
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, substantially impedes the individual's ability to live independently, and could be improved by the provision of more suitable housing conditions; includes:

Developmental Disability as defined in § 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002). Means a severe, chronic disability of an individual that:

- is attributable to a mental or physical impairment or combination of mental and physical impairments; and
- is manifested before the individual attains age 22; and
- is likely to continue indefinitely; and
- results in substantial functional limitations in 3 or more of the following areas of major life activity:
    - self-care,
    - receptive and expressive language,
    - learning,
    - mobility,
    - self-direction,
    - capacity for independent living,
    - economic self-sufficiency; and
- 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.

- 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 3 or more of the criteria described in the definition of Developmental Disability, above, if the individual, 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:

As defined by HUD, including the four categories:

Literally Homeless (HUD Homeless Definition Category 1):
(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 human 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 organizations or by federal, state and local government programs); or (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 institution.

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 statutes; (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.

Diversion:
Diversion is a strategy that quickly ends homelessness for people seeking shelter by immediately identifying alternative housing arrangements.

High Utilizer:
A small subset of very vulnerable homeless individuals who use a disproportionate share of healthcare

costs due to their unmanaged chronic conditions and frequent use of crisis health services (emergency room, urgent care, behavioral health crisis unit, etc.). Frequent use of crisis health services is commonly measured as a minimum of four ER visits in the past twelve months.

By Name List:
By Name List is the prioritized listing of all homeless individuals or households seeking services. The By Name List is populated with information retrieved from HMIS. The Coordinated Entry Lead Agency has access to By Name List.

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.

HUD and other planners and policymakers at the federal, state, and local levels use aggregate 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 McHenry County Department of Planning and Development – Community Development Division manages the HMIS for McHenry County. The software provider is WellSky . 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 Coordinated Entry System's HMIS are referred to as "participating agencies." Participating agencies are asked to follow certain guidelines to help maintain data privacy and accuracy.

Participating Agencies:
Housing providers who wish to or are required to participate in the Coordinated Entry System. Participating Partner Agencies sign a Memorandum of Understanding to identify the roles and responsibilities as a partner.

Permanent Supportive Housing:
Permanent supportive housing is an intervention coupled with supportive services designed to assist individuals and families needing long term housing assistance and support services to maintain housing stability.

Prevention:
Prevention includes programs or services designed to prevent homelessness for individuals or households at risk of eviction or foreclosure by providing short-term assistance.

Rapid Re-Housing:
Rapid re-housing is an intervention designed to help individuals and families quickly exit homelessness and return to permanent housing. Rapid re-housing assistance is offered without preconditions and the resources and services provided are tailored to the unique needs of the household.

Receiving Program:
All Participating Rapid Re-housing, Permanent Supportive Housing, and Prevention programs are Receiving Programs and are responsible for reporting vacancies to CE Lead Agency in compliance with the protocols described in this manual. 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.

Referral Receiving Case Manager:
The Case Managers at the Receiving Program.

Referring Program:
Agencies that will assist households with accessing the system ("No Wrong Door Approach").

Referring Case Manager:
The Case Managers at the Referring Program

Transitional Housing:
Transitional housing is an intervention designed to assist individuals and families with time-limited housing (up to 24 months) while providing supportive services to prepare for permanent housing.

Vulnerability Index-Service Prioritization Decision Assistance Tool:
The Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) is an assessment tool used to quickly determine whether a client has high, moderate, or low acuity.

II. Staffing Roles and Expectations

As the lead agency for the McHenry County Continuum of Care to End Homelessness, CE Lead Agency is the designated coordinating entity. As the coordinating entity, CE Lead Agency is responsible for the day-to-day administration of the Coordinated Entry System including but not limited to the following:

- Creating and widely disseminating materials regarding services available through the Coordinated Entry System and how to access those services;
- Designing and delivering training at least quarterly 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 participants to engage in coordinated entry or accept housing referrals in;
- 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 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;
- Making periodic adjustments to the Coordinated Entry System as determined necessary;
- Ensuring that evaluation and adjustment processes are informed by a broad and representative group of stakeholders;
- Updating policies and procedures; and
- Managing all Public Relations requests related to Coordinated Entry.

Project Manager – CE Lead Agency staffs the Coordinated Entry Position Title. The project manager role includes management of the Coordinated Entry System, including but not limited to the following:

- Serving as point person and lead to all workgroups and transition teams
- Providing coordinated entry training to participating agencies
- Report generating
- Communicating to user agencies and outreach coordinators
- Deactivating/reactivating client records
- Responding to requests for client deletion
- Responding to email generated questions
- Monitoring system performance (CE Staff, Database, Providers, etc.)

III. Target Population

The Coordinated Entry System is open to all households who meet the HUD definition of homeless, as defined in Section I (B). The system uses vulnerability indices & locally developed prioritization tools (described in Definitions & located in the Appendix of this manual) to rank Applicants in order of vulnerability, with the most vulnerable households ranked at the top. At the discretion of the Coordinated Entry Workgroup, applicants may be offered housing regardless of vulnerability score when there is evidence of extreme vulnerability due to the physical or mental health of a member of the household, that is not reflected in the VI-SPDAT score. Applicants identified as high utilizers may also be housed at the discretion of the Coordinated Entry Workgroup.

IV. System Overview and Workflow

The following overview provides a brief description of the path a household will follow beginning their first night of homelessness/seeking assistance to permanent housing.

Accessing the Coordinated Entry System- The Coordinated Entry System provides households experiencing homelessness access to services from multiple locations to ensure a fair and consistent process is applied across the continuum. Entry into the system may be initiated in person at a program access point or community hub location. Community providers can also initiate entry through telephone or email.

Step 1: Assessment- Assessments are facilitated by trained case managers using HMIS. The HUD Assessments, CE Assessments, RRH Assessment and population specific VI-SPDAT is generated in HMIS for all households experiencing homelessness and seeking assistance. Households will be assessed every 90 days until exiting the Coordinated Entry System.

Step 2: Prioritization – Households are then placed on the By Name List with the most vulnerable at the Top of the list. The VI-SPDAT dictates vulnerability, but chronic health conditions, chronic homelessness, are among some of the other priorities taken into prioritization.

Step 3: Referral – The agency which initiates entry into Coordinated Entry will complete a referral into Coordinated Entry through HMIS. This referral is accepted by the Coordinated Entry Lead. As program openings become available; the Coordinated Entry Lead will connect appropriate households to housing programs.

Step 4: Housing Navigation- Referral Receiving Case Managers will schedule initial housing intake appointments. The referring agency case managers will assist in this process by helping the household gather the documents that the receiving case managers will need for the intake appointment.

Step 5: Move In – Appropriate staff from accepting agency will complete needed HMIS tasks and will schedule the move in date. On moving day they will make sure that transportation is provided for the household and accompany them as they move into their new housing placement.

V. Coordinated Entry Policies and Procedures

A. Connecting to the Coordinated Entry System

Locations & Hours – Assessments are conducted at designated Program access points, and Community hub locations. Locations and hours for assessments can be found at the McHenry County CoC Website, **www.co.mchenry.il.us/cd/coc**.

Eligibility – The Coordinated Entry System uses the following criteria to match households to the most appropriate housing intervention:

HOUSING INTERVENTION	TARGET POPULATION	ELIGIBIILTY CRITERIA
Permanent Supportive Housing	• Chronically homeless households	• Chronic homeless and • Head of household with disabling condition
Rapid Re-Housing	• Non-chronically homeless • Less vulnerable • Newly homeless	• Literally homeless • Fleeing/attempting to flee domestic violence
Transitional Housing	• Young adults ages 18-24 • Survivors of Domestic Violence/Sexual Assault • Veterans • Women with Children	• Literally homeless • At imminent risk of homeless • Fleeing domestic abuse or violence

Individual program eligibility:

Program Eligibility Chart	Emergency		Transitional Housing		RRH			Permanent Housing			
R=REQUIRED A=ACCEPTABLE L=LIMITED P=PREFERENCE BLANK=NOT ELIGIBLE C= CASE BY CASE	PC PADS	A Turning Point	Home of the Sparrow TH	TLS New Horizons	Home of the Sparrow TH-RRH	Home of the Sparrow DV	Home of the Sparrow	PC Jackson/Lawndale	Thresholds McHenry Castle	Thresholds McHenry AMI	Thresholds Scattered Sites
Household Type											
Single Male	**A**			**A**							
Single Female	**A**		A	**A**	**A**		**A**				
Male with Child(ren)	**A**										
Female with Child(ren)	**A**		A		**A**	**A**	**A**				
Couple with No Child(ren)	**A**		C		**A**		**A**				
Couple with Child(ren)	**A**		C		**A**	**A**	**A**				
Unaccompanied Youth (under 18)	**A**										
Other	**A**										
Unmarried Couples	**A**		C		**A**		**A**				
Chronically Homeless											
CH Individual	**A**		A	**A**	**A**		**A**				
ChH Family	**A**		A		**A**	**A**	**A**				
Residency											
Homeless	**A**		A	**A**	**A**	**A**	**A**				
Resident of McHenry County	**A**			**A**	**A**	**A**	**A**				
Medical											
Medically Stable (no physical care required)	**R**		A	**R**	**A**	**A**	**A**				
Documented Disabling Condition	**A**		A	**A**	**A**	**A**	**A**				
No Medical Documentation	**A**		A	**A**	**A**	**A**	**A**				
Receiving SSI/SSDI	**A**		A	**A**	**A**	**A**	**A**				
Receiving Medicaid	**A**		A	**A**	**A**	**A**	**A**				
HIV/AIDS Diagnosis	**A**		A	**A**	**A**	**A**	**A**				
Mental Health/Illness											
Severe/Chronic Diagnosis	**C**		C	**A**	**C**	**C**	**A**				
Currently Stable/Receiving Treatment	**A**		A	**R**	**A**	**A**	**A**				
Willing to Accept Treatment	**A**		A	**R**	**A**	**A**	**A**				
Alcohol/Substance Abuse											
Severe/Chronic Diagnosis	**A**		C	**A**	**C**	**C**	A				
Currently Stable/Receiving Treatment	**A**		A	**R**	**A**	**A**	**A**				
Willing to Accept Treatment	**A**		R	**R**	**A**	**A**	**A**				

Veteran											
Eligible for VA Healthcare	A		A	A	A	A	A				
Discharge Status other than Honorable	A		A	A	A	A	A				
	Emergency		Transitional Housing		RRH			Permanent Housing			
	PC PADS	Turning Point	Home of the Sparrow TH	TLS New Horizons		Home of the Sparrow DV	Home of the Sparrow	PC Jackson/Lawndale	Thresholds McHenry Castle	Thresholds McHenry AMI	Thresholds Scattered Sites
Domestic Violence &/or Sexual Assault Victim											
Individual	A		A	A	A		A				
Family	A		A		A	R	A				
Family with male child <12	A		A		A	A	A				
Family with male child ,17	A		A		A	A	A				
Legal											
Pending Legal (Criminal) Charges	A		C	A	C	C	C				
Violent Criminal Background			C		C	C	C				
Murderer & Violent Offender Against Youth Registry							C				
Sex Offender			C		C	C	C				
Sex Offender w/ Victim ,<18,child victim			C		C	C	C				
Sex Offender w/ Victim>18, adult victim			C		C	C	C				
*FEMALE HEAD OF HOUSEHOLD			R		R	R	A				

<u>Marketing/Advertising</u> – Information and updates on Coordinated Entry will be shared regularly to stakeholders and the general public. McHenry County CoC will update and maintain resource lists through People in Need Resource Guide, McHelp, 211 and the McHenry County CoC website.

B. The Housing Assessment Process-Case Managers

<u>Roles and Responsibilities</u> – Referring Case Managers at program access points are the agency staff responsible for conducting assessments for those enrolling in their program. Referring Case Managers at community hub locations and outreach teams are agency staff conducting assessments for any homeless household needing access to the system. All Referring Case Managers are required to ensure a HUD Assessment, CE Assessment, RRH Assessment and current VI-SPDAT is performed with households presenting as homeless. Diversion and safety planning are key components of this phase and can be accessed via outreach and resource referral services offered at Thresholds, Pioneer Center, Turning Point, TLS Veterans, AID and Home of the Sparrow. Assessors will discuss additional housing options with households such

as connecting with family or locating and securing self-sustained housing when the household has sufficient income. Assessors will also discuss any safety concerns for participants currently or recently experiencing any form of violence and will provide general safety information to all participants.
Referring Case Managers will explain the importance of providing accurate information and possible delays in receiving services if inaccurate information is provided.

Referring Case Managers will complete updated assessments for households that have reached a 90-day anniversary from initial assessment date and are not currently housed.

Training Requirements – Case Managers are trained by respective agency. The CE Lead Agency will facilitate all case managers responsible for assessment have access to HMIS training and VI-SPDAT training.

Release of Information – All clients must sign a release of information for HMIS and CE prior to the assessment process.

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

Timeline - Assessments must be completed within seven business days of a household entering homelessness and requesting services. Upon completion of the HUD Assessment, CE Assessment, RRH Assessment and VI-SPDAT, the household will be referred to the By Name List. CE Lead Agency will check By Name List for new entries to ensure households at the top of the list are housed based on resource availability.

C. **Housing Match & Preparation-**Housing Navigation

HMIS Responsibilities – HMIS Staff at the McHenry County Department of Planning and Development – Community Development Division are responsible for the daily administration of the HMIS software and providing technical assistance and user training to participating agencies and end-users.

Case Manager Roles and Responsibilities – Case Managers are staff from partner agencies or CE Lead Agency. Case Managers work from hub locations, home agencies, or in the field. At initial contact Case Managers will explain the CE process and its importance to their housing, and provide households with a participant rights and responsibilities form and Releases of Information. Both staff and the participant sign the forms, and they are uploaded into HMIS. The Case Manager will ensure the household is preparing for housing. When a housing referral is made, the CE Lead will confirm the connection to the housing program and continue follow-up contact with the case manager until the household is housed.

Timeline – As housing opportunities open up, the CE Lead reviews the By Name List and makes contact with the Referring Case Manager and makes the referral in HMIS. Referrals need to be followed up on within 2 business days of receipt of referral. Once a referral is made to a participating provider agency, the Referral Receiving Program has 1 business day to acknowledge the receipt of the referral. The Referral Receiving Program must then accept or deny the referral within 7 business days reflecting a change in the “Need” status with in HMIS. When an appropriate housing program has an opening, and the household is accepted the referral receiving case manager notifies the client of his/her eligibility and referral decision immediately. This information is tracked in HMIS.

Unit Availability/Vacancy Posting – All Rapid Re-housing and Permanent Supportive Housing Programs are required to post vacancies to CE Lead within 2 business days of unit/bed availability. If participating providers agencies know of an impending vacancy, they are able to post the anticipated availability date up to 30 days before unit vacancy. Participating Provider Agency programs must update vacancy information with the CE Lead within 1 business day of a unit/bed being filled.

D. Prioritization & Referral

The Coordinated Entry System is designed to ensure households have fair and consistent access to available housing resources prioritized by need, with those with the highest needs receiving top priority. The CES with the approval of the McHenry County CoC uses the following criteria to determine the order of priority:

VI SPDAT Score	Priority Designation	Housing Recommendation
8-17	High	Permanent Supportive Housing
4-7	Medium	Limited-term rental subsidy and RRH
0-3	Low	No Housing Intervention

	HOUSING INTERVENTION	TARGET POPULATION	BY NAME LIST PRIORITIZATION	PRIMARY DETERIMINENT	SECONDARY DETERIMINENT
January 23, 2018	**PERMANENT SUPPORTIVE HOUSING**	Chronically Homeless Households	1st	Longest history of homelessness plus VI-SPDAT Score	Date of Assessment Age and Chronic Illnesses
			2nd	VI-SPDAT Score	Date of Assessment
			3rd	Longest history of homelessness	Date of Assessment
			4th	All other CH households	Date of Assessment Age and Chronic Illnesses
Roll out July 1, 2018	**RAPID RE-HOUSING**	Non-chronic, less vulnerable, and newly homeless individuals and households	1st	Veterans	VI-SPDAT Length of Homelessness Date of Assessment
			2nd	DV	VI-SPDAT Length of Homelessness Date of Assessment
			3rd	Families	VI-SPDAT Length of Homelessness Date of Assessment
			4th	Single Adults	VI-SPDAT Length of Homelessness Date of Assessment Age and Chronic Illnesses

Future Roll out TBD	**TRANSITIONAL HOUSING**	Non-chronic, less vulnerable, and newly homeless individuals and households	1st	Veterans	VI-SPDAT
					Length of Homelessness
					Date of Assessment
			2nd	DV	VI-SPDAT
					Length of Homelessness
					Date of Assessment
			3rd	Families	VI-SPDAT
					Length of Homelessness
					Date of Assessment
			4th	Single Adults	VI-SPDAT
					Length of Homelessness
					Date of Assessment

BY NAME LIST – There are separate lists for Permanent Supportive Housing and Rapid Re-housing. BY NAME LIST is managed according to the following:

- CE Lead monitors the list daily. As openings on their caseloads become available, they contact the next person on BY NAME LIST
- Receiving Case Managers attempt contact with the household for 7 business days.
- All attempts at contacts are recorded in HMIS as a service.
- If the household is unable to be located, the CE Lead moves to the next household on the list.
- The household must accept or decline assistance within one business day. The household's decision to decline assistance is documented in HMIS. The household will be requested to submit a written statement declining service (housing placement) and uploaded into HMIS as a file attachment. All attempts to obtain written declination will be entered into HMIS. The household will not be removed from the By Name List until they are moved into a residence; as such, any denial of housing placement will not affect their position on the By Name List. When another appropriate placement becomes available, the household will be offered the unit as determined by their ranking, regardless of any previously denied placements. The signed statement and all communication regarding the declination of services is recorded in HMIS.
- Households that reach a 90-day anniversary from initial assessment date and are not currently housed will be reassessed by their original referring agency.
- As directed by HMIS policy, any households that cannot be located within 7 business days and have no record of services in the previous 90 days will be removed from active status to inactive status and exited from all programs.

No contact/inactive policy- Case Managers will make every attempt possible to contact households to provide Coordinated Entry services and connect to referrals for housing. This includes but is not limited to:

- Requesting search assistance of the outreach services,
- Contacting the current or most recent shelters the household has received services from (per documentation in HMIS),
- Phone contact

By Name List Reassignment – As the Case Manager works to obtain verification of homelessness and disability, if the information obtained contradicts information provided at the initial assessment and affects eligibility for the selected housing intervention, the receiving Case Manager will update the VI-SPDAT and HUD assessment, CE

Assessment and RRH Assessment. The CE Lead will continue to work with the household per the procedures provided in this manual, ensuring they are placed in the appropriate housing program. If the change impacts the household's placement on the By Name List, the Case Manager will update the VI-SPDAT, HUD assessment, CE Assessment, RRH Assessment and place the household back on the By Name List. The household will be informed of the change and notified once they are reassigned to the CE Lead Agency.

<u>Receiving Program Responsibilities</u> – Once a referral is made, the Receiving Program has two business day to acknowledge the receipt of the referral. The Receiving Program must then approve or deny the referral within 7 business days. This will be accomplished by changing the referral need status from "identified" to "in –progress." The Receiving Program can reject or deny the referral if the assigned case manager has been unable to contact the household after 7 business days. If a household shows up at the Receiving Program after the 7 business days have expired, the case manager will assist the household in reentering the system through the CES. All of this information is tracked in HMIS.

<u>Document Requirement Updates</u> - Receiving Programs must make eligibility determination decisions within two business day of receipt of all required application materials. The Receiving Program orally reviews the intake decision notification with the Household to ensure that the client understands the decision, and applicable next steps, including the client's right to appeal the decision at that agency. An intake decision notification includes at a minimum:

- First available move-in date, if applicable;
- Reason the client cannot enter the program, including reason for rejection by client or program (which includes redirection to the CE Lead agency), if applicable; and
- Instructions for appealing the decision.

<u>Reasons for denial</u> – Receiving Programs may only decline individuals and families found eligible for and referred by the CE Lead under limited circumstances, including:

- There is no actual vacancy available;
- The individual or family missed 2 intake appointments without notifying receiving Case Manager;
- The Receiving Program has been unable to contact the individual or family for seven (7) business days;
- The household presents with more people than referred by the Case Manager and the Receiving Program cannot accommodate the increase;
- Based on their individual program policies and procedures, the Receiving Program has determined that the individual or family cannot be safely accommodated or cannot meet tenancy obligations with the supports provided by the program.

Programs may not 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 household. Reason for denial forms should be submitted to the client the same day the decision is made.

<u>Participant Choice</u> – Households may decline a referral because of program requirements that are inconsistent with their needs or preferences. If a household chooses to decline a referral, a written statement of declination must be completed and uploaded to HMIS. The household will remain on the By Name List. Households should be informed of the delays in obtaining housing assistance if a program is declined.

<u>Participant Appeal</u> – All participants have the right to appeal any eligibility determination issued by a Receiving Program. Instructions for submitting an appeal to the Receiving Program are provided to clients at the time that an intake decision is made by the Receiving Program. All appeals of decisions by Receiving Programs should follow

that program's appeal process. If resolution is not achieved then **t**he Receiving Case Managers 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 decisions by Receiving Programs must be made in writing and submitted to the Coordinated Entry Workgroup.**

Move-In – If the homeless individual or family is accepted, the Receiving Program must update the referral outcome in HMIS and arrange for move-in within 30 days. If the client does not move-in as scheduled or within three (3) business days of the original move-in date without reason, the Receiving Program must notify and refer the client back to the CE Lead so that the outcome is documented in HMIS.

PSH to PSH – under the CoC Program, permanent supportive housing projects may serve individuals and families from other permanent supportive housing projects who originally met the eligibility requirements for permanent supportive housing so long as the program participants were eligible for the original permanent supportive housing (Section 423(f) of the Act). This means that an individual or family may transfer from one permanent supportive housing program to another under the CoC Program. This could occur under the following circumstances:

- If there were another permanent supportive housing program that better met the service 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 permanent supportive housing program in which the individual or family is enrolled has lost its funding.

Referrals to and from other systems not using HMIS – The Coordinated Entry System appropriately addresses the needs of unaccompanied youth; veterans; and individuals and families who are fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking. Clients originating from a Domestic Violence agency will not, per statute, have their personal information entered into HMIS. Their placement on the By Name List will be an anonymous placeholder using a label such as "Turning Point Client #5." It is the responsibility of the Domestic Violence Provider to report any necessary information to HUD using their established protected protocols.

E. Case Conferences

The Coordinated Entry Workgroup, will hold meetings on a regular basis. They are tasked with reviewing the number of successful placements made, number of client declinations, and agency program policies as needed, along with other means of improving the Coordinated Entry system.

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

The McHenry County CoC takes all necessary steps to ensure that the Coordinated Entry System is administered in accordance with the requirements of the federal Fair Housing Act and Illinois Human Rights Act. These laws prohibit discrimination in housing transactions on the basis of race, color, religion, national origin, sex, familial status, disability (physical and mental), ancestry, age (40 years or older), marital status, order of protection status, military status, sexual orientation, pregnancy, or unfavorable discharge from military service. Where permitted by statute, regulation, or approved written waiver from an administrative agency, housing providers may implement preferences for certain populations as long as the preferences do not discriminate against protected classes.

In operating their housing programs, all Participating Partner Agencies who enter into a Memorandum of Understanding for the Coordinated Entry System (MOU) commit and agree to comply with applicable laws and other funding and program requirements.

Upon request, each Participating Partner Agency will provide their tenant selection plan, any applicable funding contract, and applicable administrative agency waivers to the Lead Agency of CE. The Lead Agency of CE will then

enter the Participating Partner Agency's eligibility and outreach criteria into HMIS, along with any funding contract or waiver that requires or allows the Participating Partner Agency to serve a specific subpopulation. For instance, in Housing Opportunities for Persons with AIDS (HOPWA) programs, HMIS would show a funding contract and a HUD waiver if the provider offers a single-gender program. The Coordinated Entry System may allow filtered searches for subpopulations.

VII. 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 implementation, the McHenry County Continuum of Care to End Homelessness anticipates adjustments to the processes described in this 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 by either the McHenry County Continuum of Care to End Homelessness or **CE Lead Agency**. The CE Lead and CE Workgroup will:

- Lead periodic evaluation efforts to ensure that the Coordinated Entry System is functioning as intended; such evaluation efforts shall happen at least annually.
- Lead efforts to make periodic adjustments to the Coordinated Entry System as determined necessary; such adjustments shall be made at least annually based on findings from evaluation efforts.
- Ensure that evaluation and adjustment processes are informed by a broad and representative group of stakeholders.
- Ensure 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 McHenry County CoC, in conjunction with the Steering Council and Coordinated Entry Committee. These metrics 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 this manual are met
- Number/percentage of referrals that are accepted by receiving programs
- Rate of missed appointments for scheduled assessments
- Number/percentages of Eligibility and Referral Decision appeals
- Number/percentage of program intakes not conducted through Coordinated Entry System
- Completeness of data on assessment and intake forms

These metrics shall also include indicators of the impact of the Coordinated Entry System on system-wide McHenry County CoC outcomes, such as:

- Persons referred have length of stays consistent with system guidelines
- Waiting lists are reduced for all services; eliminated for shelter program
- 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

VIII. Termination

Any Participating Partner Agency may terminate their participation in the Coordinated Entry System by giving written notice to the McHenry County CoC. Housing programs that are required to participate due to HUD guidelines will need approval by the Steering Council to terminate participation.

McHenry County CoC to End Homelesnsess

Participant Rights and Responsibilities

As a participant in coordinated entry, you have the right…

- To be treated with respect, dignity, consideration, and compassion
- To receive services free of discrimination on the basis of race, color, sex/gender, ethnicity, national origin, religion, age, sexual orientation, physical or mental ability.
- To be informed about services and options available to you.
- To withdraw your voluntary consent to participate in coordinated entry, doing so will exclude you from access to some housing programs.
- To have your personal information treated confidentially.
- To have information released only in the following circumstances:
    - When you sign a written release of information.
    - When a clear and immediate danger to you or others exist.
    - When there is possible child or elder abuse.
    - When order by a court of law.
- To file a grievance about services you are receiving or denial of services.
- To not be subjected to physical, sexual, verbal, and/or emotional abuse or threats.

As a participant in coordinated entry you have the responsibility …

- To treat other participants and staff in the continuum of care with respect and courtesy.
- To actively participate in obtaining documents, searching for appropriate housing, and other actions necessary to obtain permanent housing.
- To let your navigator/case manager know any concerns you have about the process or changes in your needs.
- To make and keep appointments to the best of your ability, or if possible to phone to cancel or change an appointment time.
- To stay in communication with your navigator/case manager by informing him/her of changes in your location or phone number and responding to the navigator/case manager's calls or letters to the best of your ability.
- To not subject agency case managers, staff, or other clients to physical, sexual, verbal, and/or emotional abuse or threats.

Participant Signature:_______________________________ Date: ____________________

Navigator/Case Manager Signature:____________________________ Date: ___________