Coordinated Entry System Operations Manual
Tarrant and Parker Counties
TX-601 Continuum of Care

Revised June 2017

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) and to fulfill the goals of the Opening Doors: Federal Strategic Plan to Prevent and End Homelessness, Tarrant and Parker Counties Continuum of Care 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 for the entire CoC;
- A specific policy to guide the operation of the coordinated assessment system on how it 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 nonvictim 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 participants to the appropriate housing intervention.

To help ensure the system efficiently and effectively responds to the needs of participants experiencing homelessness, those at risk of homelessness, and supports the work of 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 Tarrant County Homeless Coalition (TCHC), as the Lead CoC agency, is responsible for oversight of the Coordinated Entry System.

A.   Disclaimer

The Coordinated Entry System is designed to ensure participants experiencing homelessness have fair and equal access to housing programs and services within the Continuum of Care. It is not a guarantee that the participant 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 Access Points:
Places, either virtual or physical, where a participant or household in need of assistance accesses the Coordinated Entry System. Examples include central locations which cover the entire CoC, 211 or Homeless Helpline, and any homeless service provider. All entry points utilize the same assessment process to connect a participant to coordinated entry.

Chronically Homeless:
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 is defined in §102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 USC 15002). This is defined as 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 of 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 criteria listed previously, if 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).

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.
Our CoC does not use this definition

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.

Homebase:
The prioritized listing of all homeless individuals or households seeking services. Homebase is populated with information retrieved from HMIS. All participant partner agencies have the ability to view and access Homebase via www.basecamp.com, a secure website.

Homeless Management Information System (HMIS):
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 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 Tarrant County Homeless Coalition manages HMIS for Tarrant and Parker Counties. The software provider is Social Solutions. 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.

HMIS staff at TCHC are responsible for the daily administration of the HMIS software and providing technical assistance and user training to participating agencies and end-users.

Homeless Helpline:
A phone number persons experiencing homelessness or are at-risk of homelessness can call to receive resources, explore options to keep from entering the homeless system, or to have an assessment completed.

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

Outreach Teams:
Teams from various agencies who work with persons experiencing homelessness who are unsheltered. Services provided are based on the needs of the individual. Our CoC has teams which focus on specific populations (youth, mental health, physical health) as well as teams who provide general services.

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

Permanent Housing:
Permanent housing refers to housing options that are medium to long-term. This includes rapid re-housing and permanent supportive housing interventions.

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.

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 participant.

Receiving Program:
All Participating Rapid Re-housing, Permanent Supportive Housing, Transitional Housing, and Homeless Prevention programs are Receiving Programs and are responsible for reporting vacancies to TCHC 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.

Transitional Housing:
Transitional housing is an intervention designed to assist individuals and families with time-limited housing 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. The VI-SPDAT also allows communities to assess clients' various health and social needs quickly, then match them to the most appropriate-- rather than the most intensive-- housing interventions available.

II. Staffing Roles and Expectations

As the lead agency for the Tarrant and Parker County CoC, TCHC is the designated coordinating entity. As the coordinating entity, TCHC 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 annually to all key stakeholder organizations, including but not limited to the required training for coordinated entry staff;
- Following up with agencies to make sure 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 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 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 media requests related to Coordinated Entry.

Project Manager – TCHC staffs the Coordinated Entry Project Manager position. 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;
- Generating reports required for coordinated entry evaluation;
- Communicating to participating agencies and outreach coordinators;
- Deactivating/reactivating client records;
- Responding to requests for client deletion;
- Responding to email generated questions; and,
- Monitoring system performance (CE Staff, Database, Providers, etc.).

III. Target Population

The Coordinated Entry System is open to all participants who meet the HUD definition of homeless, as outlined in the HEARTH Act regulations. The system uses vulnerability indices & locally developed prioritization tools (described in Definitions & located in the Appendix of this manual) to rank participants in order of vulnerability, with the most vulnerable participants ranked at the top. At the discretion of the Coordinated Entry Subcommittee, participants 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. Participants identified as high utilizers may also be housed at the discretion of the Coordinated Entry Subcommittee.

IV. System Overview and Workflow

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

Accessing the Coordinated Entry System: The Coordinated Entry System provides participants 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 an access point, through the Homeless Helpline, or homeless outreach teams.

Below are the steps in the Coordinated Entry System:

1. Assessment: Assessments are facilitated by trained Assessors using HMIS. The HUD Assessment and population specific VI-SPDAT is completed in HMIS for all participants experiencing homelessness and seeking assistance at any access point. The Assessor will also determine

whether or not the participant can be diverted from the system or assisted with prevention funds. Assessments are updated every 90 days until exiting the coordinated entry system.

2. Housing Match: Information gathered from the HUD Assessment and VI-SPDAT are used to determine which housing intervention is the most appropriate to meet the needs of the participant. HMIS will automatically complete this step of the process.

3. Prioritization: Once the appropriate housing intervention is determined participants are placed on Homebase with the most vulnerable at the top. HMIS automatically compiles this list according to the information provided through the HUD Assessment and VI-SPDAT and in accordance with the Continuum's priority ranking.

4. Housing Navigation: System Navigators will work with participants at the top of the list. The Navigator can be one of the following: a designated Coordinated Entry System Navigator, an outreach worker, or the Housing Case Manager of the program providing housing. The System Navigator begins the process of preparing the participant for housing. This process may include, but is not limited to, the following activities: obtaining identification, social security cards, homeless verification documents; and beginning the search for a housing unit. When necessary, System Navigators will assist with securing the housing unit, application fees, and security deposits.

5. Referral- As program openings become available, System Navigators will connect participants to housing programs. System Navigators will assist in scheduling initial housing intake appointments and attend the first housing appointment with the participant.

V. Coordinated Entry Policies and Procedures

A.   Connecting to the Coordinated Entry System

Locations & Hours: Assessments are conducted at designated access points, which includes various agencies, outreach teams, and the Homeless Helpline. Locations and hours for assessments can be found on the Pocket Pal, which is distributed to service providers.   Locations and hours can also be found on Tarrant County Homeless Coalition's website www.ahomewithhope.org by clicking on the "Pocket Pal" page.

Eligibility: The Coordinated Entry System is intended to facilitate access to the most appropriate housing intervention for each participant's immediate and long-term housing needs. The following criteria are used to match participants to the most appropriate housing intervention:

HOUSING INTERVENTION	TARGET POPULATION	ELIGIBIILTY CRITERIA
Permanent Supportive Housing	• Chronically homeless households	• Chronically homeless and • Head of household with disabling condition • Fleeing/attempting to flee domestic violence
Rapid Re-Housing	• Not chronically homeless • Less vulnerable • Newly homeless	• Literally homeless • Fleeing/attempting to flee domestic violence
Transitional Housing	• GPD for veterans • Various programs for Domestic Violence and young adults	• Literally homeless • Imminent risk of homeless • Fleeing/attempting to flee domestic violence

Marketing/Advertising: Information and updates on Coordinated Entry will be shared regularly to stakeholders and the general public. Platforms for dissemination of information include the general meetings, Coordinated Entry Ad-hoc meetings, board meetings, social media and email blasts. The Pocket Pal will include information about location and hours of assessments. Pocket Pals will be updated and distributed to service providers on an annual basis. An extended Pocket Pal will be maintained on the TCHC website and updated regularly.

B. **The Housing Assessment Process**

Roles and Responsibilities: Assessors at program access points are agency staff responsible for conducting assessments for those enrolling in their emergency shelter program. Outreach teams are agency staff conducting assessments for unsheltered homeless participants needing access to the system. All assessors are required to complete a HUD Assessment and VI-SPDAT with participants presenting as homeless. At intake, assessors will also explore additional housing options with participants such as connecting with family or locating and securing self-sustained housing when the participant has sufficient income.

Upon completion of HUD Assessment and VI-SPDAT the participant will be placed on Homebase immediately. Assessors will complete updated assessments for participants that have reached a 90-day anniversary from initial assessment date and are not currently housed.

Release of Information: All clients must sign a release of information prior to the assessment process. These documents are located in the Appendix.

Client Photos: Photos should be taken at the time of assessment but are not required. In order to take and upload the photo into HMIS, "the client must check the "photo" box on the *Client Consent to Collect*

Critical Documents form.

Timeline: Assessments will be completed within the first 24 hours of a participant entering homelessness and requesting services.

C.   Housing Match & Preparation

Navigator Roles and Responsibilities: System Navigators are contracted out to a partner agency. System Navigators office out of the home agency, partner agencies, or in the field. All System Navigators will work with participants at the top of Homebase who do not have an existing case manager in order to gather documentation of homelessness, critical documents, and other services to prepare them for housing. If a participant has an existing case manager, the System Navigator will ask the participant to sign a *Consent for Release of Information* form in order to communicate with the existing case manager. The System Navigator will make frequent contact with the case manager to ensure the participant is preparing for housing. When a housing referral is available the System Navigator will confirm the connection to the housing program and continue follow-up contact with the case manager until the participant is housed. The participant will remain on the Navigator's caseload until housed but will not count in their active number of cases.

At initial contact System Navigators provide participants with the following documents: a welcome letter explaining staff and participant responsibilities and what to expect; and, participant rights. Both System Navigators and participants sign the documents and upload them into HMIS. System Navigators are responsible for assisting participants with connecting to the Receiving Program when an opening has become available. System Navigators will accompany participants to all housing appointments, serving as the participant's advocate.

Timeline: The caseload for System Navigators will be populated from Homebase, starting at the top of the list. System Navigators will meet weekly with participants and document case management meetings in HMIS, including missed appointments. When an appropriate housing program has an opening, the System Navigator notifies the participant of his/her eligibility and referral decision immediately. Once the participant accepts the housing option the System Navigator notifies the Receiving Agency. Information about both the participant's and Receiving Program's decision is tracked in HMIS.

D. Prioritization

The Coordinated Entry System is designed to ensure participants 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 Continuum of Care uses the following criteria to determine the order of priority:

HOUSING INTERVENTION	TARGET POPULATION	PRIORITIZATION	PRIMARY PRIORITIZATION	SECONDARY PRIORITIZATION
RAPID RE-HOUSING	Non-chronic, less vulnerable, and newly homeless individuals and households	1st	Veterans	VI-SPDAT
				Length of Homelessness
				Date of Assessment
		2nd	Youth	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
PERMANENT SUPPORTIVE HOUSING	Chronically homeless households	1st	VI-SPDAT Score	Date of Assessment
		2nd	Longest history of homelessness	Date of Assessment
		3rd	All other CH households	Date of Assessment

Homebase: There are separate lists for Permanent Supportive Housing and Rapid Re-housing. Homebase is managed according to the following:
- System Navigators and the agency contracted to manage System Navigators monitor the list daily. As openings on their caseloads become available they contact the next person on Homebase.
- System Navigators or Case Managers attempt contact with the participant for seven (7) business days.
- All attempts at contacts are recorded in HMIS.
- If the participant is unable to be located the System Navigator moves to the next participant on the list.
- The participant must accept or decline navigation assistance within one business day. The participant's decision to accept or decline assistance is documented in HMIS. The participant must submit a written statement declining service. If the participant declines via phone and/or is

unable to provide a written statement declining services, the System Navigator documents this in HMIS. The participant is removed from the *active* to *denied services* status. The signed statement and all communication regarding the declination of services is recorded in HMIS.

- Participants who reach a 90-day anniversary from their initial assessment date and are not currently housed will be reassessed. The assigned System Navigator or Case Manager is responsible for completing the new assessment. If the participant does not have an assigned System Navigator or Case Manger an Assessor will make contact or request the assistance of an outreach team to complete a new assessment.
- Participants that cannot be located within 7 business days and have no record of services in the previous 90 days will be removed from the active status to inactive.

No contact/inactive policy: System Navigators and Case Managers will make every attempt possible to contact participants to provide navigation services and connect to referrals for housing. This includes but is not limited to:

- Requesting search assistance from outreach teams;
- Contacting the current or most recent shelters from where the participant has received services (per documentation in HMIS);
- Posting an alert in HMIS;
- Phone contact; and
- Posting messages on community boards located at service providers frequented by the general population (i.e. day shelters, food banks, soup kitchens, clothing banks, and others).

The date, time, and outcome of each attempt will be recorded in HMIS. After 7 standard business days of searching, the System Navigator or Case Manager will move to the next participant on the list.

If the System Navigator is unable to contact a participant on his/her current caseload in 10 business days, the participant is moved off of the System Navigator's caseload and back on Homebase.

Participants that are not located and have not received any services within the previous 90 days will be moved from an active status to inactive. Participants making contact with the system once moved to the inactive list will be immediately reinstated to active. Assessors will make contact or request the assistance of an outreach team to complete an updated assessment.

E.   Referrals

Receiving Program Responsibilities: The Receiving Program can reject or deny the referral if the assigned case manager has been unable to contact the participant after seven (7) business days. If a participant shows up at the Receiving Program after the seven (7) business days have expired, the case manager will assist the participant in reentering the Coordinated Entry System. All of this information is tracked in HMIS. (See table in section F for other time frames.)

Document Requirement Updates: Receiving Programs make eligibility determination decisions within one business day of the intake interview (or when all required application materials are complete). The Receiving Program orally reviews the intake decision notification with the participant to ensure that the participant understands the decision, and applicable next steps, including the participant's right to appeal the decision. When possible, the System Navigator is available for this review. An intake decision notification includes at a minimum:

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

<u>Reasons for denial</u> – Receiving Programs may only decline participants found eligible for and referred by the System Navigator under limited circumstances including:

- The participant missed 2 intake appointments without notifying System Navigator or Case Manager;
- The Receiving Program has been unable to contact the participant for seven (7) standard business days;
- The participant presents with more people than referred by the Housing Navigator and the Receiving Program cannot accommodate the increase; or,
- 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.

90% of Coordinated Entry referrals must be accepted by the Receiving Program

Programs must utilize a Housing First Approach. They may not decline participants with psychiatric disabilities for refusal to participate in mental health services. They may also not decline a participant with substance use/abuse issues, physical disability, or based on income or employment.

The Receiving Program must update the referral outcome in HMIS for any decisions to accept or reject a participant. The reason for denial must be submitted in writing within one business day of the decision to the participant and the System Navigator or Case Manager.

<u>Participant Choice</u>: Participants may decline a referral because of program requirements that are inconsistent with their needs or preferences. If a participant chooses to decline a referral, a written statement of declination must be completed and uploaded to HMIS. The participant will be placed on Homebase and await the next available System Navigator to restart the housing process. Participants must 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 eligibility determinations issued by the Receiving Program. Instructions for submitting an appeal are provided to participants at the time that an intake decision is made by the Receiving Program. System Navigators are responsible for assisting participants in filing eligibility determination appeals, including but not limited to drafting a written appeal on behalf of the client. Appeals must be filed within 5 business days of eligibility determination. Receiving Programs use the appeals process already in place within their agency. A response is given to the participant and System Navigator within 10 business days. The final decision of the appeal is provided to the Coordinated Entry staff at TCHC, in writing, at the same time the participant and System Navigator are notified. An aggregate of appeals is reported to the Coordinated Entry Subcommittee.

<u>Move-In</u>: When the participant is accepted, the Receiving Program must update the referral outcome in HMIS and arrange for move-in within 30 days. If the participant does not move-in as scheduled or

within three (3) business days of the original move-in date, the Receiving Program must notify and refer the participant back to the System Navigator so the outcome is documented in HMIS.

PSH to PSH: Under the CoC Program, Permanent Supportive Housing (PSH) projects may serve participants from other PSH projects who originally met the eligibility requirements for PSH. Participants must have been eligible for the original PSH (Section 423(f) of the McKinney-Vento Act, as amended by the HEARTH Act). A participant may transfer from one PSH project to another under the CoC Program under the following circumstances:

- There is another PSH project that better meets the service needs of the participant;
- The participant is evicted by the landlord or housing program and the participant is still eligible for case management services; or
- The current PSH project in which the individual or family is enrolled in has lost their funding.

PSH to PSH Referral Process: The case manager at the current PSH must notify the Coordinated Entry Program Manager in writing via email to initiate the process of transferring the participant. The Coordinated Entry Program Manager will verify that the request falls within the guidelines for the transfer as outlined in this manual. The Coordinated Entry Program Manager will determine if a PSH unit is available and notify the current PSH program. The current PSH program Case Manager will be responsible for assisting the participant in completing documentation necessary for the new PSH program. Where needed, the current PSH case manager will collaborate with the new PSH case manager. If no PSH unit is available, the current PSH program must continue to work with the participant in securing alternate housing.

Referrals to and from other systems not using HMIS and/or special populations: 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.

Domestic Violence and assessments: When a homeless or at-risk participant is identified by the Coordinated Entry System to be in need of domestic violence services, that participant is referred to the domestic violence hotline immediately. If the participant does not wish to seek domestic violence specific services, the participant will have full access to the Coordinated Entry System, in accordance with all protocols described in this manual. If the domestic violence helpline determines that the participant seeking domestic violence specific services is either not eligible for or cannot be accommodated by the domestic violence specific system, the helpline will refer the participant to an access point for assessment and referral in accordance with all protocols described in this manual.

Domestic Violence Referral into CES: Case managers at the domestic violence agency will complete the HUD assessment and VI-SPDAT for participants in the domestic violence shelter. DV staff will create a de-identified list of these participants and prioritize based on their vulnerability score. The navigator assigned to the shelter will be provided with the list and these participants will be manually entered into Homebase. An updated list will be provided to the navigator on a weekly basis. Case managers in the DV shelter will gather documentation of homelessness. When housing becomes available for a participant in the DV shelter the navigator contacts the case manager at the shelter and an appointment is scheduled for the navigator to meet with the participant and case manager. The navigator and case manager collaborate to find housing for the

participant.

Veterans: All veterans are assessed at various access points within the continuum. Assessments are completed in HMIS and upon completion, veteran data is included on the Veteran Specific By-Name List as well as on Homebase. The Veteran Case Conference group meets twice a month to review clients on the list and to assign clients to agencies/case managers for housing. Once the veteran is in process, the information is provided to the Coordinated Entry Program Manager to note on the Homebase report to prevent duplicated services. The Coordinated Entry Program Manager attends the veterans case conferencing to coordinate names on each of the reports.

Unaccompanied Youth: Any youth age 17 and under is automatically referred to the Youth Emergency Shelter at ACH Child and Family Services. Unaccompanied youth age 18 – 24 can receive an assessment at any of the access points. Youth serving agencies in the community have been provided with information on access points, such as contacting one of the outreach teams to come to their agency or to call the Homeless Helpline for an assessment.

F. Time Lines

Person Responsible	Activity	Time Frame
Assessor	HUD and VI-SPDAT	Within 24-hours of entry into homelessness
Navigator	Intake scheduled with participant	Within 2 business days of contact
Receiving Agency	Acknowledge receipt of referral	Within 3 business days
Receiving Agency	Enroll or deny referral	Within 7 business days
Receiving Agency	Eligibility determination	Within 1 business day of intake interview
Assessor, Navigator, Receiving Program	HUD and VI-SPDAT updates	Every 90 days
PSH and RRH Programs	Post vacancies in HMIS	Within 2 business days of unit/bed availability
PSH and RRH Programs	Update vacancy info in HMIS	Within 3 business days of unit/bed being filled
PSH and RRH Programs	Post impending vacancies	Up to 14 days before unit vacancy
Participant/Household	File an appeal	Within 5 business days of denial
PSH and RRH Programs	Provide response to participant, navigator and CE team at TCHC	Within 10 business days of receiving appeal

G. Case Conferences

The TCHC will facilitate regular case conferences. The primary purpose of case conferences is for Case Managers to review Homebase to ensure the coordinated entry process is successfully moving participants through the system and address instances of participants remaining on the list more than 90 days. Case conferences will also provide Assessors, Navigators, and Case Managers with a platform to present challenging cases to peers and collaborate on possible interventions and/or resources to resolve barriers. Case Managers wishing to present cases will provide a brief description of the barrier, attempted resolutions, and a summary of the participant composition to the Coordinated Entry Program Manager at least 3 business days prior to the case conference.

H. Training

Training Topic	Duration	Frequency
HMIS New User training	3 hours	Annual
VI-SPDAT	3 hours	Annual
First Aid and CPR	4 hours	When expires
Safety Planning	1 hour	Annual
Diversion	1 hour	Annual
Trauma Informed Care	2 hours	Annual
Domestic Violence 101	1 hour	Annual
Crisis Intervention	4 hours	Annual
Documentation of Homelessness		Annual
Mental Health First Aid	8 hours	Orientation
Housing Advocacy and landlord engagement *Navigator only	1 hour	Annual
Housing First *Navigator only	1 hour	Orientation
Cultural Competency	3 hours	Annual
Benefits application training	4 hours	Orientation
Assessor orientation		Orientation
Navigator orientation		Orientation
Services tour		Orientation

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

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

All Participating 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 Partner Agencies to use the Coordinated Entry System in a consistent manner with the statutes and regulations that govern their housing programs.

TCHC will request from each Participating Agency their tenant selection plan and any funding contract that requires or allows a specific subpopulation of persons to be served. For instance, Housing Opportunities for Persons with AIDS (HOPWA) programs will show funding contract, a single-gender program must produce its HUD waiver. 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.

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 participants and for the housing and service providers tasked with meeting their needs, particularly during the early stages of implementation, the Continuum of Care 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 and managed by TCHC. Specifically, TCHC 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 shall 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 CoC, in conjunction with the Coordinated Entry Subcommittee. These metrics shall include indicators of the effectiveness of the functioning of the Coordinated Entry System, such as:

- Wait times from first day homeless to initial contact into homeless system;
- Extent to which expected timelines described in this manual are met;
- Number and percentage of referrals that are accepted by receiving programs;
- Number and percentages of eligibility and referral decision appeals;
- Number of program intakes not conducted through Coordinated Entry System; and,
- Accuracy of data on assessment and intake forms

These metrics shall also include indicators of the impact of the Coordinated Entry System on system-wide Continuum of Care outcomes, such as:
- Persons referred have length of stays consistent with system guidelines;
- Waiting lists are reduced for all services and eliminated for shelter program;
- Participants fit within target populations identified as priority;
- Reduction in long term chronic homelessness;

- Reduction in family homelessness;
- Reductions in returns to homelessness; and,
- 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. Housing programs required to participate due to HUD guidelines will need approval to terminate participation.

Client Consent of Data Collection Form

TCHC CoC HMIS System "ETO" │ tchc.etosoftware.com

❶ I, _____ (C*lient's   name*), understand and

acknowledge that_____(*Agency name*) is affiliated with the TCHC CoC HMIS System "ETO", and I consent to and authorize the collection of information and preparation of records pertaining to the services provided to me by the Agency. The information gathered and prepared by the Agency will be included in a Homeless Management Information System ("HMIS") database and shall be used by the Agency, TCHC and the U.S. Department of Housing and Urban Development (HUD) to:

- Help us prioritize, plan, and provide meaningful services to you and your family;
- Assist our agency to improve its work with families and individuals that are homeless;
- Allow local agencies to work better together to prevent and end homelessness;
- Provide statistics for local, state, and national policy makers to set effective goals.

I understand that the following HUD-mandated **Universal Data Elements** will be collected for the purposes of unduplicated estimates of the number of homeless people accessing services from homeless providers, basic demographic characteristics of people who are homeless, and their patterns of service use.

1. Name	8. Residence Prior to Program Entry
2. Social Security Number	9. Zip Code of Last Permanent Address
3. Date of Birth	10. Program Entry Date
4. Ethnicity and Race	11. Program Exit Date
5. Gender	12. *Unique Person Identification Number**
6. Veteran Status	13. *Program Identification Number**
7. Disabling Condition	14. *Household Identification Number**

* ETO System Generated Numbers

I also understand that the following **Program-Specific Data Elements** will be collected for programs that are required to report to HUD, the City of Fort Worth, City of Arlington and Tarrant County, the State of Texas and the United Way. Programs and agencies without this reporting requirement may also collect these elements to facilitate a better understanding of the homeless population in Tarrant and Parker counties.

1. Income and Sources	10. Destination
2. Non-Cash Benefits	11. Reasons for Leaving
3. Physical Disability	12. Employment
4. Developmental Disability	13. Education
5. HIV/AIDS	14. General Health Status
6. Mental Health	15. Pregnancy Status
7. Substance Abuse	16. Veteran's Information
8. Domestic Violence	17. Children's Education
9. Services Received	

I understand that I have the right to inspect, copy, and request all records maintained by the Agency relating to the provision of services to me and to receive a paper copy of this form.

IX. **I understand that _my records_ are protected by federal, state, and local regulations governing confidentiality of client records and cannot be disclosed to any other entity except the Agency, TCHC and HUD without my written consent unless otherwise provided for in the regulations.**

Additionally, I understand that participation in data collection is optional, and I am able to access shelter and housing services if I choose not to participate in data collection.

❷ Signature: _____ Date: _____

Relationship if minor _____

❸ Person administering this Consent Form: (**print** clearly)

Name: _____

Agency Name: _____

Client Release of Information Consent Form

TCHC CoC HMIS System "ETO" | **tchc.etosoftware.com**

tchc
Tarrant County Homeless Coalition

❶ Client Name:＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿HMIS ID#: ＿＿＿＿＿＿＿＿＿＿＿

This Agency, permitted by you, the client, has the ability to share your information contained in the TCHC CoC HMIS with other participating agencies. This sharing of information may enable agencies to better serve you. If you, the client, authorizes this sharing of information please complete the following.

❷ I, ＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿ (*Client's name*) hereby authorize

＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿ (*Agency name*) to release the following personal information contained in the TCHC CoC HMIS System "ETO" to the agencies listed on the attachment (ROI – Attachment A).

I release the above named Agency of any legal liability that may arise from the release of this information. I understand that the Agency can not release information obtained from other sources. I understand that the agency (ies) receiving this information can not re-release this information to any other agency (ies) without my expressed written consent. I also understand that this authorization for release of information will expire on ❸＿＿＿＿＿＿＿＿＿＿/＿＿＿/＿＿＿＿＿(*Recommended two year from enrollment date: MM/DD/YYYY.*) unless otherwise indicated.

I also understand that this release can be revoked, by me at any time and that the revocation must be signed and dated by me, and that revoking of the release will not affect information released prior to the revoking of the release.

❹Signature ＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿   Date ＿＿＿＿＿＿＿＿

Relationship if minor ＿＿＿＿＿＿＿＿＿＿＿＿＿＿

Witness Name (Print) ＿＿＿＿＿＿＿＿＿＿＿＿＿

Witness Signature ＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿   Date ＿＿＿＿＿＿＿＿

Client Consent to Collect Critical Documents

TCHC CoC HMIS System "ETO" | tchc.etosoftware.com

❶ I, _____ (C*lient's name*), understand and

acknowledge that_____(*Agency name*) is affiliated with the Continuum of Care TX 601 (CoC) HMIS System "ETO", and I consent to and authorize the request to collect of copies of critical documents and vital records by the Agency. The documents gathered will be included in the Homeless Management Information System ("HMIS") database and shall be used by CoC Agencies to:

- Provide an electronic storage location for copies of critical documents and vital records and allow the client to access copies of critical documents that may be lost, stolen, or needed for proof of identity or reapplication for critical documents and vital records, and
- Assist in the application and/or to determine eligibility for programs and services.

Records that I consent to be copied, scanned and attached to my HMIS Client Record include: (*Check all that apply*):

- ☐ State Identification/Drivers License
- ☐ Birth Certificate
- ☐ Social Security Card
- ☐ Birth Certificate
- ☐ Medicaid/Medicare or other Health Insurance Card
- ☐ Voter Registration Card
- ☐ Veteran Status/Military ID/DD214
- ☐ Discharge Documents (ex: Prison, Hospital, Foster Care, etc.)
- ☐ Proof of Income
- ☐ Award Letters (SSI/SSDI, VA Disability, etc.)
- ☐ Hard Copy of HUD Assessments
- ☐ Photo
- ☐ Other _____

Minor Children within the Household Included in this Consent:
(*If applicable*)

*Name:*_____*Date of Birth:*_____

*Name:*_____*Date of Birth:*_____

*Name:*_____*Date of Birth:*_____

*Name:*_____*Date of Birth:*_____

*Name:*_____*Date of Birth:*_____

I understand that I have the right to inspect, copy, and request all records maintained by the Agency within the HMIS system relating to the provision of services to me and to receive a paper copy of this form.

I understand that *my records* are protected by federal, state, and local regulations governing confidentiality of client records and cannot be disclosed to any other entity without my written consent unless otherwise provided for in the regulations.

Additionally, I understand that participation in this critical documents and vital records collection is optional.

❷ Signature:_____Date: _____

Relationship if minor _____

❸ Person administering this Consent Form: (**print** clearly)

Name:_____

Agency Name: _____

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: _____