# TX – 700 Continuum of Care

## Coordinated Access System

### Operations Manual

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Purpose and Background

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

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

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

3. Policies and procedures for evaluating individuals’ and families’ eligibility for assistance;

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

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

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

The Houston/Harris County Continuum of Care has designed the Coordinated Access System described in this manual to coordinate and strengthen access to housing for families and individuals who are homeless or at risk of homelessness throughout the city of Houston and Harris County. The Coordinated Access System institutes consistent and uniform assessment and referral processes to determine and secure the most appropriate response to each individual or family’s immediate and long-term housing needs.

The Coordinated Access System is designed to:

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

- Ensure clarity, transparency, consistency and accountability for homeless clients, referral sources and homeless service providers throughout the assessment and referral process;
Facilitate exits from homelessness to stable housing in the most rapid manner possible given available resources;

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

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

To achieve these objectives the *Coordinated Access System* includes:

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

- Establishment of **uniform guidelines** among components of homeless assistance (transitional housing, rapid rehousing, and permanent supportive housing) regarding: eligibility for services, priority populations, expected outcomes, and targets for length of stay;

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

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

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

The implementation of the *Coordinated Access System* necessitates significant, community-wide change. To help ensure that the system will be effective and manageable for homeless persons and persons at-risk of homelessness and for the housing and service providers tasked with meeting their needs, a comprehensive group of stakeholders was involved in its design. In addition, particularly during the early stages of implementation, the Houston/Harris County Continuum of Care anticipates adjustments to the processes described in this manual. A periodic evaluation of the *Coordinated Access System* will provide ongoing opportunities for stakeholder feedback. The *Coordinating Entity* will be responsible for monitoring the *Coordinated Access System*.

**Disclaimer**

*The Coordinated Access System* is designed to assess eligibility for housing programs targeted to homeless persons. It is not a guarantee that the individual will meet the final eligibility requirements for - or receive a referral to - a particular housing option.
Definitions

Terms used throughout this manual are defined below:

Chronically Homeless (HUD Definition):
(1) An individual who:
   (i) Is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
   (ii) Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions in the last 3 years; and
   (iii) Can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000 (42 U.S.C. 15002)), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability;
(2) An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
(3) A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

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

   Developmental Disability Defined in §102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 USC 15002). Means a severe, chronic disability that Is attributable to a mental or physical impairment or combination AND Is manifested before age 22 AND Is likely to continue indefinitely AND reflects need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are 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

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

### Area Median Income Limits (2014)

<table>
<thead>
<tr>
<th>Household Size</th>
<th>30% Area Median Income (HUD Extremely Low Income Limit)</th>
<th>50% Area Median Income (HUD Very Low Income Limit)</th>
<th>80% Area Median Income (HUD Low Income Limit)</th>
</tr>
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<tbody>
<tr>
<td>1 person</td>
<td>14,000</td>
<td>23,350</td>
<td>37,350</td>
</tr>
<tr>
<td>2 persons</td>
<td>16,000</td>
<td>26,650</td>
<td>42,650</td>
</tr>
<tr>
<td>3 persons</td>
<td>19,790</td>
<td>30,000</td>
<td>48,000</td>
</tr>
<tr>
<td>4 persons</td>
<td>23,850</td>
<td>33,300</td>
<td>53,300</td>
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<tr>
<td>5 persons</td>
<td>27,910</td>
<td>36,000</td>
<td>57,600</td>
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<tr>
<td>6 persons</td>
<td>31,970</td>
<td>38,650</td>
<td>61,850</td>
</tr>
<tr>
<td>7 persons</td>
<td>36,030</td>
<td>41,300</td>
<td>66,100</td>
</tr>
<tr>
<td>8 persons</td>
<td>40,090</td>
<td>44,000</td>
<td>70,400</td>
</tr>
</tbody>
</table>

### Vulnerability Index

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

#### Singles VI

The baseline for vulnerability for single adults is six (6) months of homelessness. Vulnerability scores for single adults range from 0 to 8. Applicants who receive a score of 0 are considered non-vulnerable;
however they may still be eligible for PSH. Six-months or more of homelessness in combination with one or more of the markers detailed below will give someone a vulnerability score (1 or greater):

1. Three or more hospitalizations or emergency room visits in a year
2. Three or more emergency room visits in the previous three months
3. Aged 60 or older
4. Cirrhosis of the liver
5. End-stage renal disease
6. History of frostbite, immersion foot, or hypothermia
7. HIV+/AIDS
8. Tri-morbidity: co-occurring psychiatric, substance abuse, and chronic medical condition (asthma, cancer, diabetes, etc.)

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

Family VI

Family Vulnerability is characterized by length of literal homelessness and residential instability, involvement with child welfare and/or informal separation from children, number of children, and trauma history. The Family VI assessment asks questions in the following areas:

1. Homeless history
2. Involvement with child protective services
3. Parental risk factors
4. Child risk factors

Homeless Management Information System

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

The U.S. Department of Housing and Urban Development (HUD) and other planners and policymakers at the federal, state, and local levels use 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.

Houston/Harris County’s HMIS is staffed at the Coalition for the Homeless of Houston/Harris County. The software provider is Client Track. The HMIS staff is responsible for the administration of the HMIS software and providing technical assistance to participating agencies and end-users. Agencies that participate in Houston/Harris County’s HMIS are referred to as “participating agencies.” Each participating agency needs to follow certain guidelines to help maintain data privacy and accuracy.
Staffing Roles and Expectations

Continuum of Care – Recognizing the need to stimulate community-wide planning and coordination of programs for individuals and families who are homeless, the U.S. Department of Housing and Urban Development (HUD) in 1994 instituted a requirement for communities to come together to submit a single, comprehensive application for HUD funds for housing and support services for people who have experienced homelessness. The organizational concept to embody this effort is the Continuum of Care (CoC), which is governed by a Steering Committee composed of representatives from across the community. As a result of its strong leadership, access to resources and high visibility in the community, the Coalition for the Homeless of Houston/Harris County serves as this region’s lead agency for the CoC. The Houston CoC encompasses Houston and Harris and Fort Bend counties, and its purpose is to:

- Help create integrated, community-wide strategies and plans to prevent and end homelessness;
- Provide coordination among the numerous regional organizations and initiatives that serve the homeless population, and
- Create the region’s single, comprehensive grant application to HUD for McKinney-Vento funding.

Coordinating Entity - The Coalition for the Homeless of Houston/Harris County is the designated **Coordinating Entity**. The *Coordinating Entity* is responsible for the day-to-day administration of the *Coordinated Access System*, including but not limited to the following:

- Creating and widely disseminating materials regarding services available through the *Coordinated Access 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 *Assessment Hubs*;
- Ensuring that pertinent information is entered into HMIS for monitoring and tracking the process of referrals including vacancy reporting and completion of assessments;
- Managing case conferences to review and resolve rejection decisions by receiving programs and refusals by clients to engage in a housing plan in compliance with receiving program guidelines;
- Managing an eligibility determination appeals process in compliance with the protocols described in this manual;
- Managing manual processes as necessary to enable participation in the *Coordinated Access System* by providers not participating in HMIS;
Designing and executing ongoing quality control activities to ensure clarity, transparency, and consistency in order to remain accountable to clients, referral sources, and homeless service providers throughout the coordinated access process;

Periodically evaluating efforts to ensure that the Coordinated Access System is functioning as intended;

Making periodic adjustments to the Coordinated Access System as determined necessary;

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

Updating policies and procedures.

Project Manager – The Coordinating Entity staffs the Coordinated Access Project Manager position. The project manager role includes management of the Coordinated Access System, including but not limited to the following:

- Serving as point person and lead to all workgroups and transition teams
- Providing Coordinated Access training to participating agencies
- Database administering
- 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

Assessment Hubs - Agencies selected to serve as the Assessment Hub sites are responsible for ensuring that all households experiencing homelessness and at-risk of homelessness have prompt access to Intake and Assessments and that Assessments are administered in a safe, welcoming environment.

Housing Assessors – see Policies & Procedures

Housing Navigators – see Policies & Procedures

Receiving Program - All Transitional Housing, Rapid Re-housing, and Permanent Supportive Housing programs are Receiving Programs and are responsible for reporting vacancies to the Coordinating Entity in compliance with the protocols described in this manual. All programs
that receive a referral from the Coordinated Access System are responsible for responding to that referral and participating in case conferences, in compliance with the protocols described in this manual.

Authorized User Agencies - Housing providers who wish to or are required to participate in the Coordinated Access System. Authorized User Agencies sign a Memorandum of Understanding to have access to the database to select households to interview for vacancies/anticipated vacancies or during lease up of new PSH programs.

Target Population

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

System Overview and Workflow

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

From Initial Request for Services to Permanent Housing Placement – Pathway through the Coordinated Access System

- **Step 1:** Connecting to the Coordinated Access System/Initial Request for Services - To ensure accessibility to households in need, the Coordinated Access System provides access to services from multiple, convenient physical locations. Households in need may initiate a request for services in person through any of the designated Assessment Hubs, through the call center, and/or through community outreach teams.

  Accessible information about how to obtain services through the Coordinated Access System is also available through a broad range of community-based service providers.

- **Step 2:** Housing Assessment - Housing Assessors are available at Assessment Hubs, the call center, and through community outreach staff to conduct the Coordinated Access Housing Assessment with households in need, with initial priority given to chronically homeless individuals. The assessment is completed using HMIS. An additional Vulnerability Index Assessment is generated in HMIS for all households identified as a match for Permanent Supportive Housing.
• **Step 3: Housing Match** - Information gathered from the assessment is used to determine which housing intervention is best suited to end the household’s homelessness (Permanent Supportive Housing, Transitional Housing, or Rapid Re-housing). HMIS automatically matches households to a particular housing intervention and then a specific housing program based on program eligibility.

• **Step 4: Housing Referral** - Once the recommended intervention and eligible programs have been identified in HMIS and the household individuals have decided which programs they are interested in, the following two options are available to the Housing Assessor:
  
  a. An electronic referral to the provider can be completed; or
  
  b. The household can be added to the waitlist if no open units are available.

• **Step 5: Housing Navigation** - After being referred to a housing provider, households have the option to be connected with a Housing Navigator. This connection can be made in real time or by pulling from the Coordinated Access Waitlist. The Housing Navigator can be one of the following: the original referring Case Manager, the original Coordinated Access referring Outreach Worker, or a designated Coordinated Access Housing Navigator. The Housing Navigator begins the process of securing the identified unit. This process may include, but is not limited to the following activities: Obtaining ID, obtaining social security cards, obtaining homeless verification documents, obtaining a security deposit, obtaining application fees, providing transportation to tour available units, etc. **The process from referral to move in should be completed within 30 days.**

Below is an illustration of the CA Workflow:
Coordinated Access Policies and Procedures

1. Connecting to the Coordinated Access System

1.1. Locations & Hours – Assessments are conducted at designated Assessment Hubs. A future call center will also be established at one of the Assessment HUBs. Current Assessment Hub locations and assessment hours include:

<table>
<thead>
<tr>
<th>Agency</th>
<th>Location</th>
<th>Telephone Number</th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>The BEACON</td>
<td>1212 Prairie Houston, TX 77002</td>
<td>713-220-9737</td>
<td>8 am – 12 pm M, Th, &amp; F</td>
</tr>
<tr>
<td>Star of Hope Women &amp; Family</td>
<td>419 Dowling Houston, TX 77003</td>
<td>713-222-2220</td>
<td>8 am – 12 pm T &amp; W</td>
</tr>
<tr>
<td>Star of Hope Men's Shelter</td>
<td>1818 Ruiz Houston, TX 77002</td>
<td>713-227-8900</td>
<td>TBD</td>
</tr>
<tr>
<td>VA Drop-In Center</td>
<td>1418 Preston Avenue Houston, TX 77002</td>
<td>713-794-7533</td>
<td>8 am – 12 pm Monday - Friday</td>
</tr>
<tr>
<td>Harris County Jail</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mobile Outreach</td>
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</tbody>
</table>

Assessors will be available at this location to assess individuals who will be released within 7 days to determine eligibility.

Assessment teams will conduct assessments in the field. The hours will be determined by each respective agency, but between the hours of 10:01 a.m. and 11:59 p.m.

1.2. Eligibility – Coordinated Access is intended to facilitate access to the most appropriate housing intervention for each household’s immediate and long-term housing needs and ensure that scarce permanent housing resources are targeted to those who are most vulnerable and/or have been homeless the longest. The Coordinated Access System uses the following criteria to accurately match needs to resources:
<table>
<thead>
<tr>
<th>Housing Model</th>
<th>Population</th>
<th>Priority Populations</th>
</tr>
</thead>
</table>
| Permanent Supportive Housing | • Any high needs individual with multiple barriers to housing that is literally homeless (lease-based program)  
  • Specialized eligibility requirements for subsidies including veterans, disabled, long term homeless, or domestic violence  
  • **Unique Populations:** Families with Children (not typically chronic; complete Family VI-Family preservation) | • Individuals with a disability and long-term, multiple episodes of homelessness (Vulnerability Index score of 1 or higher; chronically homeless)  
  • Veterans who are not eligible for VA housing subsidies |
| Rapid Re-Housing          | • Literally homeless households are those residing in a place not meant for human habitation, living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution  
  • Households that have reasonable potential for personal sustainability post-assistance  
  • Recently became homeless  
  • No serious known disabilities (Infrequently used as a bridge to PSH) | • Households with children residing on streets or in emergency shelters  
  • Veteran households with children residing on streets or in emergency shelters who are not eligible for VA-funded RRH |
### Housing Model

<table>
<thead>
<tr>
<th>Population</th>
<th>Priority Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Singles</td>
<td></td>
</tr>
<tr>
<td>• Families</td>
<td></td>
</tr>
<tr>
<td>• Youth (18-24)</td>
<td></td>
</tr>
<tr>
<td>• Domestic violence</td>
<td></td>
</tr>
<tr>
<td>• Pregnant Head of Household</td>
<td></td>
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<tr>
<td>• Households with a recent change in composition</td>
<td></td>
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<tr>
<td>• Households with repeat episodes of homelessness</td>
<td></td>
</tr>
<tr>
<td>• Those interested in substance use treatment</td>
<td></td>
</tr>
<tr>
<td>• Recently released</td>
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</tr>
</tbody>
</table>

**Transitional Housing**

Households that are not chronically homeless and individuals needing prevention or rapid rehousing but suffer from at least one disabling condition (substance abuse, mental health) and could benefit from quickly accessing housing and services

1.3 **Marketing/Advertising** – As needed, the *Coordinating Entity* will send information & updates regarding the *Coordinated Access System* via email to stakeholders, the 211 hotline, and the general public. The *Coordinating Entity* also distributes flyers and brochures and maintains information available on its website. In addition, all *Assessment Hubs* will display notices at each location identifying it as such.

### 2. The Housing Assessment Process

2.1. **Housing Assessors**

2.1.1. **Roles and Responsibilities** - *Housing Assessors* are repurposed staff from designated community agencies. *Housing Assessors* may office out of Assessment Hubs, be designated as the Assessor for his/her agency, or may be part of a mobile outreach team. All *Housing Assessors* are required to complete a HMIS intake and housing assessment with individuals in need of housing and pull, from HMIS, “housing matches” available to each individual. The *Housing Assessor* will then pass the referrals to the individual’s Case Manager or a *Housing Navigator*. *Housing Assessors’* responsibilities include, but are not limited to the following:
• Operating as the initial contact for the Coordinated Access System
• Conducting Housing Assessments and VI’s
• Client notification of Eligibility and Referral Decisions
• Submission of referrals to the Receiving Program through HMIS
• Participation in case conferences
• Responding to requests by the Coordinating Entity

2.1.2. Training Requirements – Housing Assessors are trained by the Coordinating Entity. The training consists of the Corporation for Supportive Housing’s 6 hours “Housing Assessor Training” in addition to training in using the Coordinated Access workflow in HMIS.

2.2. HMIS Workflow – The workflow below outlines the CA steps in HMIS:

2.3. Release of Information – All clients must sign a release of information prior to the assessment process.

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

2.5. Timeline - The Housing Assessor notifies the client of his/her eligibility and referral decision within 24 business hours. Once a referral is made, the Receiving Program has 24 business hours to contact the client. This information is tracked in HMIS.
3. Housing Matching

3.1. CFTH HMIS Responsibilities – HMIS Staff at the Coalition for the Homeless is responsible for the daily administration of the HMIS software and providing technical assistance to participating agencies and end-users.

3.2. Housing Navigators

3.2.1. Roles and Responsibilities - Housing Navigators are repurposed staff from designated community agencies. Housing Navigators office out of Assessment Hubs. All Housing Navigators work with individuals that do not have an existing case manager and would like assistance in navigating the process of securing housing from housing referral to “lease up”. The Housing Navigator provides the client with a welcome letter explaining both the client and staff’s role in the program. Both the client and staff sign the letter and it is maintained in the client’s chart. All Housing Navigators, Outreach Workers and Case Managers operating as Housing Navigators carry the following responsibilities:

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

3.2.2. Training Requirements – Housing Navigators are trained by the Coordinating Entity. The training consists of the Corporation for Supportive Housing’s 6 hours “Housing Navigator Training” in addition to training in using the Coordinated Access workflow in HMIS.

3.3. Timeline - Once the Housing Assessor has made contact with the client’s Case Manager or Housing Navigator, that worker contacts the client within 24 hours and begins the process of scheduling intake appointments. This information is tracked in HMIS.

3.4. Unit Availability/Vacancy Posting – All Transitional Housing, Rapid Re-housing, and Permanent Supportive Housing Programs are required to post vacancies in HMIS within 24 business hours of unit/bed availability. If providers know of an impending vacancy, they are required to post the anticipated availability date within 72 hours of being made aware of such availability and updating HMIS with the actual availability date once the bed becomes vacant. Programs must update vacancy information in HMIS
within 24 business hours of a unit/bed being filled. This information is crucial in determining what resources are available and where to send a client needing housing.

4. Housing Referral

4.1. Waitlist – The waitlist for permanent supportive housing consists of the following:

4.1.1. Clients are prioritized based on their VI score.

4.1.2. The waitlist is sorted by the VI score & client preference.

4.1.3. Navigators pull the waitlist data M-F, 8:00 am - 10:00 am.

4.1.4. If the waitlist indicates an opening, the Navigators start the process of contacting the client who is next on the list & that indicated a preference for that program.

4.1.5. Navigators attempt to make contact with the client for three (3) business days.

4.1.6. If the client cannot be contacted within that timeframe, then staff move on to the next client on the list.

4.1.7. Once staff makes contact with the client, the client must decide immediately whether to accept or decline the unit.

4.1.8. If the client accepts the unit, he/she moves forward in the next steps towards move-in.

4.1.9. If the client declines the unit, then the next client on the waitlist is contacted and the client that refused is moved down to the bottom of the waitlist based on their VI score.

4.1.10. Assessments resume M-F, 10:00 am – 8:00 am the following day once Navigator waitlist duties are completed.

4.2. Receiving Program Responsibilities – The Receiving Program makes contact with the client within 24 hours. If the client misses the appointment, Receiving Programs will schedule a new intake appointment within 3 business days and should hold the vacancy until the intake appointment is concluded. Clients who have missed a second appointment, and who later present at or call the Receiving Program, will be referred back to the Housing Navigator and that referral will be documented in HMIS.

4.2.1. 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). A copy of the intake decision notification is provided to the client presenting for services. The Receiving Program will make best faith efforts to obtain the client’s signature to acknowledge receipt and maintain a signed copy in intake records. In instances
in which the client signature cannot be obtained, the *Receiving Program* will indicate the reason on the unsigned decision document and maintain in intake records. The *Receiving Program* orally reviews the intake decision notification with the client to ensure that the client understands the decision, and applicable next steps, including the client’s right to appeal the decision. An intake decision notification includes at a minimum:

- first available move-in date, if applicable; and
- reason the client cannot enter the program, including reason for rejection by client or program (which includes redirection to the *Housing Navigator*), if applicable.
- instructions for appealing the decision.

### 4.2.2. Reasons for denial

*Receiving Programs* may only decline individuals and families found eligible for and referred by the *Housing Assessor* under limited circumstances including:

- there is no actual vacancy available;
- the individual or family missed two intake appointments;
- the household presents with more people than referred by the *Housing Assessor* and the *Receiving Program* cannot accommodate the increase;
- the individual or family was denied by independent housing providers due to certain criminal behaviors; 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.

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

### 4.2.3. Client Choice

Clients may decline a referral because of program requirements that are inconsistent with their needs or preferences. There are no limitations on this decision. For example, clients may decline participation in programs requiring sobriety.
4.2.4. **Client Appeal** – All clients have the right to appeal eligibility determinations issued by either the *Coordinating Entity* or any *Receiving Program*. Instructions for submitting an appeal are provided to clients at the time that an intake decision is made by the *Receiving Program*. *Housing Assessors* and *Housing Navigators* are responsible for assisting clients in filing eligibility determination appeals, including but not limited to drafting a written appeal on behalf of the client. All appeals of decisions by *Receiving Programs* should be made in writing and submitted to the *Coordinating Entity*.

4.3. **Move-In** – If the homeless individual or family is accepted, the *Receiving Program* must document that acceptance 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, the *Receiving Program* must notify and refer the client back to the *Housing Navigator* so that the outcome is documented in HMIS.

To the extent feasible given available funding and as necessary, the *Receiving Program* will provide the individual or family with move-in assistance including transportation of household members and personal belongings.

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

4.4.1. **Domestic Violence (DV)** – When a homeless or at-risk individual/household is identified by the *Coordinated Access System* to be in need of domestic violence services, that individual/household is referred to the domestic violence hotline immediately. If the individual/household does not wish to seek DV specific services, the individual/household will have full access to the *Coordinated Access System*, in accordance with all protocols described in this manual. If the DV helpline determines that the individual/household seeking DV specific services is either not eligible for or cannot be accommodated by the DV specific system, the helpline will refer the client to an *Assessment Hub* for assessment and referral in accordance with all protocols described in this manual.

4.4.2. **Veterans** – When a homeless or at-risk individual is identified by the *Coordinated Access System* to be a Veteran, additional questions concerning service era, length of service, and discharge status will be asked. If eligible for VA services, the Veteran will be given the option of being referred to the VA Drop-In Center. If the Veteran chooses that option, then that individual is referred to the VA Drop-In Center immediately. If the VA Drop-In Center determines that the individual seeking veteran specific services is not eligible for such services or if
the individual has been dishonorably discharged, the client will be referred to an Assessment Hub for assessment and referral in accordance with all protocols described in this manual.

5. Case Conferences

5.1. The Coordinating Entity will require a case conference to review and resolve rejection decisions by Receiving Programs. The purpose of the case conference will be to resolve barriers to the client receiving the indicated level of service. Such a case conference will be held in all instances in which an individual or family is declined by a program.

In cases in which a homeless individual or family is facing program termination for refusing to engage in a housing plan or otherwise taking steps to resolve his/her/their homelessness, the Provider will notify the Coordinating Entity. The Coordinating Entity may then require a case conference to review and determine next steps. The purpose of the case conference will be to discuss interventions used to date and resolve barriers to securing permanent housing. Such a case conference will be held in all instances in which an individual or family has declined more than two placements. Providers may also request a case conference, at their discretion, in other circumstances in which a client household is insufficiently engaged in actions necessary to secure a permanent placement.

The Coordinating Entity will determine which parties will attend a case conference, including but not limited to the Housing Assessor, the Housing Navigator, the Receiving Program, the client, and other contacts as determined necessary. The Coordinating Entity will make all logistical arrangements for the case conference, including but not limited to notifying all parties.

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

The Coordinating Entity takes all necessary steps to ensure that the Coordinated Access 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 Access 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 Authorized User Agencies who enter into an MOU for the Coordinated Access System agree to take full accountability for complying with Fair Housing and all other funding and program requirements. The MOU requires User Agencies to use the Coordinated Access System in a consistent manner with the statutes and regulations that govern their housing programs.

The Coordinating Entity will request from each Authorized User Agency their tenant selection plan and any funding contract that requires or allows a specific subpopulation of persons to be served. For instance, Housing Opportunities for Persons with AIDS (HOPWA) programs will show 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 Access System may allow filtered searches for subpopulations while preventing discrimination against protected classes.

Evaluating and Updating Coordinated Access System Policies and Procedures

The implementation of the Coordinated Access 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 Houston/Harris County Continuum of Care anticipates adjustments to the processes described in this manual. To inform those adjustments, the Coordinated Access System will be periodically evaluated, and there will be ongoing opportunities for stakeholder feedback, including but not limited to Referral and Receiving Program work groups convened and managed by the Coordinating Entity. Specifically, the Coordinating Entity is responsible for:

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

- Leading efforts to make periodic adjustments to the Coordinated Access 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 Access System is updated as necessary to maintain compliance with all state and federal statutory and regulatory requirements

Evaluation efforts shall be informed by metrics established annually by the Coordinating Entity, in conjunction with the CoC Steering Committee and Coordinated Access Transition Team. These metrics shall include indicators of the effectiveness of the functioning of the Coordinated Access 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/Percentage of persons declined by more than one (1) provider
• Number/Percentages of Eligibility and Referral Decision appeals
• # of program intakes not conducted through Coordinated Access System
• Completeness of data on assessment and intake forms

These metrics shall also include indicators of the impact of the Coordinated Access 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; eliminated for shelter
• Program components meet outcome targets
• Reductions in long term chronic homelessness
• Reduction in family homelessness
• Reductions in returns to homelessness
• Reduced rate of people becoming homeless for first time

Termination

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