



System Operations Manual

TX – 700 Continuum of Care

Prepared by the Coalition for the Homeless of Houston/Harris County serving as Lead Agency to the TX-700 Continuum of Care.

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

These materials within this Coordinated Access System Operations Manual have been developed locally for the TX-700 Continuum of Care (also called “The Way Home” and including Houston, Pasadena, Conroe; and Harris, Fort Bend, and Montgomery Counties) and are not evidence based. They are intended to offer an example of how tools can be simplified and tailored to meet the objectives of a system that coordinates access to housing for homeless individuals, youth, and families. The tools are still in development and will continue to be refined locally based on feedback from assessors, providers and clients.

Please note that the tools for families and youth were developed in early 2015 and still remain in the early testing phase. They are being provided within this document to showcase how the Houston system is using a different indicator of vulnerability for each subpopulation.

(Updated: May 2017)

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Coordinated Access System Operations Manual

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I. 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:

- (i) Policies and procedures for providing an initial housing assessment to determine the best housing and services intervention for individuals and families;
- (ii) A specific policy to guide the operation of the centralized or coordinated assessment system on how its system will address the needs of individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking, but who are seeking shelter or services from non-victim service providers;
- (iii) Policies and procedures for evaluating individuals' and families' eligibility for assistance;
- (iv) Policies and procedures for determining and prioritizing which eligible individuals and families will receive transitional housing assistance;
- (v) Policies and procedures for determining and prioritizing which eligible individuals and families will receive rapid rehousing assistance;
- (vi) Policies and procedures for determining and prioritizing which eligible individuals and families will receive permanent supportive housing assistance;

The 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 Houston, Pasadena, Conroe; and Harris, Fort Bend, and Montgomery Counties. 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 (Rapid Re-housing, and Permanent Supportive Housing) regarding: eligibility for services, priority populations, expected outcomes, and targets for length of stay;
- ❖ Agreed upon **priorities for accessing homeless assistance**;
- ❖ **Referral policies and procedures** from the system of coordinated 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*.

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.

II. Definitions

Terms used throughout this manual are defined below:

Chronically Homeless (HUD Definition):

(1) An individual who:

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

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

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

(2) An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or

(3) A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Disability (HUD Definition):

A Physical, Mental or Emotional Impairment, including impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury that is expected to be long-continuing or of indefinite duration, 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

2015 Area Median Income Limits (Houston, Baytown, Sugar Land, Metro Area)

Household Size	30% Area Median Income (HUD Extremely Low Income Limit)	50% Area Median Income (HUD Very Low Income Limit)	80% Area Median Income (HUD Low Income Limit)
1 person	14,600	24,300	38,850
2 persons	16,650	27,250	44,400
3 persons	20,090	31,200	49,950
4 persons	24,250	34,650	55,450
5 persons	28,410	37,450	59,900
6 persons	32,570	40,200	64,350
7 persons	36,730	43,000	68,800
8 persons	40,890	45,750	73,200

Housing Prioritization Tools

Three separate assessment tools will be used to prioritize homeless households for entry into Permanent Supportive Housing or Rapid Re-housing programs. The assessment tools target youth, families, and single adults. All three tools focus on length of literal homelessness and residential instability, involvement with child welfare and/or informal separation from children, number of children, trauma history, substance abuse history, and employment history. The assessments ask questions tailored to each population and include the following:

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

Homeless Management Information System

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

The U. S. Department of Housing and Urban Development (HUD) and other planners and policymakers at the federal, state, and local levels use 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 Way Home'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 The Way Home's HMIS are referred to as "participating agencies." Each participating agency needs to follow certain guidelines to help maintain data privacy and accuracy.

III. 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 Way Home CoC encompasses Houston, Pasadena, Conroe; and Harris, Fort Bend, and Montgomery 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 *Coordinated Access Staff*;
- Ensuring that pertinent information is entered into HMIS for monitoring and tracking the process of referrals including vacancy reporting and completion of assessments;
- Managing case conferences to review and resolve rejection decisions by receiving programs and refusals by clients to engage in a housing plan in compliance with receiving program guidelines;
- Managing an eligibility determination appeals process in compliance with the protocols described in this manual;
- Managing manual processes as necessary to enable participation in the *Coordinated 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
- Managing all PR requests related to the *Coordinated Access System*.

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 (Coordinated Access Staff, Database, Providers, etc.).

Assessment Hubs - Agencies selected to serve as an *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 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.

IV. 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.

V. 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

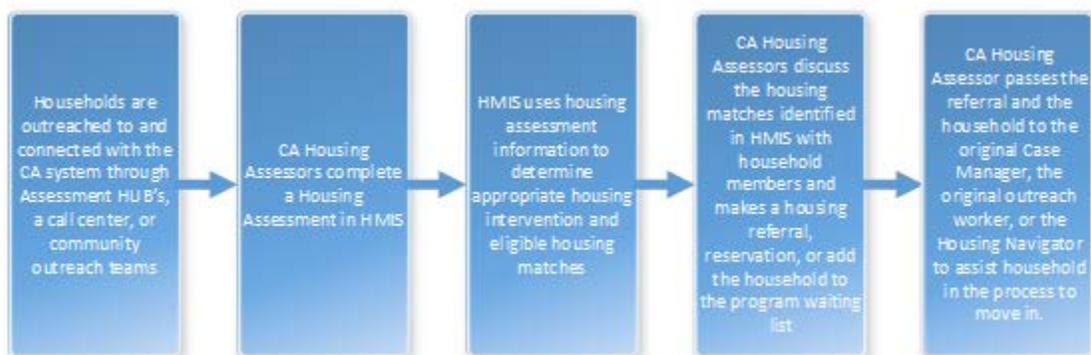
- Step 1: Connecting to the Coordinated Access System/Initial Request for Services – To ensure accessibility to households in need, the *Coordinated Access System* provides access to services from multiple, convenient physical locations. Households in need may initiate a request for services in person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

Detailed information regarding Hub locations and hours of operation are posted on the Coalition for the Homeless of Houston/Harris County's website www.homelesshouston.org.

- Step 2: Housing Assessment – *Housing Assessors* are available at Assessment Hubs, the call center, and through community outreach teams to conduct the *Coordinated Access Housing Assessment* with households in need. 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 and to prioritize referrals. Additional next step assessments are generated in HMIS for all households identified as a match for Rapid Re-housing and to prioritize referrals. Households must be re-assessed if more than 90 days have passed since the previous assessment.

- 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 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, an electronic referral to the provider can be completed and the following two options are available to the *Housing Assessor*:
 - a. An electronic referral to the provider can be completed and a reservation made to pull the unit from HMIS; 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 will 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, and providing transportation to tour available units. **The process from referral to move in should be completed within 30 days.**

Below is an illustration of the CA Workflow:



VI. 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 can be found on the Coalition for the Homeless of Houston/Harris County's website www.homelesshouston.org.

- 1.2. Eligibility – The *Coordinated Access System* 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 the appropriate housing intervention:

Permanent Supportive Housing

Permanent housing that is coupled with supportive services that are appropriate to the needs and preferences of residents.

Individuals have leases, must abide by rights and responsibilities, and may remain with no program imposed time limits.

Housing may include various combinations of subsidy resources and services. Supportive housing in Houston is Housing First, and follows a harm reduction philosophy.

Program Description	Essential Program Elements	Time Frame	Population	Desired /Expected Outcomes
<p>Rental assistance with supportive services for persons who are coming from the street or shelter/interim housing. Majority of programs serve households with a disabled head-of-household, but disability requirement will be based on subsidy source requirements.</p> <p>Programs can operate on a project-based or scattered-site model.</p>	<p>Case Management</p> <ul style="list-style-type: none"> Assistance with lease process Provision of or linkage to: Assessment, Intervention, link to mainstream resources, community building, peer to peer and all other services that assist a person in remaining stably housed Services are voluntary to the clients and are not a condition of the lease <p>Rental Subsidy</p> <ul style="list-style-type: none"> Provides a rental subsidy to make the unit affordable Provides assistance in accessing housing relocation resources/supports (security deposits, utilities, furnishings, etc.) Ensure coordination between property manager or landlord <p>Health Care Access</p> <ul style="list-style-type: none"> Wellness services Physical and mental health services <p>Harm Reduction and Housing First</p> <ul style="list-style-type: none"> All supportive housing embraces and practices Harm Reduction and Housing First Incorporate proven best practices and evidence-based practices Programs do not require sobriety or medication/treatment compliance as a condition of housing attainment or retention 	<p>No time limits</p>	<ul style="list-style-type: none"> Any high needs individual with multiple barriers to housing that is literally homeless (lease-based program) Specialized eligibility requirements for subsidies including veterans, disabled, long term homeless, or domestic violence <p>Prioritizing: Disabling condition and long-term, multiple episodes of homelessness (Vulnerability Index score of 1 or higher) and veterans</p> <p>Unique Populations:</p> <ul style="list-style-type: none"> Families with Children 	<p>Outcome: Clients will remain in permanent housing.</p> <p>Indicators: Threshold: 80% clients will remain permanently housed for 6 months. Threshold (increasing): 20% of all participants have employment income.</p> <p>Threshold (increasing): 56% of all participants have non-employment income.</p> <p>Threshold (increasing): 56% of participants obtain mainstream benefits.</p>

Rapid Re-Housing

Program of stabilization and assessment, focusing on re-housing all persons, regardless of disability or background, as quickly as possible in appropriate permanent housing.

Program Description	Essential Program Elements	Time Frame	Population	Desired /Expected Outcomes
<p>Short-term rental assistance and supportive services program that rapidly re-houses and stabilizes persons who are homeless into appropriate permanent housing.</p>	<p>Case Management</p> <ul style="list-style-type: none"> • Housing location • Housing stabilization planning using common tools • Employment assistance • Linkage to mainstream resources • Linkage to mental health services as appropriate • Linkage to medical services as needed • Linkage to substance use treatment services as appropriate • Transportation assistance • Financial management <p>Domestic Violence Specific Considerations:</p> <ul style="list-style-type: none"> • Access to crisis intervention services • Safety planning • Legal advocacy <p>Temporary Financial Assistance</p> <ul style="list-style-type: none"> • Rental assistance based on lease and housing stabilization plan <ul style="list-style-type: none"> ○ Need based rental assistance • Utility assistance • Childcare • Job Training <p>Housing Relocation</p> <ul style="list-style-type: none"> • Provision of or formalized partnership to housing referrals and placement services • Linkage to community supports and/or wraparound system of services in relation to housing placement • Temporary financial assistance (security deposits, utility deposits, furniture, household supplies) <p>Harm Reduction and Housing First</p> <ul style="list-style-type: none"> • All supportive housing embraces and practices Harm Reduction and Housing First • Incorporate proven best practices and evidence-based practices • Programs do not require sobriety or medication/treatment compliance as a condition of housing attainment or retention 	<p>Up to 24 months of rent subsidy and supportive services, during which households are stabilized</p>	<p>Literally homeless households or those residing in shelters. Households that show the ability to become self-sufficient in a short period of time as evidenced by: having income potential, and do not need intense services to remain housed; recently became homeless; no serious known disabilities</p> <p>May be used as a bridge to PSH</p> <p>Priority populations: 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.</p>	<p>Outcome: Households will secure and maintain appropriate, affordable permanent housing.</p> <p>Indicators:</p> <p>The Way Home CoC Threshold: 80% of households will exit to permanent housing.</p> <p>The Way Home CoC Threshold: 70% of households remain housed 3 months after exit.</p> <p>The Way Home CoC Threshold: 70% of households increase income during program enrollment.</p> <p>The Way Home CoC Threshold: 70% of participants obtain mainstream benefits.</p>

Rapid Re-Housing for Young Adults (ages 18-24 years old)

Program of stabilization and assessment, focusing on re-housing all persons, regardless of disability or background, as quickly as possible in appropriate permanent housing.

Program Description	Essential Program Elements	Time Frame	Population	Desired /Expected Outcomes
<p>Supportive services program that rapidly re-houses and stabilizes young adults (ages 18-24 years old) who are homeless into appropriate permanent housing with up to 24 months of rental assistance.</p>	<p>Case Management</p> <ul style="list-style-type: none"> • Housing navigation • Housing stabilization planning using common tools • Linkage to mainstream resources • Linkage to mental health, medical, and substance use treatment services as appropriate • Transportation assistance • Financial, lease, household management • Negotiating housemate agreements <p>Peer Specialist</p> <ul style="list-style-type: none"> • <p>Employment Assistance</p> <ul style="list-style-type: none"> • Rapid Employment Model • Job coaching • Emphasis on retention methods <p>Temporary Financial Assistance</p> <ul style="list-style-type: none"> • Rental assistance based on lease and housing stabilization plan • Utility assistance • Childcare <p>Best Practices/Evidence-Based Practices</p> <ul style="list-style-type: none"> • Developmentally appropriate program models are employed • Trauma-informed programming and housing • Self-Sufficiency focused case planning • Job coaching, rapid employment and job retention practices are incorporated into program • Housing embraces and practices Harm Reduction and Housing First • Incorporate proven best practices and evidence-based practices • Programs do not require sobriety or medication/treatment compliance as a condition of housing attainment or retention 	<p>Up to 24 months of rent subsidy and supportive services, during which households are stabilized</p>	<p>Literally homeless 18-24 year old households or those residing in shelters. LGBTQ young adults, pregnant and parenting young adults, young adults with extensive involvement in juvenile justice system and/or child welfare system.</p> <p>May be used as a bridge to PSH</p> <p>Priority populations: Households who are transgender, pregnant and parenting, or lesbian, gay or bisexual.</p>	<p>Outcome: Young adult households will secure and maintain employment and permanent housing.</p> <p>Indicators:</p> <p>The Way Home CoC Threshold: 80% of households will exit to permanent housing.</p> <p>The Way Home CoC Threshold: 70% of households remain housed 3 months after exit.</p> <p>The Way Home CoC Threshold: 70% of households increase income during program enrollment.</p> <p>The Way Home CoC Threshold: 70% of participants obtain mainstream benefits.</p>

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 www.homelesshouston.org.

2. The Housing Assessment Process

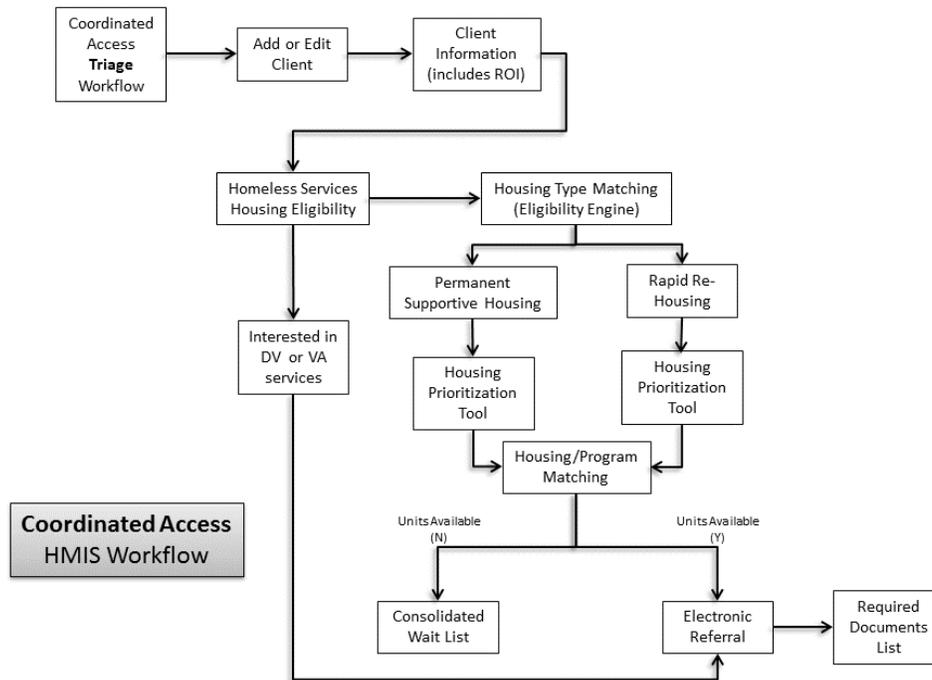
2.1 Housing Assessors

2.1.1 Roles and Responsibilities - *Housing Assessors* are 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 community 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, and Next step assessments
- Client notification of *Eligibility and Referral Decisions*
- Submission of referrals to the *Receiving Program* through HMIS
- Collecting and uploading all documents available at assessment
- Participation in case conferences
- Responding to requests by the *Coordinating Entity*

2.1.2 Training Requirements – *Housing Assessors* are trained by the *Coordinating Entity*. The training consists of the six (6) hour “Housing Assessor Orientation” in addition to HMIS training on the *Coordinated Access* workflow.

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 immediately. Once a referral is made, the *Receiving Program* has 24 business hours to acknowledge receipt of the referral. The *Receiving Program* must then enroll or deny the referral within seven (7) days. The *Receiving Program* can reject or deny the referral if the assigned case manager has been unable to contact the household after seven (7) days. If a household shows up at the *Receiving Program* after the seven (7) days have expired, the case manager will assist the household in reentering the system through the *Coordinated Access System*. All of 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 and user training to participating agencies and end-users.

3.2 Housing Navigators

3.2.1 Roles and Responsibilities - Housing Navigators are staff from designated community agencies. *Housing Navigators* office out of *Assessment Hubs*, their home agencies, or in the field. All *Housing Navigators* work with individuals who 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*, *Community Outreach Workers*, and *Case Managers* operating as *Housing Navigators* carry the following responsibilities:

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

3.2.2 Training Requirements – *Housing Navigators* are trained by the *Coordinating Entity*. The training consists of the six (6) hour “Housing Navigator Orientation” in addition to HMIS training on the Coordinated Access workflow.

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 Rapid Re-housing, and Permanent Supportive Housing Programs are required to post vacancies in HMIS within twenty-four (24) business hours of unit/bed availability. If providers know of an impending vacancy, they are able to post the anticipated availability date up to fourteen (14) days before unit vacancy. Programs must update vacancy information in HMIS within twenty-four (24) business hours of 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 – There are separate waitlists for Permanent Supportive Housing and Rapid Re-housing. The waitlists consist of the following:

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

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

4.1.3 Assessors pull the waitlist daily.

4.1.4 If the waitlist indicates an opening for either Permanent Supportive Housing or Rapid Re-housing, the Assessors create a referral to the program with the opening.

4.1.5 If the referral was made to a Permanent Supportive Housing program, then the Assessors will also create a reservation for the open unit to remove it from that program's inventory.

4.1.6 If the program to which the referral was made is one that requires a Navigator, then the Assessor will also create a referral to the appropriate Navigator.

4.1.7 Navigators or Case Managers Attempt to make contact with the client for seven (7) business days.

4.1.8 If the client cannot be contacted within that time frame, then staff move on to the next client on the list.

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

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

4.1.11 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 appropriate waitlist based on their VI or next step assessment score.

4.2 Receiving Program Responsibilities – Once a referral is made, the *Receiving Program* has twenty-four (24) business hours to acknowledge receipt of the referral. The *Receiving Program* must then enroll or deny the referral within seven (7) days. The *Receiving Program* can reject or deny the referral if the assigned case manager has been unable to contact the house hold after seven (7) days. If a household shows up at the *Receiving Program* after the seven (7) days have expired, the case manager will assist the household in reentering the system through the *Coordinated Access System*. All of this information is tracked in HMIS.

4.2.1 Document Requirement Updates - *Receiving Programs* make eligibility determination decisions within one (1) 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 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 households found eligible for and referred by the *Housing Assessor* under limited circumstances including:

- there is no actual vacancy available;
- the household missed two intake appointments;
- the *Receiving Program* has been unable to make contact with the household for seven (7) consecutive business days;
- the household presents with more people than referred by the *Housing Assessor* and the *Receiving Program* cannot accommodate the increase;
- the household was denied by independent property owner/landlord due to certain criminal behaviors; or
- based on their individual program policies and procedures, the *Receiving Program* has determined that the household cannot be safely accommodated or cannot meet tenancy obligations with the supports provided by the program.

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

4.2.3 Client 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 household 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 PSH to PSH – under the CoC Program, Permanent Supportive Housing (PSH) projects may serve individuals and families from other PSH projects who originally met the eligibility requirements for PSH so long as the program participants were eligible for the original PSH (Section 423(f) of the McKinney-Vento Act, as amended by the HEARTH Act). This means that an individual or family may transfer from one PSH program to another under the CoC Program. This could occur under the following circumstances:

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

4.4.1 PSH to PSH Referral – If any of the above scenarios apply, a staff member from the current PSH must notify the *Coordinated Access Project Manager* in writing via email to initiate the process of transferring the client. The *Coordinated Access Project Manager* will verify that the request falls within the guidelines for the transfer as outlined in this manual. The *Coordinated Access Project Manager* will determine if a PSH unit is available, create the referral in HMIS, and notify the

current PSH program. The current PSH program will then be responsible for assisting the program participant in completing the documentation necessary for the new PSH program. Transfer requests outside of the ones outlined in this manual will not be approved. If not PSH unit is available, then the current PSH program will have to continue to work with the program participant in securing alternate housing options.

4.5 Referrals to and from other systems not using HMIS – 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.

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

4.5.2 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 VA services, the *Housing Assessor* at the VA Drop-In Center will complete the CA Assessment in HMIS and will either refer the household to an available unit, or add the household to the appropriate waitlist in accordance with the process outlined 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 household receiving the indicated level of service. Such a case conference will be held in all instances in which a household is declined by a *Receiving Program*. Case conferences will be held in all instances in which a household has declined more than two placements.

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

In cases in which a household is facing program termination, the *Receiving Program* 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 including plans to have the household re-assessed for a more suitable housing program.

The *Coordinating Entity* will determine which parties will attend a case conference, including but not limited to the *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.

VII. 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.

VIII. 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 will be displayed on dashboards located on the *Coordinating Entity's* website and shall include indicators of the effectiveness of the functioning of the *Coordinated 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:

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

IX. 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.

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Client Name _____

Last Four of Social Security Number _____

Coordinated Access Housing Intervention Assessment

A. History of Homelessness

Where did you stay last night?

Literally Homeless

- Place not meant for human habitation
 - Emergency Shelter
 - Transitional Housing (not chronic)
 - Hotel paid for by an agency
 - Institution (<90 days)
- Prior to institution must be 1, 2, or 4 above

Not Literally Homeless

- Friend or Family
- Own Housing/Permanent Housing
- Motel paid for by client
- Institution (>90 days)
- Other _____

How many people are in your household?

Adults = Children =

- Desired area for housing: Harris County – Southwest Harris County – Northwest
- Harris County – Northeast Harris County – Southeast
- Ft. Bend County Montgomery County

Document your housing for the past 3 years. ("Let's start with last night and work our way backwards.")

Homeless occasions can only be streets, emergency shelter, hotels paid for by agencies, or <90 days institution (if in one those locations prior)

Dates:

Location (Be specific; street names, over pass, building):

Are you a veteran? Yes No

If yes, what was your discharge? Honorable General Other than Honorable
 Bad Conduct Dishonorable

If yes, how many months of active duty did you serve? _____

Are you interested in access VA services? Yes No

If yes, refer directly to a Veteran service agency for appropriate housing.

Are you homeless because someone is hurting you? Yes No

Are you interested in accessing DV services? Yes No

Would you like a referral to access DV services? Yes No

If yes, refer directly to a domestic violence service agency for appropriate housing.

B. Health History

Have you been diagnosed with any of the following?

Check all that apply.

Serious mental illness

Substance Use Disorder

Developmental disability

How frequently do you use? Daily Weekly

Chronic physical illness or disability that limits your ability to work or perform daily activities

Monthly No longer using

HIV/AIDS

Have you ever been involuntarily hospitalized for a mental health condition? Yes No

Do you have health insurance? Yes No

How many times have you been to the ER in the past 2 years? _____

If yes: What type of insurance do you have?

VA Medicaid Medicare Gold Card

Private Other

If Medicare or Medicaid: Who is your insurance company?

United Healthcare Molina

Amerigroup/Anthem

C. Criminal History

1. How many times have you been incarcerated/in jail in the past 2 years?

2. Do you have a past felony conviction(s)?

Yes No

3. Have you or anyone who will live with you been convicted of a sexual offense?

Yes No

D. Employment & Income

Please describe your current employment situation or income received

- 1. Do you currently have income? Yes No
If yes, how much? _____
- 2. Where does your income come from?
 Employment SSI/SSDI VA Retirement
- 3. When was the last time you worked?
 Currently employed 30 days 31-90 days
 3-6 months 6-12 months 1 yr or more
- 4. How often do you go to Workforce Solutions?
 Every Day (Where? _____)
 Once per week Once a month
 Twice a year Never
- 5. Do you need to secure disability income?
 Yes No
If yes: Are you currently applying?
 Were you in Special Ed classes?
 Have you seen a doctor in the past 6 months?
 Have you ever been involuntarily hospitalized for a mental health condition?
 Have you been diagnosed with any life threatening conditions? (_____)

Client Name _____

Last four of SSN _____

If we follow Federal Priorities:

1. Veterans
2. Chronics
3. Families/Youth
4. Singles

AND

If we agree that all Youth and Chronics are vulnerable

If we say PSH is for

- Chronics
- Youth (Chronic or 21-31 Score)
- Families (Chronic or 39-54 Score)

AND

If we say RRH is for

- Youth (Non-Chronic and 0-20 Score)
- Families (Non-Chronic and 0-38 Score)
- Singles (Non-Chronic)

AND

If we say that all programs with youth specific beds will retain those beds for youth

THEN...

We prioritize as follows:

Housing Intervention	Prioritization	Subpopulation	Secondary Prioritization
PSH	1	Chronic Youth	1. Veteran
			2. Prioritization Score
			3. Length of Homelessness
			4. Date of Assessment
	2	Chronic Families	1. Veteran
			2. Prioritization Score
3. Length of Homelessness			
4. Date of Assessment			
3	Chronic Singles	1. Veteran	
		2. Prioritization Score	
		3. Length of Homelessness	
		4. Date of Assessment	
4	Non-Chronic 21 – 31 Score Youth	1. Veteran	
		2. Prioritization Score	
		3. Length of Homelessness	
		4. Date of Assessment	
5	Non-Chronic 39 – 54 Score Families	1. Veteran	
		2. Prioritization Score	
		3. Length of Homelessness	
		4. Date of Assessment	
6	Non-Chronic High Scoring Singles	1. Veteran	
		2. Prioritization Score	
		3. Length of Homelessness	
		4. Date of Assessment	
		Non-Chronic and 0-20 Score Youth	1. Veteran

Community-Wide Prioritization Standards for Coordinated Access

RRH	1		2. Prioritization Score
			3. Length of Homelessness
			4. Date of Assessment
	2	Non-Chronic and 0-38 Score Families	1. Veteran
			2. Prioritization Score
			3. Length of Homelessness
			4. Date of Assessment
	3	Non-Chronic Singles	1. Veteran
			2. Prioritization Score
			3. Length of Homelessness
			4. Date of Assessment

	<p><i>Coalition for the Homeless of Houston/Harris County</i></p> <p>Subject: Service Delivery</p> <p><i>Applies to: The Way Home</i></p>	<p>Housing Prioritization</p> <p>Effective: 07/25/2016</p>
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PURPOSE:

To ensure that homeless individuals and families assessed through Coordinated Access receive services in the most expedient way possible and that access to homeless assistance prioritizes those with the greatest needs who are least likely to end their homelessness in the absence of CoC support.

POLICY:

It is the policy of The Way Home that individuals and families with the most severe service needs and the longest lengths of time homeless are prioritized for housing.

PROCEDURE:

The Houston – Harris County Continuum of Care and The Way Home, with the input from area homeless providers, have established guidelines that outline the order of priority for housing homeless individuals and families. All current and newly developed Permanent Supportive Housing beds have been dedicated to individuals and families that are chronically homeless. All Permanent Supportive Housing turn-over beds have been prioritized for individuals and families that are chronically homeless. All Rapid Rehousing beds have been dedicated to literally homeless families with minor children and to youth ages 18-24. The steps below further outline the prioritization used for each subpopulation.

ORDER OF PRIORITY IN CoC PROGRAM FUNDED PERMANENT SUPPORTIVE HOUSING

1. **First Priority – Chronically homeless individuals and families with the longest history of homelessness and the most severe service needs. Within the first priority, the CoC has stipulated that vulnerable sub-populations will be placed in housing in the following order:**
 - a. Chronically homeless youth (ages 18-24) that have been homeless living in a place not meant for human habitation, a safe haven, or in an emergency shelter for at least 12 months continuously or has had 4 separate occasions of such in the past 3 years.
 - i. The chronically homeless youth, when assessed through Coordinated Access, will be assigned a Vulnerability Index (VI) score between 0-8, with 8 being the most severe service needs.
 - b. Chronically homeless families with the head of household having been homeless and living in a place not meant for human habitation, a safe haven, or in an emergency shelter for at least 12 months continuously or has had 4 occasions of such in the past 3 years.
 - i. The chronically homeless head of household of a family, when assessed through Coordinated Access, will be assigned a Vulnerability Index (VI) score between 0-8, with 8 being the most severe service needs.
 - c. Chronically homeless individuals who have been homeless and living in a place not meant for human habitation, a safe haven, or in an emergency shelter for at least 12 months continuously or has had 4 occasions of such in the past 3 years.
 - i. The chronically homeless individual, when assessed through Coordinated Access, will be assigned a Vulnerability Index (VI) score between 0-8, with 8 being the most severe service needs.

- 2. Second Priority – Chronically homeless individuals and families with the longest history of homelessness. Within the second priority, the CoC has stipulated that vulnerable sub-populations will be placed in housing in the following order:**
- a. Chronically homeless youth (ages 18-24) that have been homeless living in a place not meant for human habitation, a safe haven, or in an emergency shelter for at least 12 months continuously or has had 4 separate occasions of such in the past 3 years; and
 - i. the CoC has not identified any chronically homeless youth (ages 18-24) who meets all of the criteria for housing under the first priority.
 - b. Chronically homeless families with the head of household having been homeless and living in a place not meant for human habitation, a safe haven, or in an emergency shelter for at least 12 months continuously or has had 4 occasions of such in the past 3 years; and
 - i. the CoC has not identified any chronically homeless families with a head of household who meets all of the criteria for housing under the first priority.
 - c. Chronically homeless individuals who have been homeless and living in a place not meant for human habitation, a safe haven, or in an emergency shelter for at least 12 months continuously or has had 4 occasions of such in the past 3 years; and
 - i. the CoC has not identified any chronically homeless individual who meets all of the criteria for housing under the first priority.
- 3. Third Priority – Chronically homeless individuals and families with the most severe service needs. Within the third priority, the CoC has stipulated that vulnerable sub-populations will be placed in housing in the following order:**
- a. Chronically homeless youth (ages 18-24) that have been homeless living in a place not meant for human habitation, a safe haven, or in an emergency shelter on at least four separate occasions in the last 3 years, where the total length of those separate occasions equals less than one year; and
 - i. the CoC has not identified any chronically homeless youth (ages 18-24) who meets all of the criteria for housing under the first or second priorities.
 - b. Chronically homeless families with the head of household having been homeless and living in a place not meant for human habitation, a safe haven, or in an emergency shelter on at least four separate occasions in the last 3 years, where the total length of those separate occasions equals less than one year; and
 - i. the CoC has not identified any chronically homeless families with a head of household who meets all of the criteria for housing under the first or second priorities.
 - c. Chronically homeless individuals who have been homeless and living in a place not meant for human habitation, a safe haven, or in an emergency shelter on at least four separate occasions in the last 3 years, where the total length of those separate occasions equals less than one year; and
 - i. the CoC has not identified any chronically homeless individual who meets all of the criteria for housing under the first priority and second priorities.

ORDER OF PRIORITY IN CoC AND ESG PROGRAM FUNDED RAPID REHOUSING

- 1. First Priority – Literally homeless youth with the most severe service needs and risk factors**
- a. The literally homeless youth (ages 18-24) has been living in a place not meant for human habitation, a safe haven, or in an emergency shelter for any period of time.
 - b. The chronically homeless youth, when assessed through Coordinated Access, will be assigned a rapid rehousing youth triage score between 0-18, with 18 being the most severe service needs and risk factors such as foster care/CPS, mental health, and criminal histories.

- c. The literally homeless youth with the highest triage score and longest time homeless will be placed in housing first, followed by those with the longest period of time homeless, followed by those with the most severe service needs.

2. Second Priority – Literally homeless families with minor children and the most severe service needs

- a. The literally homeless family has been living in a place not meant for human habitation, a safe haven, or in an emergency shelter for any period of time.
- b. The literally homeless family, when assessed through Coordinated Access, will be assigned a rapid rehousing family triage score between 0-10, with 10 being the most severe service needs and risk factors hindering family reunification such as CPS, mental health, & criminal histories.
- c. The literally homeless family with the highest triage score and longest time homeless will be placed in housing first, followed by those with the longest period of time homeless, followed by those with the most severe service needs.

3. Third Priority – Literally homeless individuals with the most severe service needs

- a. The literally homeless individual has been living in a place not meant for human habitation, a safe haven, or in an emergency shelter for any period of time.
- b. The literally homeless individual, when assessed through Coordinated Access, will be assigned a rapid rehousing singles triage score between 0-15, with 15 being the most severe service needs.
- c. The literally homeless individual with the highest triage score and longest time homeless will be placed in housing first, followed by those with the longest period of time homeless, followed by those with the most severe service needs.

Single Adult Housing Prioritization Tool

		Answer	Score
1a	Chronic?	Yes/No/Logic	5
1b	Do you have a disabling condition? (only show if chronic = no)	Yes	1
1c	Have you been homeless before? (only show if chronic = no)	Yes	1
1d	How many times have you been homeless in the past 3 years? (only show if chronic = no)	>4	1
2	Age?	60+	2
3	How many times in the past year have you accessed medical services in the ER?	1-4	1
		5+	2
4	Do you have now or have you ever had the following? (kidney disease, heart stroke, liver disease, (heart disease, arrhythmia, irregular heartbeat), (asthma, emphysema, COPD), Hepatitis C	1-2	1
		3+	2
5	Do you have diabetes?	Yes	1
		Insulin Dep	2
6	Have you had any of the following? (symptomatic AIDS, blindness, deafness, cancer, down syndrome, amputation of one or both legs, spinal cord injury with inability to walk without walker or similar device, stroke with difficulty walking or using hand or arm, muscular dystrophy, cerebral palsy, or muscular atrophy with difficulty walking, sleeping, or using hands or arms, severe mental retardation, tracheotomy, colostomy, open wounds with instructions to keep clean, end-stage renal disease, end-stage liver disease, amyotrophic lateral sclerosis (ALS or Lou Gherig's disease), confinement to bed, required use of a wheelchair, walker, or crutches, terminal illness, or in hospice)	Yes	3
7	Are you currently pregnant?	Yes	1
8	Now or in the past have you had a brain stent or been treated for a head injury such as traumatic brain injury, contusions, concussion, etc.?	Yes	2
9a	Has a doctor or professional ever recommended mental health services?	Yes	1
9b	Are you currently receiving services for any of those?	No	1
10	Have you ever been taken to the hospital against your will?	Yes	1
11	In the past year, have you had thoughts of hurting yourself or someone else?	Yes	1
12a	Are you currently using drugs or alcohol?	Yes/No	0
12b	How many times per week?	>3	1
13	Were you in Special Education or Resource Classes when you were in school?	Yes	1
14	Do you have a HS Diploma or GED?	No	1
15a	Are you currently employed?	No	1
15b	How many jobs have you lost in the past 12 months?	>3, none	1
16a	Have you experienced any of the following in the past 6 months?		
16b		Arrest	1
16c		Prostitution	1
16d		Domestic Violence	1
16f		Sex Offense	1
17	Who can you count on for financial support? (if you had a small bill that needed to be paid and you were out of money for the month)	<1 person	1

Chronic Max = 33; Non-chronic Max = 31

Family Housing Prioritization Tool

		Answer	Score
1a	Chronic?	Yes/No/Logic	5
1b	Do you or anyone in your household have a disabling condition? (only show if chronic = no)	Yes	1
1c	Have you been homeless before? (only show if chronic = no)	Yes	1
1d	How many times have you been homeless in the past 3 years? (only show if chronic = no)	>4	1
2	Have you received rental and/or voucher assistance from any agency in the past 5 years?	Yes	4
3a	Have you ever held a lease in your own name?	No	4
3b	Have you ever paid rent on your own for at least a year?	No	2
3c	How long ago was that?	3+	4
4	Do any children in your household receive disability income?	Yes	1
5	What is your total household monthly cash income?	<\$800/month	1
6a	Are you or any adults in your household currently employed?	No	2
6b	As an adult, when was the last time you worked full-time?	0-6 mos	0
		6-12 mos	1
		12+ mos	2
		Never	3
6c	How long were you at the job where you worked full-time?	0-6 mos	3
		6-12 mos	2
		12+ mos	1
6d	As an adult, when was the last time you worked part-time?	0-6 mos	1
		6-12 mos	2
		12+ mos	3
6e	How long were you at the job where you worked part-time?	0-6 mos	3
		6-12 mos	2
		12+ mos	1
7	Do you have a high school diploma or GED?	No	1
8a	Has a doctor or professional ever recommended mental health services? (Assessor - select yes if symptoms of mental illness are observed)	Yes	1
8b	Are you currently receiving services for any of those?	No	5
9	How many times in the past year have you accessed medical services in the ER?	1-4	1
		5+	2
10	Are you or in any adult in your household currently pregnant?	Yes	1
11a	Do you have any minor children currently living with you?	Yes/No	
11b	If so, what are their ages?	0-5	3
		6-12	2
		13+	1
12a	Do you currently have an open CPS case?	Yes	1
12b	Have you had an open CPS case in the past 2 years?	Yes	1
12c	Do you have any children currently in CPS or someone else's custody?	Yes	1
13a	Do you or any of the adults in your household currently use drugs or alcohol?	Yes/No	0
13b	How many times per week are drugs or alcohol use?	>3	1
14a	Have you been arrested in the past 6 months?	Yes	1
14b	Have you been incarcerated for longer than 90 days in the past year?	Yes	1
15	Have you experienced domestic violence in the pasty 60 days?	Yes	1
16	Who can you count on for financial support? (If you had a small bill that needed to be paid and you were out of money for the month, is there anyone that usually helps you out?)	<1 person	1

0-12 = Income/Diverson
13-25 = RRH
26-38 = RRH+
39-56 = PSH

Chronic Max = 57
Non-chronic Max = 56

Young Adult Housing Prioritization Tool

		Answer	Score	
1a	Chronic?	Yes/No/Logic	5	
1b	Have you been homeless before? (only show if chronic = no)	Yes	1	
1c	How many times have you been homeless in the past 3 years? (only show if chronic = no)	>4	1	
2a	How many jobs have you lost in the past 12 months	>3, none	1	
2b	Are you working a job where someone else controls your money?	Yes	1	
3	Do you have a Diploma or GED?	No	1	
4a	Do you have any children that you're responsible for?	Yes	1	
4b	Do you have an open CPS case?	Yes	1	
4c	Have you had an open CPS case in the past 2 years?	Yes	1	
5	Are you currently pregnant?	Yes	1	
6	Were you abused as a child (physically, emotionally, or sexually)?	Yes	1	
7	Have you ever been in CPS custody?	Yes	1	
8	Have you ever been kicked out of or felt unsafe at home because you came out as LGBT?	Yes	1	
9	Have you ever left home because of violence between family members or to you?	Yes	1	
10a	Are you being forced to do things that make you feel uncomfortable?	Yes	1	
10b	Have you ever traded sex for anything (like food, shelter, money)?	Yes	1	
11	Do you have any mental health or brain issues that might make it hard for you to live on your own?	Yes	2	
12a	Has a doctor or professional ever recommended mental health services?	Yes	1	
12b	Are you currently receiving any of those services	No	1	
13a	Have you ever thought about hurting yourself?	Yes	0	
13b	Have you ever tried to kill yourself?	Yes	1	
14a	Do you use alcohol or drugs?	Yes/No	0	
14b		Marijuana	Yes	0
		Alcohol	Yes	0
		KUSH, spice, K2, or any other synthetic marijuana	Yes	1
		Meth, crack, cocaine, heroin	Yes	1
14c	Has your drug or alcohol use ever resulted in the any of the following:			
		Arrest	1	
		Living in a shelter or on the street	1	
		Prostitution	1	
		Theft	1	
		Domestic Violence	1	
		Loss of employment	1	
15a	Have your ever been in juvenile detention?	Yes	1	
15b	Have many days have you been in jail or prison in the past 2 years?	Insert #	0	
16	How many adults can you count on for emotional support? (On the days when you are so down and you don't know what to do is there an adult that you visit with or call?)	<1 person	1	
17	How many adults can you count on for financial support? (If you had a small bill that needed to paid and you were out of money for the month is there an adult that will usually help you out?)	<1 person	1	

Chronic Max = 34

Non-chronic Max = 31



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Coordinated Access System

Memorandum of Understanding (MOU) between the **Coalition for the Homeless Houston/Harris County (CFTH)**, and _____

PURPOSE

The Department of Housing and Urban Development (HUD)'s new regulations requires that all Continuums of Care (CoCs) develop and implement a coordinated access and assessment system for all CoC funded programs. A Coordinated Access System (CAS) is a *centralized or coordinated process designed to coordinate program participant intake, coordinate assessments, and coordinate the provision of referrals to housing*. The CAS will enable clients to move quickly through the system and be matched to the best intervention strategy that will permanently and effectively end their homelessness. The CAS will also reduce duplication of efforts, reduce returns to homelessness, and assist with ending homelessness.

In order to accomplish effective coordination with mainstream and homeless services, formal agreements dictating client eligibility, intake, service provision expectations, and staffing are being developed with mainstream and homeless service providers on behalf of the system of homeless providers. The agreements will also ensure that all providers are using the system in an open, transparent, and consistent way.

GENERAL PROVISIONS

(CFTH) will:

- 1) Serve as the Lead Agency in the Continuum of Care (COC);
- 2) Maintain the Homeless Management Information System (HMIS), including the CAS Workflow;
- 3) Coordinate the system of homeless and homelessness prevention services in the Harris, Fort Bend, and Montgomery County continuum area;
- 4) Provide lead staff to guide the CAS Workgroup and any relevant subgroups;
- 5) Coordinate, integrate, and leverage resources to maximize impact of services for individuals who are experiencing homelessness;
- 6) Develop and implement policies and procedures on how the CAS will be operated;
- 7) Provide training to all staff dedicated to the CAS including Housing Assessors and Navigators;
- 8) Provide guidance and supervision to CAS staff as it relates specifically to the CAS;
- 9) Evaluate performance and progress of the CAS and make adjustments as necessary.
- 10) Oversee the Case Conferences and Appeals process as necessary.
- 11) Provide branding materials (shirts, business cards, etc.) for the use of CAS staff upon start-up only; and



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the media in regards to CAS.

12)

Approve any press releases and communication with

will:

- 1) Serve as a member of the CAS Workgroup for the purpose of engaging in a joint venture to develop and implement an array of integrated services designed to stabilize housing for people who are literally homeless or imminently at-risk of homelessness;
- 2) Provide XX primary staff who, as members of the _____ Team and supervised by a _____ manager, will serve as CA Housing Assessors;
- 3) Agree to assess and refer clients for services through the CAS only;
- 4) Enter and maintain timely client data in HMIS;
- 5) Name a designated staff contact for the CAS.
- 6) Provide all necessary supplies and technology equipment at Assessment Hub location;
- 7) Ensure all CAS staff wear and use materials related to CAS (shirts, business cards, etc.); and
- 8) Coordinate and receive approval for and press releases and communication with the media in regards to the CAS.

CONFIDENTIALITY

All parties agree that they shall be bound by and shall abide by all applicable Federal or State statutes or regulations pertaining to the confidentiality of client records or information, including volunteers. The parties shall not use or disclose any information about a recipient of the services provided under this agreement for any purpose connected with the parties' contract responsibilities, except with the written consent of such recipient, recipient's attorney, or recipient's parent or guardian.

EQUAL OPPORTUNITY

CFTH, and _____ mutually agree to be bound by and abide by all applicable anti-discrimination statutes, regulations, policies, and procedures as may be applicable under any Federal or State contracts, statutes, or regulations, or otherwise as presently or hereinafter adopted by the agency.

TERMS OF AGREEMENT

This MOU shall be effective upon adoption by each signatory agency and entity.



COALITION
FOR THE
HOMELESS

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This MOU shall be reviewed and revised as needed to further implementation of strategic and long-term goals of the project.

This MOU can be expanded, modified, or amended, as needed, at any time by the consent of all agencies.

This MOU shall be in effect until the end of this project unless terminated by mutual agreement in writing prior to the project end date.

By: _____

Name: _____

Title: _____

Date: _____

COALITION FOR THE HOMELESS OF HOUSTON/HARRIS COUNTY

By: _____

Name: _____

Title: _____

Date: _____