



uniting central alabama to end homelessness

Coordinated Entry Policies and Procedures

Revised April 2022

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It is important to note that this Policy and Procedure manual is ever-changing as we encounter new client challenges, new agency challenges, and new HUD-related challenges.

Coordinated Entry Version Breakdown

Version	Date Released	Key Changes
1.0	February 1, 2018	N/A
2.0	October 4, 2018	<ul style="list-style-type: none"> - Updated Coordinated Entry Priority Ranking - Voted to place higher priority on households with children vs households without children - Voted to place higher priority on individuals that possess documentation of chronic status vs individuals with no documentation of chronic status
3.0	February 6, 2020	<ul style="list-style-type: none"> - Updated Coordinated Entry Priority Ranking - Voted to make chronic disability documentation a requirement before an individual is referred to PSH program - Voted to require child custody documentation - Voted to no longer conduct coordinated assessments for individuals currently residing in a 90-day program
4.0	May 7, 2020	<ul style="list-style-type: none"> - Updated Minimum/Maximum Standards for ESG Assistance - Voted to extend the minimum and maximum financial assistance standard for ESG HP/RRH
5.0	December 3, 2020	<ul style="list-style-type: none"> - Added ESG-CV HP & RRH Assistance - Updated Coordinated Assessment to Coordinated Entry
6.0	November 4, 2021	<ul style="list-style-type: none"> - Updated Nondiscrimination Statement
7.0	April 26, 2022	<ul style="list-style-type: none"> - Added Overseeing Housing Placement Specialist - Updated Third Party Verification Form and Instruction Sheet

Overview of Coordinated Entry

Coordinated Entry (CE) refers to the practice of conducting in-depth assessments of needs and barriers of people experiencing homelessness and people at imminent risk of homelessness at the earliest point possible. The goals are to: (1) divert people from homelessness whenever possible; (2) provide prevention services when indicated; (3) objectively match people with the type, level, and duration of services that best meet their needs and; (4) to house the most vulnerable populations - including those experiencing chronic homelessness, Veterans, families, and youth.

The AL-500 Continuum of Care (CoC) Board of Directors designated One Roof with the authority to manage and oversee the Coordinated Entry process. The AL-500 CoC geographic service area includes Jefferson, Shelby, and Saint Clair Counties.

Benefits of a Coordinated Entry System

- Coordinated Entry creates easier access to services, improves and streamlines referrals, and prioritizes and targets more effectively.
- Coordinated Entry helps move people through the system, reduces duplication of efforts, serves clients effectively, assists with ending chronic homelessness, better matches services to client's needs, and reduces returns to homelessness.
- Through Coordinated Entry, a housing and prioritization assessment is administered that determines appropriate interventions and priority placement for households. Those with more urgent and immediate needs will be prioritized for placement over households that have less intensive needs.

Guiding Principles of Coordinated Entry

- The Coordinated Entry procedures incorporate mechanisms for determining whether potential participants meet specific requirements of the projects for which they are prioritized and to which they are referred.
- Coordinated Entry coordinates participant intake, assessment, and referrals.
- Coordinated Entry's process and operating hours do not delay access to emergency services such as emergency shelter, domestic violence services, or street outreach services. Outside of Coordinated Entry's operating hours, participants can access emergency services by directly calling or presenting at agencies who provide those services. After emergency services are provided, those agencies then connect participants to Coordinated Entry.
- All Coordinated Entry access points and methods offer the same assessment approach and referrals using uniform decision-making processes.
- The Coordinated Entry process is completed over the phone, but walk-ins are also welcome.
- Shelter and street outreach activities are conducted on a daily basis with shelters, day centers, and Street Outreach teams.
- All people in AL-500 CoC's geographic area, including people experiencing chronic homelessness, Veterans, families, youth, and survivors of domestic violence, have fair and equal access to the Coordinated Entry process, regardless of where or how they present for services. The AL-500 CoC geographic service area includes Jefferson, Shelby, and Saint Clair Counties.
- Information gathered through Coordinated Entry is used to guide homeless assistance planning and system change efforts in the community.
- Coordinated Entry follows the Housing First model to eliminate screening out people due to perceived barriers to housing services, including but not limited to, too little or no income, active or a history of substance abuse, domestic violence history, resistance to receiving services, the type or extent of a

disability-related services or supports that are needed, history of evictions or poor credit, lease violations or a history of not being a leaseholder, or criminal record.

How One Roof's Coordinated Entry Works

Coordinated Entry (CE) provides streamlined access to the homeless services system thereby allowing households facing housing loss to quickly access the services they need and for which they are eligible without having to call multiple social service programs.

- Client may access Coordinated Entry via phone or in person at the One Roof office which is centrally located in Birmingham, Alabama. Clients may also access Coordinated Entry through street outreach and shelter outreach efforts.
- The CE team will complete prescreening questions about a client's homeless status and if the client is fleeing a domestic violence situation.
- Using a client's answers, a CE team member can complete the appropriate assessment.
 - If the client is in need of homeless prevention services, the CE Homeless Prevention Prescreening will be completed to determine if the client is eligible for homeless prevention services. The client will be provided with referrals to organizations in the community who provide assistance relating to the particular situation the client presents.
 - If the client is in need of housing or emergency services, the CE Diversion Triage will be completed. Clients will be immediately referred to an appropriate emergency shelter or street outreach resources.
 - If the client falls within a prioritized population of chronically homeless, Veteran, families, or youth, a full coordinated assessment and vulnerability index will be completed. The client will then be placed on the centralized priority list / waiting list.
 - If the client is not a prioritized population, a diversion entry will be created in PromisSE (HMIS), and the client will be provided with referrals to resources in the community that provide assistance relating to the particular situation the client presents.
 - If the client is staying in a place not meant for habitation, the client will be connected with the CE Outreach Team to verify the client's homeless status. The Outreach Team will also complete diversion triage to evaluate the most appropriate assessment and resources for the client.
- Prior to completing the CE Homeless Prevention Prescreening, CE Diversion Triage, or a full coordinated assessment, a CE team member will fully explain about the referral process to One Roof's partner agencies. All clients will be provided information and referrals to resources in the community for immediate emergency services as well as other housing resources outside of the Continuum of Care.
- After the assessment is complete, the CE Team Lead will place the client on the priority list based on the client's vulnerability score, set by the VI-SPDAT 2.0, and the priority ranking, based on the HUD Notice CPD-16-11. (see Coordinated Entry Priority Ranking section below)
- All Coordinated Entry partner agencies must notify Coordinated Entry by phone or email when there is availability in their program.
- When there is a program availability, the CE Team Lead will check the priority list and make an appropriate referral for the next eligible client at the top of the priority list. This referral is made electronically through PromisSE, the local Homeless Management Information System (HMIS).
- Upon receipt, the Coordinated Entry partner agency will follow up with the client. The agency will accept, cancel, or decline the referral after meeting with the client to discuss the program.
- Using the notes section or case plan in PromisSE, the agency will notify Coordinated Entry about the meeting and the status of the housing process.
- If the client and agency accept the referral, then the client will work directly with the agency towards the housing service and the client's coordinated assessment entry will be closed.

- If the client and/or agency declines or cancels the referral, the agency will notify Coordinated Entry with an explanation, and the client will maintain their place on the priority / waiting list until the next housing placement is available. A client's refusal of housing or service options does not limit them from accessing other forms of assistance or future Coordinated Entry housing and service referrals.

Action Steps for Agencies Participating in the CE Process

1. Become a full pledge One Roof member of the Continuum of Care.
2. Compose program eligibility for assistance and submit to Coordinated Entry.
3. Establish an Agency point of contact for Coordinated Entry to directly refer clients as appropriate.
4. Provide clear communication about resources available to the community.

Nondiscrimination Statement for Participating Agencies

The One Roof and all CoC and ESG Funded Programs will comply with all HUD (as specified in HUD CPD-17-01 Section 1(d)) nondiscrimination requirements, including, but not limited to:

- The Fair Housing Act prohibits discriminatory housing practices based on race, color, religion, sex, national origin, disability, or familial status;
- Section 504 of the Rehabilitation Act prohibits discrimination on the basis of disability under any program or activity receiving Federal financial assistance;
- Title II of the Americans with Disabilities Act prohibits public entities, which includes State and local governments, and special purpose districts, from discriminating against individuals with disabilities in all their services, programs, and activities, which include housing, and housing-related services such as housing search and referral assistance;
- Title VI of the Civil Rights Act prohibits discrimination since race, color, or national origin under any program or activity receiving Federal financial assistance;
- Title III of the Americans with Disabilities Act prohibits private entities that own, lease, and operate places of public accommodation, which include shelters, social service establishments, and other public accommodations providing housing, from discriminating based on disability;
- And, HUD's Equal Access Final Rule (24 CFR 5.105(a)(2)) prohibits discriminatory eligibility determinations in HUD-assisted or HUD-insured housing programs based on actual or perceived sexual orientation, gender identity, or marital status, including any projects funded by the CoC Program, ESG Program, and HOPWA Program.

One Roof is an Equal Opportunity Employer. One Roof supports and is committed to the principle of non-discrimination. It is our policy to hire, promote, train and to carry out all employment and service decisions without regard to race, color, religion, age, gender, perceived sexual orientation, national origin or ancestry, political affiliation or belief, Veteran's status, geographic location, marital status, or status as a qualified individual with a disability, and in accordance with applicable state and federal statutes, executive orders and regulations. The Coordinated Entry referral process is informed by Federal, State, and local Fair Housing laws and regulations and ensures participants are not "steered" toward any particular housing facility or neighborhood because of race, color, national origin, religion, sex, disability, or the presence of children.

CoC- and ESG-funded providers shall not discriminate on the basis of any protected characteristic, including race, ethnicity, color, national origin, language, ancestry, religion, sex, familial status, age, gender identity, LGBTQ+ (lesbian, gay, bisexual, transgender, queer/questioning, etc) status, marital status, domestic or sexual violence victim status, or sensory, mental, or physical disability.

This means that One Roof CoC and partner agencies and their staffs, volunteers, and contractors will not:

- Deny any person facilities, services, financial aid, or other benefits.
- Provide services that are different, or are provided in a different form, from that provided to others under the program or activity.
- Subject any person to segregated or separate treatment in any facility or in any matter or process related to receipt of any service or benefit under the program or activity.
- Restrict in any way access to, or the enjoyment of any advantage or privilege enjoyed by others in connection with, facilities, services, financial aid, or other benefits under the program or activity.
- Treat any person differently from others in determining whether the person satisfies any admission, enrollment, eligibility, membership, or other requirement or condition, which individuals must meet to be provided shelter, services, or other benefits provided under the program or activity.
- Deny meaningful access to persons with limited English proficiency, to include translated documents, notice of participant’s rights, grievance forms, and other materials vital for program access or fail to work with language services or an interpreter to assist persons who speak an alternate primary language other than the staff persons and need assistance communicating.

One Roof CoC partner agencies shall make housing available to all otherwise eligible individuals regardless of actual or perceived sexual orientation, gender identity, or marital status. Agencies will ensure equal access to programs for all individuals and their families; provide housing, services, and/or accommodations in accordance with a clients’ gender identity; and determine eligibility without regard to actual or perceived sexual orientation, gender identity, or marital status.

Coordinated Entry Assessment Tool

One Roof Coordinated Entry (CE) utilizes the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) Version 2 as the standardized assessment tool to measure homeless individuals’ and homeless families’ vulnerability to housing instability. The VI-SPDAT is a nationally recognized, evidence-based, best practice tool for measuring vulnerabilities and prioritizing services for individuals experiencing homelessness or at-risk of experiencing homelessness. For youth ages 18-24 experiencing homelessness, One Roof utilizes the Transition Age Youth – Vulnerability Index – Service Prioritization Decision Assistance Tool (TAY-VI-SPDAT). For family households experiencing homelessness, One Roof utilizes the Vulnerability Index – Family Service Prioritization Decision Assistance Tool (VI-FSPDAT). For ESG Homeless Prevention programs, the Continuum of Care has created its own CE Homeless Prevention Prescreening tool to help prioritize assistance for at-risk individuals and families eligible for these projects. This was developed in coordination with ESG recipients and subrecipients to allow for coordinated screening, assessment, and referrals for ESG projects consistent with the written standards for administering ESG assistance.

In accordance to HUD CPD-17-01, individuals may choose what information to disclose in the assessment. Refusal to answer questions will not limit their access to other forms of assistance. The assessment cannot require disclosure of specific disabilities or diagnosis. Specific diagnosis or disability information may only be obtained for purposes of determining program eligibility to make appropriate referrals.

Recommendations for housing programs are based on the results of the assessment:

<i>Score:</i>	<i>Recommendation:</i>
0-3:	no housing intervention
4-7:	an assessment for Rapid Re-Housing
8+:	an assessment for Permanent Supportive Housing/Housing First

Per the 2015 NOFA application, all CoC funded programs agreed to prioritize chronically homeless individuals and families for permanent housing. Therefore, if a chronically homeless individual scores an 8 or above on the VI-SPDAT and a PSH bed is not available, Coordinated Entry will still refer the individual/household to an appropriate RRH program.

Coordinated Entry Priority Ranking

For all CoC and ESG assistance, the One Roof Continuum of Care has prioritized the following populations: chronically homeless, Veterans, families, and youth age 18 – 24. The CoC has also prioritized chronically homeless individuals and families for permanent housing. Once a client completes a full coordinated assessment, they are prioritized based on the criteria set forth by HUD Notice CPD-16-011 (outlined below) and their VI-SPDAT score. If one or more individuals/families fall into the same prioritized group and have the same VI-SPDAT score and rank, the CE team will utilize the CoC’s sub-priority groups (outlined below) to determine which individual/family will receive the next available and appropriate referral to housing.

Prioritizing Persons Experiencing Chronic Homelessness

Originally approved by One Roof CoC June 10, 2015, and updated based on the HUD Notice CPD-16-011

- 5 - Chronic person + Disability + 12 months or more of homelessness (continuously or on at least four occasions in the last three years where those occasions cumulatively total at least 12 months)
- 4- Literal Homeless + Disability + 12 months or more of homelessness but fewer than 4 episodes
- 3 - Literal Homeless + Disability + less than 12 months of homelessness
- 2 - Literal Homeless without Disability + Any length of homelessness
- 1 - HUD Transitional Housing + Literal Homeless prior to entry into TH OR TH+ DV Victim (not literal homeless prior)
- 0 – Category 2 Homeless

The categories of prioritized homelessness (as listed above) provide a numerical ranking system for individuals/families that complete a coordinated assessment – known as a referral ranking.

Priority Subdivisions for Chronically Homeless, Veterans, Families and Youth

Voted and Approved by One Roof Continuum of Care on October 4, 2018

Coordinated Entry Priority Criteria Table

Priority Population	Priority Subdivisions	Priority Ranking
Chronically Homeless	<ol style="list-style-type: none"> 1. Chronic disability documentation* 2. Exposure to elements (sleeping outside) 3. Chronically Homeless families with children 	<ol style="list-style-type: none"> 1. Referral Ranking (5 - chronic status, as defined above) 2. VI-SPDAT Score (highest to lowest) 3. Date of assessment (first to most recent)
Veterans	<ol style="list-style-type: none"> 1. Veteran Families with children 2. Exposure to elements (sleeping outside) 	<ol style="list-style-type: none"> 1. Referral Ranking (highest to lowest) 2. VI-SPDAT Score (highest to lowest) 3. Date of assessment (first to most recent)
Families	<ol style="list-style-type: none"> 1. Exposure to elements (sleeping outside) 2. Pregnancy and/or minor children 3. Age of family (parent(s) under 24 or over 55) 	<ol style="list-style-type: none"> 1. Referral Ranking (highest to lowest) 2. VI-SPDAT for families with children (highest to lowest) 3. Date of assessment (first to most recent)

Youth	<ol style="list-style-type: none"> 1. Exposure to elements (sleeping outside) 2. Youngest youth 3. Youngest youth pregnant and/or with minor children 	<ol style="list-style-type: none"> 1. Referral Ranking (highest to lowest) 2. TAY-VI-SPDAT Score (highest to lowest) 3. Date of assessment (first to most recent)
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In accordance to HUD Notice CPD-17-01, data from the assessment may not be used to prioritize households for housing and services on a protected basis, such as based on a diagnosis or disability. If two or more homeless households within the same geographic area are identically prioritized for referral to the next available unit, the CE Team Lead will refer the household that first presented for assistance to the next available unit.

Priority ranking is based on the answers the client provides during the assessment. The Corresponding Agency will verify eligibility and documentation. Both Corresponding Agencies and Coordinated Entry should follow the order of priority above while also considering the goals and any identified target populations served by the project for the client referral.

*See Appendix: C Disability Documentation Request for more details.

Coordinated Entry Centralized Housing Priority/Waiting List

One Roof maintains a single prioritized list for referrals into CoC funded programs, which is created through the Coordinated Entry process and CoC Priority Ranking. This list is updated frequently to reflect most up-to-date data and is informed by the CoC's street outreach initiatives. Data collected for clients on the centralized waiting list is self-reported information from the client and information gathered through PromisSE and street outreach. It is the responsibility of the Corresponding Agency to gather and confirm documentation related to homeless and/or disability status upon a client's intake and entry into their program.

Coordinated Entry will conduct 45 day follow ups for clients remaining on the waiting list. Clients who are unable to be contacted and/or deemed inactive will be exited from the waiting list and their coordinated assessment entry will be closed. Clients are inactive if there are no service entries in PromisSE within the last 45 days. Clients who self-resolve their homeless situation will be exited from the waiting list and their coordinated assessment entry will be closed. A client's coordinated assessment entry will also be closed if there is a case note, from a partner agency, indicating that a client is currently housed.

Provision of Care through CoC Funded Projects

All individuals and families entering a HUD CoC-funded unit or bed must first go through Coordinated Entry and receive a housing referral for that project.

Permanent Supportive Housing / Permanent Housing

All permanent housing projects will be prioritized for individuals and families experiencing chronic homelessness. To receive Permanent Supportive Housing an individual or family must meet the HUD definition for chronic homelessness.

Transitional Housing

All transitional housing will operate with low-barriers, work to quickly move people into permanent housing, not require participation in supportive services, and, for transitional housing projects, not require any preconditions for moving into transitional housing (e.g., sobriety or minimum income threshold).

Rapid ReHousing

To ensure that CoC Rapid ReHousing funding is utilized in the most effective way to appropriately assist clients and support the community's need, the CoC established standards for the length of assistance.

Minimum length of assistance: 6 months

Maximum length of assistance: 18 months

We are required to have written standards to provide guidance for determining what percentage or amount of rent each program participant must pay while receiving Rapid ReHousing assistance. We have included an example below from the CoC partner, Housing Assistance Fund, of their 2018 Rapid ReHousing assistance breakdown for guidance.

The goal of all CoC Rapid ReHousing Programs is housing stability. Each Rapid ReHousing participant will work towards assuming 100% of both their monthly rent and utilities. With this goal in mind each participant will need to assume portions of the rent throughout their time on the program. The following is an example of a step-down process though all participants may not require the same length of services. At minimum, each portion adjustment is to occur at the time the client's 90-day re-assessment is conducted.

Timeframe	Percentage of Total Rent
0-3 months/1 st 90 days	0%
3 to 6 months/ 2 nd 90 days	10% to 25%
6 to 9 months/ 3 rd 90 days	30% to 50%
9 to 12 months/ 4 th 90 days	50% to 75%
12 to 15 months/ 5 th 90 days	80% to 100%

Provision of Care for ESG Funded Projects

All individuals and families receiving Rapid Re-housing or Homeless Prevention assistance through an ESG-funded project must go through Coordinated Entry (CE) and receive a service referral for that project.

ESG Homeless Prevention

Using the CE Homeless Prescreening Tool, CE team members will assess a client's vulnerability to losing their current housing and determine whether a client is prioritized for ESG homeless prevention assistance.

Priority Criteria for ESG Homeless Prevention Assistance:

- 1.) The household has experienced homelessness in the last 36 months (3 years)

OR

- 2.) The household meets at least **two** of the following local criteria:
 - Veteran in household (Veteran cannot be eligible for other Veteran specific assistance)
 - Household consists of all Unaccompanied Youth (18-24) or is headed by an Unaccompanied Youth
 - Household is a Family and/or is pregnant
 - Household has experienced an economic hardship in last 90 days (e.g., loss or reduction of income, medical emergency, etc.)

- There must be a documentable reduction of 40% of household income in the past 90 days.
- There has been a fire or natural disaster in the past 90 days resulting in loss of housing for a client currently in CoC or ESG funded housing AND no other supports are available.

If there is a 5-day period during which no callers meet either Priority 1 or Priority 2, then callers who fall into at least one (1) of the listed Priorities will be screened and referred to ESG Homeless Prevention programs.

Partner agencies who receive ESG Homeless Prevention funding for the sole purpose of supporting the tenancy of clients who are also enrolled in a CoC-funded Rapid ReHousing project may provide that assistance without requiring said client to go through Coordinated Entry again.

ESG Rapid ReHousing

Referrals to ESG Rapid Re-Housing projects will originate from the CoC's Centralized Priority / Waiting List. Sub-recipients and sub-sub-recipients cannot serve or provide assistance to households who were not referred by Coordinated Entry.

Minimum / Maximum Standards for ESG Assistance

To ensure that ESG funding is utilized in the most effective way to appropriately assist clients and support the community's need, the CoC established standards for the length of assistance and amount of ESG assistance that can be provided to each client.

Minimum length of assistance: 2 months	Minimum amount per client: \$1,000
Maximum length of assistance: 18 months	Maximum amount per client: \$6,000

ESG-CV HP & RRH Assistance

Voted and Approved by One Roof Continuum of Care on December 3, 2020

ESG-CV assistance are limited funds used to prevent, prepare for, and respond to coronavirus, among individuals and families who are homeless or receiving homeless assistance and to support additional homeless assistance and homelessness prevention activities to mitigate the impacts created by coronavirus. All individuals and families receiving Rapid Re-housing or Homeless Prevention assistance through an ESG-CV project must go through Coordinated Entry and receive a service referral for that project.

Priority Criteria for ESG-CV Homeless Prevention Assistance:

- 1.) The household has experienced hardship and has become homeless or is at-risk of becoming homeless because of the COVID-19 pandemic;
AND
- 2.) The household meets one or more of the following criteria:
 - Household has previously experienced homelessness
 - Household member is a Veteran (Veteran cannot be eligible for other Veteran specific assistance)
 - Household consists of all Unaccompanied Youth (18-24) or head of household is an Unaccompanied Youth
 - Household has dependent children and/or household member is pregnant
 - Household has experienced an economic hardship because of COVID-19 (e.g., loss or reduction of income, medical emergency, etc.)

Partner agencies who receive ESG-CV Homeless Prevention funding for the purpose of supporting the tenancy of clients who are also enrolled in a CoC-funded Rapid ReHousing project may provide that assistance without requiring said client to go through Coordinated Entry again. In these cases, the household's need for ESG-CV assistance must be directly related to COVID-19 (loss or reduction of income, etc.).

ESG-CV Rapid ReHousing

Referrals to ESG-CV Rapid ReHousing projects will originate from the CoC's Centralized Priority / Waiting List. Sub-recipients and sub-sub-recipients cannot serve or provide assistance to households who were not referred by Coordinated Entry.

Minimum / Maximum Standards for ESG-CV HP & RRH Assistance

To ensure that ESG-CV funding is utilized in the most effective way to appropriately assist clients and support the community's need, the CoC established standards for the length of assistance and amount of ESG-CV assistance that can be provided to each client.

Minimum length of assistance: 2 months

Minimum amount per client: \$1,000

Maximum length of assistance: 12 months

Maximum amount per client: \$8,000

It is possible to waive the maximum amount of assistance that can be provided to each client/household with the approval of the Continuum of Care. Sub-recipients and sub-sub-recipients can request this waiver by emailing gordon@onroofonline.org.

Access Points

One Roof will serve as the centralized access point for Coordinated Entry (CE). Individuals and families can access Coordinated Entry via phone, in-person, or through street outreach efforts. If a client is unwilling or unable to call and/or is unwilling or unable to come to the One Roof office, an Outreach Specialist will meet a client at a neutral, safe location.

The Jefferson County Office of Human-Community Services and Economic Development and Shelby County Emergency Services will serve as remote access points for ESG projects located in Jefferson and Shelby counties respectively. Access points will utilize the same Coordinated Entry Policies and Procedures outlined in this document.

All access points will provide connections to mainstream and community-based emergency assistance services such as food assistance programs and income assistance.

Marketing materials will be distributed to referral agencies such as United Way 211, Crisis Center, etc. and procedures on referral process will be agreed upon by outside agencies.

Assessor Training

One Roof will provide on-going training and support for participating staff at organizations serving as an access point for the Coordinated Entry (CE) process or otherwise conduct assessments. Mandatory refresher trainings for staff will occur at least annually, and the written materials and protocols will be distributed.

The purpose of this annual training is to provide all staff administering assessments with access to materials that clearly describe the methods by which assessments are to be conducted with fidelity to the Coordinated Entry process, including its policies and procedures, requirements for use of assessment information to determine prioritization, and criteria for uniform decision-making and referrals. It will also include how to conduct a trauma-informed assessment. All CE staff are trained in 6 Core Competencies:

- 1.) Assertive Engagement – approaches client engagement from the perspective that clients are willing to make changes, and that it is the responsibility of caseworkers and support staff to adapt their engagement to create an environment that is conducive to change.
- 2.) Client-Centered Approach – focuses on the needs and abilities of clients to guide service work practice. Client-Centered Approach ensures that interventions are collaborative and individualized. It seeks to empower the individual to direct the intervention and assess what resources they need.
- 3.) Critical Time Intervention (CTI) – is a time-limited evidence-based practice that mobilizes support for society’s most vulnerable individuals during periods of transition. It facilitates community integration and continuity of care by ensuring that a person has enduring ties to their community and support systems during these critical periods.
- 4.) Harm Reduction – refers to policies, programs and practices aimed at reducing the risks and negative effects associated with substance use and addictive behaviors for the individual, the community and society as a whole.
- 5.) Motivational Interviewing – an evidence-based practice in working with clients that has proven to be successful. In this approach, the service provider allows the client to direct the change rather than telling the client what they need to do. This approach is about having a conversation about change.
- 6.) Trauma-Informed Care – is an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma. Trauma-Informed Care also emphasizes physical, psychological and emotional safety for both consumers and providers, and helps survivors rebuild a sense of control and empowerment.

Additional training will be provided to promote cultural and linguistic competent practices, including proper use of pronouns and respect for religious views.

Marketing

The Coordinated Entry (CE) marketing plan is to reach and provide material to all organizations who serve people experiencing homelessness but are not members of the CoC.

This plan is divided into urban areas and rural areas. In the urban areas with populations greater than 20,000 residents (Birmingham, Hoover, Bessemer, Alabaster, Homewood, Pelham, Trussville, Center Point, Hueytown, Leeds, Irondale, Moody, Fairfield, Pleasant Grove), One Roof will use the following marketing tactics:

- Develop info sheets with location of all shelters and distribute via public libraries, shelters, faith communities, and parks to encourage them to call or visit Coordinated Entry.
- Distribute backpacks to chronically homeless individuals who are living on the streets after they complete a coordinated assessment. The backpacks include toiletries, socks, non-perishable food, first-aid kit, map and information on shelters, hand sanitizer, and other items needed to survive on the street.
- Develop postcards/business cards for homeless shelters and agencies to direct potential clients on how to complete the Coordinated Entry process.
- Train first responders to direct people they encounter who are experiencing homelessness to a shelter.

In rural areas without shelters or services, One Roof will network with faith communities, first responders, and elected officials to help identify people experiencing homelessness in the area.

Information to be included in marketing materials:

- One Roof logo, address and phone number

- One Roof web site
- Shelter information
- Definition of Chronically Homeless
- Where to receive emergency assistance for:
 - Food
 - Shelter
 - Clothes, Blankets, etc.
 - Legal
 - Medical

Special Populations Outreach

To reach targeted special populations One Roof will distribute materials to organizations/agencies that serve these populations. The frontline staff of these organizations will receive information on the definition of chronically homeless and how to refer the client to Coordinated Entry.

Chronically Homeless

- Firehouse
- First Light
- Salvation Army
- Pathways
- Church of the Reconciler
- Faith Chapel Care Center

Veterans

- VA Hospital
- The Phoenix Clinic
- SSVF and other Veteran specific service providers
- Veteran Coordination Group

Families

- YWCA Interfaith
- Family Promise
- Faith Communities *

Youth

- Hope House / Family Connection
- Youth Towers
- Children's Aid Society
- The Magic City Acceptance Center (a queer youth drop in center)
- Gateway (an organization that serves at risk youth)
- Children's Hospital (offers medical services to transgender youth)
- City of Birmingham Department of Youth Services

Victims of Domestic Violence

- YWCA of Central Alabama Domestic Violence Shelter
- Safe House of Shelby County
- One Place Metro Alabama Family Justice Center
- Law Enforcement

* To effectively work with various faith communities One Roof will contact the state faith organizations (Alabama Baptist Association, etc.) and offer materials and information on the most effective way faith communities can help people experiencing homelessness. Many faith communities in the region provide food, clothing, and meals to people experiencing homelessness near their church or in the public parks. When they are providing those services, we will encourage them to direct people to Coordinated Entry or a local shelter.

Overviewing Coordinated Entry Outreach

The One Roof Coordinated Entry (CE) Outreach team is a group comprised of four Street Outreach Specialists and two Peer Outreach Specialists. Each CE Outreach Specialist will identify and build rapport with homeless individuals and families living on the streets or in locations not meant for human habitation (e.g. street, car, park, abandoned building, under bridge, bus station, airport, or campground). Outreach performs targeted street outreach to specific populations including youth, families, Veterans, and chronically homeless. The end goal of interacting with people experiencing unsheltered homelessness is to connect them to partner agencies and resources that they would otherwise have a hard time accessing in order to help them transition out of homelessness.

One Roof's CE Outreach Team's mission is to identify, engage, and assist the most vulnerable unsheltered clients in gaining stable, safe, and affordable housing; collaborate with partner agencies to build Continuum of Care capacity; and advocate for just economic, social, and health policies that affect our clients' ability to thrive and live within dignity.

Outreach Duties Prioritized

One Roof CE Outreach Team duties can be categorized into four priority areas:

Primary Duties

1. Providing life sustaining services to street clients
2. Providing case management services to street clients identified as exceptionally vulnerable

Secondary Duties

3. Using unique insights to advocate for our clients within the homeless service system and within broader systems
4. Using first-hand knowledge to assist in One Roof and/or Continuum-wide capacity building projects

Considering Non-Prioritized Projects

- Since One Roof's Outreach Team is considered one of the organization's direct services, Outreach's priorities are to conduct Life Sustaining Services and provide Case Management to eligible street clients.
- Advocacy and Capacity Building are considered secondary duties. There are a few exceptions to this rule, though, pertaining to One Roof hosted projects that require the assistance of all One Roof staff. These exceptions are considered priorities and include, but are not limited to, conducting the Point-In-Time Count, participating in Project Homeless Connect, participating in Cardboard Connect, assisting with Homeless Simulations, and attending Resource Fairs. Another exception is conducting SSI/SSDI Outreach, Access, and Recovery (SOAR) referrals and applications. One Roof Outreach Specialists must discuss the possibility of becoming a SOAR Specialist with One Roof Administration, and if granted the opportunity, are free to take on SOAR clients at the discretion of the CE Team Lead and SOAR Supervisor.

- Other non-priority projects need to clearly fit into the Advocacy or Capacity Building areas. Outreach Specialists should use their own discretion in committing to non-priority projects, in order to ensure they are spending enough time on providing the core services of case management, crisis intervention, and meeting immediate needs.
- When presented with an opportunity to participate in a non-priority project and before committing to the effort--whether the initiator is a One Roof staff member, a partner agency, or a community member--the Outreach Specialist should first consider whether the project falls under advocacy and/or capacity building and, secondly, whether they can realistically participate without neglecting their core duties.

Outreach Caseload

For all CoC and ESG assistance, the One Roof Continuum of Care has prioritized the following populations: chronically homeless, Veterans, families, and youth age 18 – 24. Unsheltered clients who fall into at least one of the four priority areas (i.e. chronically homeless, Veterans, families, and/or youth) and are determined to be the most vulnerable should be on an Outreach Caseload. Caseload clients are seen regularly by the Outreach team, are continually experiencing unsheltered homelessness and are assigned to Outreach Specialists for continued engagement and services.

Each Outreach Specialists should average around 8-15 of the most vulnerable unsheltered clients on a caseload at a time. Given the high service needs of program clients, maintaining manageable caseloads is an important program feature to provide personalized care. If an Outreach Specialist would like to increase their caseload, they should discuss this with the CE Team Lead or during the weekly CE team meetings. This will be conferenced on an individualized case-by-case basis. Outreach Specialists will case conference if the client would benefit by being on a caseload based on the client's vulnerability and need for case management. Caseloads are staggered based upon length of time clients are in the program and their progression towards transitioning out of homelessness.

See Appendix B: Coordinated Entry Outreach Workflow for more details.

Outreach Specialist and Client Roles

- Outreach Specialist Role: CE Outreach will provide case management services to unsheltered clients who are not able to access services with the goal of obtaining permanent housing. Outreach Specialists will assist the client with meeting all the goals agreed upon in the Individualized Client Action Plan (ICAP). Consistent engagement means Outreach Specialists will provide more substantial and extensive services to caseload clients compared to the diversion services and resources provided to non-caseload clients (e.g. instead of providing diversion clients with a public housing application, Outreach Specialists will assist caseload clients in filling out an application). Outreach Specialists will take a client-centered approach and allow clients to lead the service-provision process based on their comfort and desire to access specific services. If a client is working with a case manager with another agency, then the client will continue to work with that case manager.
- Client Role: The client is responsible for working with their Outreach Specialist and leading the ICAP process. They are responsible to delineate the boundaries of service provision and articulate what services they are ready to access. Clients are to work towards their own housing stability with the assistance of their Outreach Specialist; they are not to solely depend on the work of the Outreach Specialist. To the best of their ability, they are also responsible to attend all agreed upon appointments with their Outreach Specialist or referral services in a timely manner.
- See Appendix: D CE Individualized Client Action Plan (ICAP) for more details.

Most Vulnerable Outreach (MVO)

Most communities have more people in need of homelessness assistance than they can serve, particularly for persons who need supportive housing placement. Therefore, communities need to make tough decisions regarding how those limited resources are allocated. The One Roof Outreach team completes MVO weekly to search for people experiencing homelessness who are least likely to access services.

- The MVO Calendar will indicate when the teams are out for MVO.
- The Outreach Teams are equipped to go into the field with hygiene kits, water, weather necessary items (gloves, hats, ponchos, sunscreen, etc.), diversion resources, and computers for documentation as necessary.
- Areas may need to be visited twice by the team if there is evidence of clients staying there but the client is not there. Team members usually leave hygiene packs and contact cards.

Outreach Responsibilities

Homeless Verifications

- The 'Third Party Unsheltered Homeless Verification Form' (TPV) is to be used to provide third-party documentation verifying current or prior occasions in which an individual or head of household is or was residing in a place not meant for human habitation. See Appendix: G Third Party Verification Form and Instruction Sheet for more details.
- A TPV is used to verify the Category 1 homelessness required by One Roof's partner housing agencies. This tool helps free up the time of the Outreach team. Instead of the Outreach Specialists verifying a client's homeless status, a TPV can be completed if that client interacts with other agencies or community members/businesses.
- Verification for people residing in accommodations not designed for sleeping can be visually verified during outreach. Case managers must document location, date, and time the individual was seen sleeping in such accommodations.
- Documentation of homelessness is required for every case file. In the case that a client is dubiously homeless, Outreach Specialists must be creative in verifying homelessness.

Outreach Collaboration and Referrals

SOAR Referrals

- The following SSI/SSDI Outreach, Access, and Recovery (SOAR) documents are to assist Outreach Specialists and partner agencies with referring clients to the SOAR program. They should be used to gain knowledge on who will be an eligible candidate for the SOAR program and to refer to the SOAR Case Managers.
- SOAR Documents should include:
 - SOAR Triage
 - SOAR Referral Application
 - Referral Workflow
 - Waitlist Workflow

For additional information on SOAR Documents, refer to the Coordinated Entry Policies and Procedures Appendix E and Appendix F.

Overviewing Housing Placement Specialist

One Roof and its partner agencies believe private market landlords are critical partners in the work to help people quickly exit homelessness and maintain permanent housing. To support this partnership between

service providers and landlords, One Roof has a dedicated team member to assist in connecting those seeking housing through our partner agencies (prospective residents) to those who are offering housing (property owners and managers).

The Housing Placement Specialist acts as a liaison between One Roof's partner agencies, the individuals/families receiving housing assistance, and landlords who provide qualified housing. In addition to this coordination, One Roof actively engages with prospective property owners and managers who are interested in renting to tenants receiving housing assistance through our partner agencies.

Housing Placement Specialist Responsibilities

- Recruit and maintain excellent working relationships with private landlords and leasing corporations in Jefferson, St. Clair, and Shelby Counties.
- Develop and maintain lists of available housing units.
- Coordinate with Coordinated Entry (CE) staff to connect with client referrals from the CE Prioritization Housing List.
- Assess housing barriers, needs, and preferences of individuals and families experiencing homelessness.
- Develop an action plan for locating housing, including intake interview to determine client's needs, goals, and eligibility for available rental units in the community.
- Conduct outreach to and negotiation with landlords and leasing corporations.
- Provide mediation between landlords and clients.
- Create and maintain consistent communication channels, both verbal and written, between several parties (e.g., tenant, landlord, service provider, collaborating agencies, etc.)
- Serve as an ongoing liaison between property managers, tenants, and service providers.
- Use the local Homeless Management Information System (HMIS) to record all client interactions.
- May assist in transporting clients to housing appointments using agency vehicles.
- Assist with any other duties as requested including participation in all major agency functions.

Referral Process

Once a Corresponding Agency receives the referral, they will contact the client to set up an intake to verify all eligibility information. Coordinated Entry (CE) is not responsible for collecting documentation that verifies a client's eligibility for programs. The coordinated assessment serves as a prescreening tool to assess vulnerability. Although some documentation might be readily available through HMIS and/or documents collected during the assessment process, the Corresponding Agencies are ultimately responsible for gathering all necessary documentation to determine eligibility.

Receiving Referrals

Upon receiving a referral from Coordinated Entry, the Corresponding Agency will attempt to contact the client within 3 business days to schedule an intake. Providers may schedule client intakes to collect additional data and assess for program fit. Interview must be conducted within 10 days of receiving a referral.

If the client cannot be contacted within 10 business days, the Corresponding Agency will notify the CE Team and move to the next eligible person on the waiting list. This will be noted in HMIS, and the referral will be cancelled instead of declined. The Corresponding Agency must document in HMIS their attempts to contact a referred client.

If the client misses the appointment, the Corresponding Agency will schedule a new intake appointment and should hold the vacancy until the intake appointment is concluded. If the client misses a second appointment, the referral can be cancelled and noted in HMIS.

Accepting Referrals

If the client is accepted into a program and accepts the referral, the Corresponding Agency must document that acceptance in HMIS through the referral system. The referral will then be complete and the client will be removed from the waiting list and the coordinated assessment entry will be closed.

If a client is accepted into a program and then either voluntarily leaves or contact with that client is lost, after due diligence in reaching out to contact, the Corresponding Agency can exit the client from their program. If/when a client returns or contacts the Corresponding Agency, the agency should direct them back to Coordinated Entry. The client's entry will be reopened and the client will be placed back on the waiting list for another referral.

Referral Rejection Policy

Both CoC providers and program participants may decline or cancel referrals, although service denials should be infrequent and must be documented in HMIS. All participating projects and the client must provide the reason for service denial and may be subject to a limit on number of service denials.

If the Corresponding Agency declines a referral, it will need to be marked in HMIS as Referral Outcome Declined. If the client chooses to cancel a referral, it will need to be marked in HMIS as Referral Outcome Cancelled. At a minimum, all projects' referral denial/cancellation reasons must include one of the following which will be marked in HMIS through the referral system.

Referral Outcome Declined -

- Program at bed/unit/service capacity at time of referral.
 - Mark in HMIS – *All Services Full*
- Based on the individual program policies and procedures, the Corresponding Agency has determined that the client/household cannot be safely accommodated or cannot meet tenancy obligations with the supports provided by the program.
 - Mark in HMIS – *Service Not Accessible*

If a corresponding agency wishes to decline a referral, they must first case conference with CE Team Lead or her/his/their designee.

Referral Outcome Canceled –

- Client/household does not meet required criteria for program eligibility
 - Mark in HMIS – *Client Not Eligible*
- Client/household refused further participation or client moved out of CoC area.
 - Mark in HMIS – *Client Refused Services*
- Client/household unresponsive to multiple communication attempts.
 - Mark in HMIS – *Unable to Contact Client*
- Client resolved crisis without assistance.
 - Mark in HMIS – *Inactive*
- Client could not meet landlord requirements (include specific reasons cited by the property management - ex. background check)
 - Mark in HMIS - *Landlord Rejected*

- Client/household missed two intake appointments.
 - Mark in HMIS – *Client Not Compliant*
- Client/household presented with more people than referred by the CE Team Lead, or her/his/their designee, and the Corresponding Program cannot accommodate the increase.
 - Mark in HMIS – *Client Not Compliant*

If the reason for denial/cancellation is not listed above, then the Corresponding Agency will need to add it in the referral notes of the reason and mark in HMIS – *Unknown*.

Re-assessments

If an individual/household is on the waiting list and conditions or circumstances change which would alter a client's/household's vulnerability, the individual/household should contact Coordinated Entry to update information contained in their original coordinated assessment to determine if a level of care change should occur. All individuals/households who complete a coordinated assessment are instructed to inform the CE team if their circumstances or situation changes. These changes are also documented during the 45 day follow ups.

If a Corresponding Agency meets with a client during an intake interview and feels there was pertinent information not shared at the initial coordinated assessment, a re-assessment will be required. The Corresponding Agency will need to refer the client back to Coordinated Entry. Usually this can take place immediately over the phone, Monday - Friday 9:00 a.m. - 4:00 p.m.

Referrals for Domestic Violence Services

The ESG and CoC program rules do not require ESG or CoC-funded victim service providers to use the CoC's Coordinated Entry process, if they use an alternative Coordinated Entry for victim service providers in the area that meets HUD's minimum Coordinated Entry requirements. The process used by the victim service providers in the One Roof Continuum of Care meets these requirements.

One Roof ensures participants may not be denied access to the Coordinated Entry process on the basis that the participant is or has been a victim of domestic violence, dating violence, sexual assault or stalking.

When a homeless or at-risk individual/household is identified as needing domestic violence (DV) services, that individual/household is referred to the domestic violence crisis line immediately. If the individual/household does not wish to seek DV specific services, the individual/household will have safe and private access to the Coordinated Entry system. If the DV crisis line determines that the individual/household seeking DV specific services is either not eligible for or cannot be accommodated by the DV specific system, the individual/household can contact Coordinated Entry for a full assessment and referral as appropriate.

If a client is currently in a confidential DV shelter and the individual/household contacts Coordinated Entry for other housing resources in the Continuum, the coordinated assessment is completed on paper. The CE Team will contact the most appropriate agency when the client is next on the waiting list for a referral. Privacy is a high priority of the Continuum so the client will not be entered into PromisSE until the client leaves the DV shelter and enters another housing program. Any paper intake forms will be kept in a locked file in the One Roof office.

Emergency Transfer Plan

Pursuant to the HUD Final Rule implementing the Violence Against Women Act (VAWA), the CoC has in place an Emergency Transfer Plan in the event that an internal or external emergency transfer may be necessary for those households that believe there is a threat of imminent harm from further violence if the tenant remains within their current dwelling unit. A tenant receiving rental assistance through, or residing in a unit subsidized under, a covered housing program who is a victim of domestic violence, dating violence, sexual assault, or stalking qualifies for an emergency transfer if:

- The tenant expressly requests the transfer; and
- The tenant reasonably believes there is a threat of imminent harm from further violence if the tenant remains within the same dwelling unit that the tenant is currently occupying; or
- In the case of a tenant who is a victim of sexual assault, either the tenant reasonably believes there is a threat of imminent harm from further violence if the tenant remains within the same dwelling unit that the tenant is currently occupying, or the sexual assault occurred on the premises during the 90-calendar-day period preceding the date of the request for transfer.

CoC Program Interim Rule Section 578.51(c) establishes that a consumer may move to a different Continuum of Care geographic area to protect their health and safety and retain their CoC-funded rental assistance if they reasonably believe they are imminently threatened by harm from further domestic violence, dating violence, sexual assault, or stalking. Documentation of reasonable belief of further domestic violence, dating violence, sexual assault, or stalking includes written observation by the housing or service provider; a letter or other written documentation from a victim service provider, social worker, legal assistance provider, pastoral counselor, mental health provider, or other professional from whom the victim has requested assistance; a current restraining order, recent court order, or other court records; or law enforcement reports or records. The housing or service provider may also consider other documentation such as emails, voicemails, text messages, social media posts, and other communication, including certification from the victim, utilizing optional HUD Form 5382.

Client Appeal

All clients and Corresponding Agencies have the right to appeal the client's vulnerability score if they believe additional consideration should be made for unique population base vulnerabilities and risk factors. All vulnerability score appeals should be directed to the Coordinated Entry Team Lead. All appeals of scores by clients or Corresponding Agencies should be made in writing and submitted to Coordinated Entry. Appeals should outline reasons why a client's score should be reconsidered. Agencies' internal appeal process for entering specific projects or programs is separate from Coordinated Entry and One Roof.

Privacy Protections

PromisSE is a shared, computerized record keeping system that captures information about people experiencing homelessness or near homelessness, including their service needs. One Roof participates in PromisSE which collects information on clients served by its member agencies and the services they provide.

One Roof collects and stores information in PromisSE for purposes of assessing and referring participants through the Coordinated Entry process. Coordinated Entry Privacy Policy is compliant with all HUD standards for HMIS and is HIPAA compliant by design.

With client permission as indicated by a signed Release of Information (ROI), client information can be shared with other HMIS participating agencies throughout the implementation. The information entered by participating providers and shared with client consent includes: basic identifying demographic data (e.g., name, birthdate, and gender), the nature of the client's situation, and the services and referrals received from the participating agency. The collection and use of all personal information is guided by strict standards of privacy. The CoC prohibits denying services to participants if the participant refuses to allow their data to be shared unless Federal statute requires collection, use, storage, and reporting of a participant's personally identifiable information (PII) as a condition of program participation

Incorporating Mainstream Services

One Roof maintains a list of mainstream services available in the CoC coverage area. This will include health services, food pantries, income support, clothes closets, etc. Referrals to these services will be made available to clients as needed. One Roof employs a SOAR Specialist to assist chronically homeless individuals in their application for social security benefits. This service is available to all individuals who access Coordinated Entry. See Appendix F: SOAR Referral Application for more details.

ADA Compliance

One Roof is committed to complying fully with the Americans with Disabilities Act (ADA) and ensuring equal opportunity for persons with disabilities. All Coordinated Entry processes are conducted on a non-discriminatory basis.

"Disability" includes a physical or mental impairment that substantially limits one or more life activities, a record of such impairment, or being regarded as having such an impairment. "Physical or mental impairment" may include such things as orthopedic visual, speech, and hearing impairments, cerebral palsy, autism, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, Human Immunodeficiency Virus (HIV), developmental disabilities, mental illness, drug addiction, and alcoholism.

One Roof is committed to ensuring non-discrimination in all terms. Reasonable accommodation is available to all clients as needed, as long as the accommodation does not cause undue hardship on One Roof. Access points are accessible to individuals with disabilities, including accessible physical locations for individuals who use wheelchairs, as well as clients who are least likely to access homeless assistance.

Coordinated Entry provides appropriate auxiliary aids and services necessary to ensure effective communication as needed. Coordinated Entry takes reasonable steps to offer materials and participant instruction in multiple languages to meet the needs of minority, ethnic, and groups with Limited English Proficiency (LEP). Coordinated Entry contracts with M&N Language Services.

Grievance Policy

Clients who complete the Coordinated Entry process will be informed of the Coordinated Entry Grievance Policy and their ability to file a grievance if they find their experience with Coordinated Entry unsatisfactory, including perceived discrimination. All individual's or family's concerns and grievances will be resolved promptly and fairly, in the most informative and appropriate manner. Partner agencies will also inform clients of their individual organization grievance policy for their agency.

Any Coordinated Entry related grievances should be directed to:

One Roof
Attn: Operations Director
1515 6th Avenue South
Birmingham, AL 35233
info@oneroofonline.org

Grievances must be presented to One Roof in writing, either by letter or email. Client who require assistance to complete their written grievance may contact the One Roof office for special accommodations.

Coordinated Entry Evaluation

Coordinated Entry will solicit feedback at least annually from participating projects and from households that participated in the Coordinated Entry process during that time period. Feedback collected through this solicitation will be used to address the quality and effectiveness of the entire Coordinated Entry process, including its policies and procedures.

Coordinated Entry will utilize a combination of several methodologies to collect stakeholder feedback, including but not limited to surveys, focus groups, and individual interviews. Feedback collected using these methods will approximate the diversity of the participating providers and households served. Coordinated Entry will solicit feedback from at least one provider within each housing/assistance type, e.g., PSH, TH, RRH, etc., and will solicit feedback from a random sampling of households that participated in the Coordinated Entry process. All feedback collected through these means will be presented to the Coordinated Entry Committee for review and evaluation. Based on the collected feedback, this committee will propose any necessary updates to the Coordinated Entry Policies and Procedures.

APPENDIX A: Coordinated Entry Definitions and Terms



Affordable Housing – any type of housing, including rental/home ownership, permanent/temporary, for-profit/non-profit, that costs less than 30% of a household’s pre-tax income.

At-Risk of Homelessness – people who are not experiencing homelessness, but whose current economic and/or housing situation is precarious or does not meet public health and safety standards.

Best Practice – an intervention, method or technique that has consistently been proven effective through the most rigorous scientific research and has been replicated across several cases or examples.

Case Management – a collaborative and client-centered approach to service provision for persons experiencing homelessness. In this approach, a case worker assesses the needs of the client (and potentially their families) and when appropriate, arranges, coordinates and advocates for delivery and access to a range of programs and services to address the individual’s needs.

Chronic Disease – a long-lasting medical condition that cannot be prevented by vaccines, or in many instances, be cured.

Coordinated Entry – a process developed to ensure that all people experiencing a housing crisis have fair and equal access to services and are quickly identified, assessed for, referred, and connected to housing and assistance based on their strengths and needs.

Diversion – a strategy to prevent homelessness for individuals seeking shelter or other homeless assistance by helping them identify immediate alternate housing arrangements, and if necessary, connecting them with services and financial assistance to help them return to permanent housing.

Encampments – one or more persons occupying a tent or other structure not meant for permanent human habitation in the same or reasonably close location for two or more consecutive nights.

Episodically Homeless – refers to those who move in and out of homelessness.

Gender Identity – a person’s subjective experience of their own gender. It is a deep internal feeling of whether they are female, male, genderqueer or anywhere else along the gender spectrum. A person’s gender identity may be the same as or differ from the sex assigned to them at birth.

Harm Reduction – refers to policies, programs and practices aimed at reducing the risks and negative effects associated with substance use and addictive behaviors for the individual, the community and society as a whole.

Homeless Diversion – a form of homeless prevention that helps people who are experiencing a housing crisis and are seeking emergency shelter to preserve their current housing situation or make immediate alternative arrangements without having to enter shelter. Diversion also refers to secondary prevention, which is the practice of assisting newly homeless clients resolve their housing situation as quickly as possible to prevent them from experiencing chronic homelessness.

Homelessness – describes the situation of an individual, family or community without stable, safe, permanent, appropriate housing, or the immediate prospect, means and ability of acquiring it. It is the result of systemic or societal barriers, a lack of affordable and appropriate housing, the individual/household's financial, mental, cognitive, behavioral or physical challenges, and/or racism and discrimination. Most people do not choose to be homeless, and the experience is generally negative, unpleasant, unhealthy, unsafe, stressful and distressing.

Housing First – a recovery-oriented approach to ending homelessness that centers on quickly moving people experiencing homelessness into independent and permanent housing. It is followed by provision of additional supports and services as needed.

Individual and Relational Factors – apply to the personal circumstances of a homeless person, and may include: traumatic events, personal crisis, mental health and addictions challenges, which can be both a cause and consequence of homelessness and physical health problems or disabilities. Relational problems can include family violence and abuse, addictions, mental health problems of other family members and extreme poverty.

Individualized Client Action Plan (ICAP) – an individual client action plan prepared by an Outreach Specialist to identify the client's need or problem and outline what the agency and client need to do in order to meet the client's goals particularly related to helping them transition out of homelessness. An ICAP is completed for clients who are on the Outreach Caseload.

LGBTQ2S – the acronym stands for lesbian, gay, bisexual, transgender, transsexual, queer, questioning, and Two-Spirit people.

Life Sustaining Services – services that One Roof Outreach Team provides to clients who are living in places not meant for habitation to help keep them as safe and healthy as possible while experiencing homelessness. The goal of Life Sustaining Services is not to make living on the streets comfortable for clients, but to mitigate the worst health consequences that life on the streets would otherwise afford.

Most Vulnerable Outreach (MVO) – the One Roof Outreach team dedicates a morning and afternoon (varying days) a week for two teams to go out to designated (planned) and undesignated (new) locations to search for people experiencing homelessness who are least likely to access services.

Motivational Interviewing – an evidence-based practice in working with clients that has proven to be successful. In this approach, the service provider allows the client to direct the change rather than telling the client what they need to do. This approach is about having a conversation about change.

Panhandling – a subsistence strategy that refers to begging for money, food and other items. The activity is considered to be part of informal economy and is commonly associated with homelessness.

Permanent Supportive/Supported Housing – combines rental or housing assistance with individualized flexible and voluntary support services for people with high needs related to physical or mental health, development disabilities and substance use. It is an option to house chronically homeless individuals with high acuity.

Point-in-Time (PIT) Counts – provide a “snapshot” of the number of people experiencing homelessness on a specific date (usually one day but occasionally up to a week) in a community.

Prevention – refers to one of the main strategies in addressing homelessness that aims to stop people from becoming homeless in the first place.

Rapid Re-Housing – an approach to housing that is similar to Housing First as it has no “readiness requirement.” This approach is best suited for people experiencing episodic and transitional homelessness, however.

Severe Mental Illness (SMI) – defined as a serious and persistent mental or emotional disorder (e.g. schizophrenia, mood-disorders, schizo-affective disorders) that interrupts people’s abilities to carry out a range of daily life activities such as self-care, interpersonal relationships, maintaining housing, employment or stay in school.

Sexual identity – how a person identifies to whom they are sexually and romantically attracted (e.g., lesbian, gay, bisexual, heterosexual, etc.)

SSI/SSDI Outreach, Access, and Recovery (SOAR) – a program designed to increase access to Social Security Administration (SSA) disability benefits for eligible individuals who are experiencing or at risk of homelessness and have a mental illness, medical impairment, and/or a co-occurring substance use disorder.

Street Outreach – incredibly important work that involves moving outside the walls of the agency to engage people experiencing homelessness who may be disconnected and alienated not only from mainstream services and supports, but from the services targeting homeless persons as well.

System Integration – formalized coordinated approach to planning, service delivery, and management. An integrated system is an intentional, coordinated, suite of services that is centrally funded and managed. Systems integration aims to align services to avoid duplication, improve information-sharing, increase efficiency (e.g., reduce wait-times), and provide a seamless care experience for individuals and families.

System of Care – strengths-based, culturally relevant, participatory framework for working with children and families.

System Prevention – refers to working with mainstream institutions to stop the flow of individuals from mental health care, child protection and corrections into homelessness.

Systems Failures – occur when other systems of care and support fail, requiring vulnerable people to turn to the homelessness sector, when other mainstream services could have prevented this need.

Transgender – a term used to describe people whose gender identity does not match with the sex they were assigned at birth. Transgender is also used as an umbrella term and can encompass those who identify as gender queer and gender fluid and whose gender identities challenge gender norms. Transgender is an adjective, and should never be used as a noun. For example, say “Chris is a transgender person,” not, “Chris is a transgender.” It is never necessary to add an ‘-ed’ to the end of ‘transgender.’

Transitional Housing – refers to supportive, yet temporary type of accommodation that is meant to bridge the gap from homelessness to permanent housing by offering structure, supervision, support, life skills, education, etc.

Trauma – an event outside the range of usual human experiences that would be markedly distressing to almost anyone and cause victimization.

Unsheltered – living on the streets or in places not intended for human habitation.

Vulnerability Index–Service Prioritization Decision Assistance Tool (VI-SPDAT) – a pre-screening tool developed as a more concise version of the SPDAT, a comprehensive assessment tool created to be used by front-line homeless service workers to prioritize which clients should receive services first. This comprehensive tool measures clients’ needs, vulnerabilities, abilities, and support to prioritize and help determine services for individuals experiencing homelessness or at-risk of experiencing homelessness. One Roof uses the VI-SPDAT as part of Coordinated Entry.

Warm Transfer – a warm transfer is the process in which a client is supported in their transition from one provider in the Continuum of Care to another. Clients may develop a relationship with a CE Outreach Specialist and benefit from continued involvement until a natural transition point occurs. The client should be given the option of warm transfers throughout the Continuum of Care. For example, the client should be asked if they would like the provider who completed the assessment to attend the initial meeting with the agency they have been matched with for housing and/or other resources.

APPENDIX B: Coordinated Entry Outreach Workflow

In Field / Street Outreach

- Ensure that client has completed either an in-person Homeless Verification or Third Party Verification.
- First Day of Contact
 - Have client sign a new Release of Information and enter under ROI tab
 - Sign the ROI under “Witness” Section
 - Upload to HMIS under ROI Tab
 - Shred the paper copy
 - Create Entry/Exit under *4315—AL500 One Roof—CAO Outreach (SSO)*
 - Fill out all relevant information, especially Narrative, Disability Status, Income, Health Insurance, Non-cash Benefits, and Veteran Status
 - Determine whether client is eligible to complete a Coordinated Assessment entry (3719)
 - If client is CE eligible, determine whether it is more appropriate to complete a coordinated assessment at that time or set an in-person/phone appointment for a later date
 - Follow the CA Intake Assessment-HMIS Script workflow
 - Determine whether the client is interested in receiving case management (CM) services until acquiring housing, or if you perceive that CM would be beneficial
 - If client vocalizes interest, determine whether client has reliable way to communicate with Outreach Workers or can easily be found in the field
 - If client can communicate or can easily be found, inform them that they will be placed on an Outreach Caseload during the upcoming CES meeting, after which their Outreach Worker will inform them of their placement
 - Case conference client at next CES meeting and determine whose caseload they should be placed on
 - If client vocalized interest in case management and does not have a communication method and will not be easy to find consistently, create Entry/Exit under *4119—AL500 One Roof – CA Outreach (STO)* and inform client that they have been placed on your caseload
- Except in extenuating circumstances that have been discussed with the entire CE Team, the following is only applicable to clients who have been determined to CE eligible and are interested in Outreach Case Management
 - Create Entry/Exit under *4119 – AL500 One Roof – CA Outreach (STO)*
 - This is to be created either during initial contact with client, during an in-person Homeless Verification, or after a CES meeting during which client was placed on your caseload
 - Complete first section
 - Be sure to add if the client was referred by another agency
 - Important to describe where the client stayed last night
 - Select Outreach Type
 - CE Referral – if the client is a referral through Coordinated Entry to a partner agency
 - CE Priority – if the client is a Coordinated Entry Priority (Chronically Homeless / Veteran / Family / Youth)
 - CE Outreach – if the Outreach team meets with the client through street outreach
 - CEO Verification – if the client is a referral for engagement to build rapport and verify street homelessness
 - Complete the Date of Engagement as the same date of CAO entry (4119)
 - Add “Current Living Situation” Sub-assessment
 - Add “Coordinated Entry Assessment” Sub-assessment
 - Add “Coordinated Entry Event” Sub-assessment

- Answer “Chronically Homeless,” “Youth,” “Family,” and “Veteran Status” questions; ensure you respond to “If a client is a Veteran, which branch?” even if client is not a veteran - respond, “Not a veteran.”
 - Answer “Legal” and “Other” questions
 - Update or complete the rest of the HUD questions
 - Add Case Manager under *AL500 – One Roof – CA Outreach (STO)*
 - Add Goal under Case Plans tab
 - Provider - *AL500 – One Roof – CA Outreach (STO) (4119)*
 - Case Manager – add name
 - Classification – Outreach
 - Type –
 - Engagement – when reaching out to make contact with a client or when working with a client who is currently on the streets
 - Overall Status – In Progress
 - Projected Follow Up Date
 - If the client is a new street client, add the follow up for 1 month away
 - If the client is a CE referral, add the follow up for 2 business days
 - Follow Up User – *AL500 – One Roof – CA Outreach (STO) (Staff Name)*
 - Add Goal --- this will bring up another box to add the first Case Note
 - Add Case Note --- see CE Outreach Case Note Example Document
 - In the Homeless Verification case note, add the following statements when completed
 - Add a line space to distinguish the statements from the case note
 - “Homeless verification completed.
CE Outreach entry completed.”
 - Add Multiple Services --- takes you to the Service Transactions page
 - Refer to Multiple Services CE Outreach Procedure for how to add multiple service transactions
 - Refer to CEO Services for list of potential services to add
 - Each time a contact/touch is completed in person with a street client with an open entry, a service transaction needs to be recorded for Case Management
 - Record as many services that were conducted along with the Case Management service
 - If client has an opened Coordinated Assessment entry (3719), open up the entry and add the following statement into the narrative
 - “Made contact with client for homeless verification. Started a CE Outreach entry.”
--Initials
- Repeated Engagement
 - After opening a CAO entry (4119), complete the following for each in person client interaction:
 - Client Profile Tab – Add an outreach touch
 - Case Plan Tab – Update the following:
 - Case Note
 - Follow Up Date
 - Multiple Service Transactions
 - Update the interim if there has been any information change for the client
- Exiting Clients
 - When exiting a client from CAO entry (4119), complete the following steps:
 - Be sure that the box is checked for all the household members
 - Exit Date –
 - Date when transferred client to a shelter/program
 - Date when a CE referral is accepted by a partner agency
 - After 90 days of inactivity and unable to contact client
 - Reason for Leaving – Completed program
 - Destination – Same as where the client entered CEO entry

- Notes – Any applicable notes about reason of leaving, examples below
 - Connected and transferred client to Salvation Army
 - Firehouse PSH Accepted Referral
 - Unable to contact client and no recent activity in HMIS in last 90 days
 - Save & Continue
 - Complete Assessment Disposition question in Other section
 - Drop down menu to most appropriate answer
 - Close out the case plan/goal so that it will come off of the follow up list by completing the following steps
 - Edit the pencil in the Outreach goal
 - Overall Status – Closed
 - If Closed Outcome – Achieved / Abandoned
 - Follow Up Made – Yes
 - Completed Follow Up Date – Date exiting CAO entry (4119)
 - Outcome at Follow Up – Achieved / Abandoned / Failed / Etc.
 - Only add more case notes or services if it was provided at the CAO exit (4119)
 - Save & Exit
- Shelter Clients / Non Street Clients –
 - If client is a prioritized population, complete a Coordinated Assessment entry (3719)
 - If client is not a prioritized population, complete a CA Diversion entry (4183)
 - Do not add an entry for Outreach (4119)
 - Client Profile Tab – Add an outreach touch if client is in an emergency shelter

APPENDIX C: Disability Documentation Request

If you do not receive Social Security Benefits for a disability, you will need to get disability documentation from a doctor. You will need to get the following information:

This client is in need of disability documentation for a HUD-funded Housing Program. This documentation will NOT be used for disability benefits determination.

This client needs a letter from a licensed professional, who can diagnose and treat that specific disabling condition.

- The letter needs to be typed and be on practice/hospital letterhead
- The letter needs to state the following:
 - The disability is expected to be of long duration
 - The disability impedes the person's ability to live independently
- AND**
- The disability is of the nature that could be improved by more suitable housing conditions
- The letter needs to be signed and dated by physician at the bottom

*If you have any questions or concerns, please contact One Roof at 205-254-8833

If you receive Social Security Benefits for a disabling condition

- If you receive SSI or SSDI for a disabling condition, you can go to the Social Security office and request a benefits request form. You must state that the form needs to state that you are receiving the benefits for a disabling condition. This letter will suffice as disability documentation.

APPENDIX D: CE Individualized Client Action Plan (ICAP)

Client Action Plan

Continuum ID #:

CE Specialist:

Date:

Client Name:

Purpose of Visit:

Housing Stability Goal(s):

Barrier(s):

Strength(s):

Next Meeting Date:

Client Preferred Method of Contact:

Client Action Initial Action Steps:

Client Action(s):

CE Specialist Action(s):

Community Referral(s):

Client Signature:

CE Specialist Signature:

APPENDIX E: SOAR Waitlist Form

Client's Name: _____ Referring Staff/Agency: _____

Reason for Waitlist

NOTE: We will prioritize clients who have applications for the following conditions: Terminal Illness (TERI), Presumptive Disability (PD), Compassionate Allowance (CAL), Quick Disability Determination (QDD) or Wounded Warrior. While we will continue to work with all clients, if a referral for one of the above listed conditions is received, that application will be prioritized over others.

The client you referred to our agency is being placed on the SOAR Waitlist for the below reason:

- Caseload at capacity
- Recent referral prioritized due to dire need
- Insufficient evidence
- Need to establish Primary Care Physician/Psychiatrist

The client has been advised to contact SOAR Case Manager after _____ months of treatment or if there is current evidence of a decline in their health.

Worker will follow up with the client on _____.

Client is advised to follow up with SOAR Case Manager via phone on _____.

SOAR Case Manager

Date

APPENDIX F: SOAR Referral Application

To assess SOAR eligibility, we are looking for basic information on:

- The presence of medical and/or psychiatric conditions or symptoms which would fit an SSA listing
- Current treatment, or a history of treatment for conditions - at least 12 months
- Inability to work and earn SGA (\$1260/month in 2020) due to medical and/or psychiatric conditions (not because they cannot find work or were laid off)
- Impairments in functioning due to medical and/or psychiatric conditions

Please complete in full and fax or scan to soar@oneroofonline.org at 205-502-4600

Client Name/Alias: _____ Date of Referral: _____

Referring Staff/Agency: _____

Staff/Agency Contact Number: _____

Staff/Agency Email: _____

Client Contact Number: _____ - _____

Client Identifying Information:

DOB: _____ Gender: _____ Pronouns: _____ Race: _____
(must be within 30 days of 18 years of age, or within 180 days if exiting foster care)

SSN: _____ Grade Level Completed: _____ Marital Status: _____

Current Living Arrangements (address, shelter, area of town): _____

Employment Status (circle): Full-time/ Part-time

Veteran: _____ Branch of Service: _____ Discharge Status: _____

Emergency Contact Name/Number: _____

Part A: Homelessness/At-Risk Assessment

Where is the candidate currently living? *Check the appropriate selection*

Homeless:

Place Not Meant Habitation Shelter Transitional Housing

At-Risk of Homelessness:

Couch Surfing Received an eviction notice or owes back rent/utilities
 Permanent supportive housing that is grant-funded (Housing First Placement)
 Exiting Foster Care Institution- Hospital, nursing home, etc. Jail/ Prison

If homeless, how long has the client been homeless: _____ Year(s) _____ Month(s)

Is the client in an institution or jail? Y/N

If yes, are they expected to be released within 30 days? Y/N

Were they experiencing homelessness before entering the facility? Y/N

Has the client had difficulty maintaining housing? Y/N

If yes, please described: _____

Part B: Current Application for SSA Benefits or Pending Appeal

Has the client recently applied for Social Security benefits? Y/N

If yes, date of application: _____ Decision on application: Pending/Denied

If denied, did the client appeal? Y/N

If yes, are they waiting on a decision? Y/N

Are they working with a lawyer? Y/N

Part C: Diagnostic Information

Please list all mental and physical health diagnoses: _____

Where has the candidate been treated for these conditions? _____

Date of last doctors visit: _____

Has the client ever received treatment for substance use, past or present? Y/N

If yes, provide the name of the most recent treating source (s)

If so, where: _____

SOAR specialists will contact the client to follow up on the information provided on this form. A full intake assessment may be required to gather additional supporting evidence to determine if we can assist the client with a SOAR application.

APPENDIX G: Third Party Verification Form and Instruction Sheet



THIRD PARTY UNSHELTERED HOMELESS VERIFICATION FORM

Distributed by: _____ Distributed on: _____

Applicant Name: _____ Date of Birth: _____
 Participant HMIS #: _____ Date Form Completed: _____
 Total Number in the Household: _____ Number of Minors: _____
(under age 18)

APPLICANT RELEASE AUTHORIZATION

I, _____, hereby authorize _____
(Applicant Name) (Name of Third Party Verifier)
 to release information, to One Roof and the partner agencies, regarding my living situation. I understand this information is used for the purpose of determining homeless status.
 Signature of Applicant: _____ Date: _____

This form is intended to be used by a third party source who can verify the status of a client as experiencing homelessness. The remaining sections of this form are to be completed by the third party verifier who may provide details of their contact with an individual or head of household in order to document that the individual or household is currently or has previously resided in a place not meant for human habitation (e.g. street, car, park, abandoned building, under bridge, bus station, airport, or campground).

The third party verifier has physically observed where the individual or head of household is or has been residing. Observations can include descriptions of encounters, location, person's living space, belongings, frequency of stay in an area, etc. Please see instruction sheet for further details.

A third party verifier simply stating the person or household is homeless does NOT qualify as an observation.

THIRD PARTY VERIFIER

Name and Title	Business / Agency / Organization Name
Email	Contact Number

OBSERVATION OF CURRENT HOMELESS STATUS WITHIN LAST 7 DAYS

I certify that _____ has been staying at _____
(Applicant Name) (Location of Current Living Situation)
 _____ . This observation occurred on _____ .
(Date within the Last 7 Days)

I can confirm this from the direct physical observation of the current living situation described below: _____

I certify that the person(s) named above is/are currently resided in a public or private place not designated for, or ordinarily used as a regular sleeping accommodation for human beings such as on the streets or in a car, park, abandoned building, under bridge, bus station, airport or campground.

Signature: _____ Date: _____

OBSERVATION OF PRIOR OCCASION(S) OF HOMELESS STATUS

Description of prior encounters that have occurred within the last 3 years. For each observation, please provide the date and a description of the location (place not meant for habitation) in which the encounter occurred:

Date(s)	Description

I certify that the person(s) named above has/have previously resided in a public or private place not designated for, or ordinarily used as a regular sleeping accommodation for human beings such as on the streets or in a car, park, abandoned building, under bridge, bus station, airport or campground.

Signature: _____ Date: _____

AGENCY/STAFF CERTIFICATION

I have contacted the third party verifier and can certify that, to the best of my knowledge and belief, all the information presented and attached to this form is true, accurate, and complete.

Staff Name: _____ Date Received: _____

Staff Signature: _____ Date Verified: _____

Additional Notes:

**** This form is to be used to verify homeless status only. Completing this form does not guarantee housing services through One Roof or partner agencies. ****



THIRD PARTY UNSHELTERED HOMELESS VERIFICATION FORM INSTRUCTION SHEET

The 'Third Party Unsheltered Homeless Verification Form' is to be used to provide third-party documentation verifying current or prior occasions in which an individual or head of household is or was residing in a place not meant for human habitation.

- **Applicant Name** – individual or head of household experiencing homelessness
- **Third Party Verifier** – someone in the community who has observed and is willing to verify an individual or head of household's episode(s) of homelessness
- **Place Not Meant for Human Habitation** – sleeping and residing in a place not designed for or ordinarily used as a regular sleeping accommodation (e.g. street, car, park, abandoned building, under bridge, bus station, airport, or campground)
- **Current Homeless Status** – description of the applicant's current living situation that the third party verifier has physically observed within the last 7 days
- **Prior Occasion(s) of Homeless Status** – description of prior encounters that have occurred within the last 3 years where the third party verifier has physically observed the applicant's living situation

Who can provide third party verification?

A third party source can be, but is not limited to, a community member, business/property owner, a neighborhood resident, a shopkeeper, a law enforcement officer, a healthcare professional, and/or a service provider. Any person that has **physically observed/seen** the individual or head of household residing in a place not meant for human habitation may complete this form for documentation of the applicant's current and/or prior occasions of homelessness.

What qualifies as an acceptable observation?

The third party verifier has **physically observed/seen** where the individual or head of household is or has been residing in a place not meant for human habitation. The third party verifier will provide details of their contact with the applicant in order to document that the applicant is currently or has previously resided in a place not meant for human habitation. Detailed observations must include descriptions of encounters, location, person's living space, belongings, frequency of stay in an area, etc., and the date(s) during which that observation occurred.

A third party verifier simply stating the person or household is homeless does NOT qualify as an observation.

The third party verifier can only verify homelessness at the time in which they observed the applicant. For example, you observed the applicant on 1/12/2020. At that time, you observed that they were currently living in an abandoned building and had been since 10/1/2019. You can only verify that they were homeless on 1/12/2020, not the previous months in which you did not personally observe the applicant. The observation may only qualify as third-party documentation for the specific month(s) in which they observed the applicant.

What parts of the form need to be completed?

- The applicant will complete the first section - Applicant Release Authorization - with their signature.
- The rest of the form is completed by the third party verifier
- The form must include a written observation from the third party verifier of the conditions where the applicant is currently or has previously resided.
- The form is due back to One Roof within 10 business days of when the form was completed.
- One Roof will contact the third party verifier to certify that all the information presented on the form is true, accurate, and complete.

**** This form is to be used to verify homeless status only. Completing this form does not guarantee housing services through One Roof or partner agencies. ****