Prince George's County Continuum of Care Coordinated Entry Policy

1. Introduction

The CoC Interim Rule defines several responsibilities of a Continuum of Care in §~~(~~578.7(a)(8). One of these responsibilities is to establish and operate either a centralized or coordinated assessment system, in consultation with recipients of ESG program funds within the geographic area. This coordinated entry/assessment system provides an initial, comprehensive assessment of the needs of individuals and families for housing and services. The Prince George's County Continuum of Care (CoC) has developed the following Coordinated Entry Policy as written standards for providing assistance using McKinney-Vento Homeless Assistance funds in accordance with the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act CoC Program Interim Rules. As part of the Prince George's County Continuum of Care (MD-600) all Homeless Services Partnership (HSP) member agencies and organizations must participate in the process and accept housing referrals from the Coordinated Entry System.

A coordinated entry/assessment system is defined to mean a coordinated process designed to coordinate program participant intake, assessment, and provision of referrals. To meet basic minimum requirements, the CoC's coordinated entry system must:

- Cover the entire geographic area of the County,
- Be easily accessed by individuals and families seeking housing or services,
- Be well advertised,
- Include a comprehensive and standardized assessment tool.

The CoC is required to establish and consistently follow written standards for providing assistance. At a minimum, these written standards must include:

- Policies and procedures for evaluating individuals' and families' eligibility for assistance
- Policies and procedures for determining and prioritizing which eligible individuals and families will receive transitional housing assistance;
- Policies and procedures for determining and prioritizing which eligible individuals and families will receive rapid re-housing assistance;
- Policies and procedures for determining and prioritizing which eligible individuals and families will receive permanent supportive housing assistance;
- Policies and procedures that ensure assistance is provided fairly and methodically; and
- Policies and procedures to ensure continuous coordinated entry system performance, including implementation of HUD's Coordinated Entry data elements to standardize data collection on core components of coordinated entry -- access, assessment, prioritization, and referral.

Coordinated Entry systems are important in ensuring the success of homeless assistance and homeless prevention programs in communities. In particular, such assessment systems help communities systematically assess the needs of program participants and effectively match each individual or family with the most appropriate resources available to address that individual or family's particular needs.

Prince George's County's Coordinated Entry process is designed to identify, engage, and assist homeless individuals and families and ensure those who request or need assistance are connected to proper housing and services. Coordinated Entry will ensure that the people who receive housing are the ones who are most in need, not those who are the easiest to serve.

There are three core components to the Coordinated Entry system:

1. Standardized access to housing programs
2. Standardized Assessment that prioritizes people with the longest histories of homelessness and the most extensive needs
3. Coordinated referral that ensures persons are housed as appropriately as possible in the least restrictive environment

2. Overview of the Coordinated Entry System

Most communities, Prince George's County included, lack the resources to meet the needs of all people experiencing homelessness. By utilizing Coordinated Entry, the County ensures that households experiencing homelessness receive the level of assistance that is most appropriate to resolving their homelessness, and that households with the most severe service needs are prioritized for assistance and receive it in a timely manner. Severe service needs are defined as at least one of the following: repeated incidents of emergency department (ED) use (defined as more than four visits per year) or hospital admissions, two or more chronic conditions as defined in §1945(h)(2) of the Social Security Act, or frequent and repeated incarceration for crimes related to homelessness i.e. trespassing, public urination.

Key elements of Coordinated Entry are:

- Designated Coordinated Entry staff who facilitate housing referrals within the CoC and have the management responsibility to implement the day-to-day workflow of the process;
- Use of standardized assessment tools to assess client needs;
- Prioritization of clients with the longest time homeless and the most barriers to returning to housing;
- Referrals based on the results of the assessment tool(s) to homeless assistance programs, mainstream services, behavioral health providers, and other appropriate programs;
- The use of a By Name List which documents all literally homeless persons within the CoC (whether they are sheltered or unsheltered) and a Prioritization List made up of clients referred by all Access Points, all clients who meet the HUD definition of "chronically homeless", and all unsheltered individuals known to DSS Street Outreach;
- Documentation of vulnerability scores, ranking on the priority housing list, referrals, etc. in HMIS or other shared database to ensure transparency;
- Regular (bi-weekly) Coordinated Entry Prioritization Team meetings that include representatives from Emergency Shelter (ES), Joint Transitional Housing/Rapid Rehousing (TH-RRH), Rapid Rehousing (RRH), and Permanent Supportive Housing (PSH) providers, Behavioral Health, DSS Street Outreach and other Access Points and CoC housing providers; and
- A Coordinated Entry Steering Committee made up of a relatively small group of executive-level decision-makers from the major providers and/or funders of housing or services and mainstream service providers which meets at least quarterly and is responsible for:

- Policy oversight: establishing and reviewing policies, procedures and performance benchmarks, measuring performance and identifying system gaps;
- Evaluation responsibility to assess the performance of the system and create a feedback loop for policy oversight;
- Conflict Resolution and Coordination of funding resources; and
- Drafting interim amendments to the Coordinated Entry Policy which are needed to address unexpected circumstances, and which will be approved by the CoC at the next meeting of the Homeless Services Partnership and incorporated (if necessary) into the next update to the Coordinated Entry Policy.

The implementation of coordinated entry is a national best practice. When implemented effectively, coordinated entry can:

- Reduce the number of phone calls people experiencing homelessness must make before finding crisis housing or services;
- Reduce new entries into homelessness through coordinated system-wide diversion and prevention efforts;
- Prevent returns to homelessness by placing people in appropriate housing that meets their needs;
- Reduce or remove the need for individual provider wait lists for services;
- Foster increased collaboration between homelessness assistance providers;
- Improve a community's ability to perform well on Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act outcomes and make progress on ending homelessness;
- Target limited funding to achieve maximum results.

Nondiscrimination

All housing assistance made available through the Prince George's County CoC is available to eligible persons regardless of race, color, national origin, religion, sex, age, familial status, or disability and without regard to actual or perceived sexual orientation, gender identity, or marital status and must comply with the nondiscrimination and equal opportunity provisions of Federal civil rights laws in accordance with 24 CFR 5.105 (a) including, but not limited to the following:

- 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 VI of the Civil Rights Act prohibits discrimination on the basis of race, color or national origin under any program or activity receiving Federal financial assistance; and
- 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 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 on the basis of disability.

Data Management/Privacy Protections

The coordinated entry process is designed to ensure adequate privacy protections of all participant information. The CoC has written policies and procedures for obtaining participant consent to share and store participant information for purposes of assessing and referring participants through the coordinated entry process. These are detailed in the Prince George's County's HMIS Policies and Procedures Manual, which is hereby incorporated into this policy.

Training

The CoC will provide training protocols and at least one annual training opportunity to participating staff at organizations that serve as access points or otherwise conduct assessments. The purpose of the 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 CoC's coordinated entry process, including its written policies and procedures and any adopted variations.

Evaluation

The Coordinated Entry Steering Committee is responsible for developing and updating written procedures that describe the frequency of and method used for evaluations of the Coordinated Entry System as required by HUD, including how many participants will be selected and the process by which their feedback will be collected, and must describe a process by which the evaluation will be used to update existing policy and procedures. Evaluations will be conducted bi-annually and will be designed to answer the core questions:

- Does the CoC's implementation of coordinated entry efficiently and effectively assist persons to end their housing crisis?
- Are the housing and services interventions in the CoC more efficient and effective because of coordinated entry?

Marketing & Education

In order to reach all County residents who may be in need of services, the CoC affirmatively markets housing and supportive services to eligible persons regardless of race, color, national origin, religion, sex, sexual orientation, gender identity, gender expression, age, familial status, or actual or perceived disability. The CoC utilizes a number of means to disseminate information about the county's coordinated entry system and educate potential users of the system, as well as agencies and service providers who may work with people who are experiencing or at-risk of homelessness. Special outreach and marketing campaigns utilizing radio, social media and print media have been designed and are utilized to reach specific subpopulations including domestic violence survivors, transition aged youth, and veterans.

The County's homeless hotline is featured prominently on the county's website as well as being listed in area service guides, and posted in day centers, social service offices, public library branches, and PG Parks Recreation Centers throughout the county. The street outreach team works closely with area emergency rooms, Fire/EMS mobile integrated health, crisis response teams, public safety agencies, and public libraries to ensure that they are knowledgeable about the county's coordinated entry system and

how to help someone access it. Coordinated Entry staff attends cross-disciplinary meetings with the Departments of Health, Corrections, Education, Social Services, specialty courts, and domestic violence and veteran service providers in order to identify potential system users and to ensure that information on how to access services is well known throughout the county. Additionally, public events which serve individuals who are homeless or those at risk of homelessness (like the annual Point in Time enumeration, holiday food and gift giveaway, and Veteran Stand Down/Homeless Resource Day) are advertised widely on social media, in newspapers, and on local radio stations. DSS keeps a record of these marketing activities.

3. Coordinated Entry System in Prince George's County

Access, Initial Contact, and Engagement

The County has a 24/7 homeless hotline, dedicated drop-in centers, and street outreach teams to ensure that anyone in need of services can easily access them. Broad access allows homeless households to be referred to the hotline or to street outreach (whichever is more appropriate) by day centers, libraries, hospitals, public safety agencies, mental health and social service providers, the religious community, and others.

Homeless Hotline

The County's 24/7 hotline is staffed by people who are trained in trauma-informed care and well educated in the County's homeless services and coordinated entry system. Staff screen and assess all callers utilizing the Triage Assessment Tool to determine if they are homeless or at risk of imminent homelessness. All clients are assisted in being linked to mainstream resources outside the Homeless Services System including: Social Services, Energy Assistance, Somatic and Behavioral Health, SOAR, Employment Programs, Food Pantries, etc. Basic client information is entered into HMIS, along with the documentation of any services or referrals which were provided.

If a client meets the criteria for being homeless or at imminent risk of homelessness, hotline staff immediately makes efforts to resolve the household's housing crisis through mediation, emergency rental assistance, and/or "rapid re-housing lite". If these diversion efforts are not successful and homelessness for the individual/family cannot be prevented the individual/family will be placed in emergency shelter, provided space is available. Regardless of whether space is available the household's information will appear on the CoC's By Name List.

Street Outreach

People living on the street or other places not meant for human habitation are linked to an outreach team who triages the case and ensures the client's basic needs are being met as completely as possible. They help facilitate obtaining identification, access to behavioral and somatic health providers, food and clothing, and remain in contact with the client until a housing plan can be implemented. Street Outreach team members enter client information in HMIS and in cases where the person is self-reporting more than one year of continuous homelessness or multiple episodes of homelessness, they help gather information to prove chronicity.

Access Points

All providers of services to homeless households within the CoC have the ability to refer clients onto the Coordinated Entry Prioritization List, either directly as an Access Point, or through the Street Outreach program. Access Points must have staff who are trained and authorized in HMIS and must participate in the Coordinated Entry Prioritization Team. PGCCoC Access points include emergency shelters, drop-in centers, outreach teams, special population workgroups, DV providers, and other organizations which provide services to people experiencing homelessness.

Special Populations

Case managers across the CoC are trained to identify when a client is part of a special population which is a prioritized focus of the CoC and where special resources may be available. When a case manager or counselor at any point in the CoC workflow identifies that a client is a member of a special population, appropriate referrals are made:

- Survivors (Domestic Violence, Human Trafficking, Sexual Assault and others): CCSI, House of Ruth, DASH, CAFY, and Trafficking and Sexual Assault Provider partners
- Unaccompanied Youth and Young Adults (13-24): Sasha Bruce Youthwork, Promise Place, Covenant House, iMind, Mary's Center, University of Maryland College Park, MMYF, and St. Ann's
- Veterans: VA and SSVF providers – Friendship Place, Housing Counseling Services, US Vets, Vesta Inc.
- Returning Citizens: PGCDoC Reentry Division, The Bridge Center at Adams House, Welcome Home, American Justice Reentry & Rehabilitation, Destiny Power & Purpose Inc.
- Chronically Homeless and persons experiencing severe somatic and behavioral health challenges: Street Outreach Team, QCI Behavioral Health, Crisis Response, Safe Journey House, iMind Behavioral Health, Mobile Integrated Healthcare (within Fire/EMS), Health Care Alliance, and the CLASP and ACIS teams
- Elderly and Aging: Adult Protective Services, In Home Aide, TDAP, Assisted living and nursing homes, adult day care, and Metro access.

Survivors

Victims of human trafficking, sexual assault and/or domestic violence (including dating violence, sexual assault, or stalking) will be served by a separate DV coordinated entry process that meets HUD requirements as detailed in the Coordinated Entry Notice and maintains confidentiality requirements outlined in the Violence Against Women Act (VAWA). Survivors access the same housing resources available to the CoC as a whole through the Prioritization Team bi-weekly meeting but do so after their personally identifying information is anonymized. This will ensure that confidentiality and therefore safety can be maintained. Victims of domestic violence may enter the DV coordinated entry process through the county's 24 hour crisis intervention hotline, the 24 hour homeless hotline or through a victim service provider, which is defined in section 401 (32) in the McKinney-Vento Act as a private nonprofit organization whose primary mission is to provide services to victims of domestic violence, dating violence, sexual assault, or stalking.

Unaccompanied Homeless Youth and Transitional Age Youth

Because of the unique needs of Transition Age Youth, the CoC uses a process that includes the use of resources that the County has developed specifically to address their needs. Youth enter the coordinated entry process through youth specific street outreach teams and drop in centers, the PGCPS McKinney-Vento Program, the Maryland Crisis Connect Hotline, the Department of Juvenile Services, the Homeless Hotline, and referral from youth service providers.

Veterans

Because of the unique needs of Veterans, the County uses a separate coordinated entry process that meets HUD requirements as detailed in the Coordinated Entry Notice. The process includes the use of the Composite Score Index and full SPDAT and accesses resources that the County has developed specifically to address their needs. Veterans enter the coordinated entry process through special street outreach teams, SSVF and GPD programs, the VA, the homeless hotline, and Serving Together office.

Screening and Assessment

Prince George's County utilizes two assessment tools to guide referrals for emergency rental assistance, rapid re-housing, joint transitional-rapid rehousing, subsidized and unsubsidized housing, and permanent supportive housing based on client need, program eligibility and services offered. The Triage Assessment is our universal initial screening tool, and the Composite Score Index is a more in-depth screening and prioritization schema focused specifically on referrals to supportive housing. Some of the criteria used to determine a client's position on the Priority List include:

- HMIS data, which can help determine chronicity, patterns of homelessness, and prior use of rental assistance.
- The extent to which people, especially youth and children, are unsheltered.
- High utilization of crisis or emergency services, including emergency rooms, jails, and psychiatric facilities, to meet basic needs.
- Significant health or behavioral health challenges or functional impairments which require a significant level of support in order to maintain permanent housing.
- Vulnerability to victimization, including physical assault or engaging in trafficking or sex work.
- Vulnerability to adverse impacts from communicable diseases.

As a method of measuring and sorting these vulnerabilities, the Coordinated Entry Prioritization Team utilizes a Composite Score Index to efficiently identify which clients have the most barriers to returning to housing so they can be prioritized for a housing intervention.

Triage Assessment Tool

The Triage Assessment is an intake and assessment tool which captures data elements required for all clients being served by the CoC, regardless of their point of access into the system. It assesses a client's eligibility for referral to special programs (Veteran, Unaccompanied Homeless Youth, Transition Age Youth, DV, Chronic, etc.) and homelessness prevention and diversion interventions.

It incorporates the HUD required Crisis Needs Assessment and the Current Living Situation and Coordinated Entry Event sub-assessments.

Composite Score Index

A Composite Score allows the particular vulnerabilities of homeless households in consideration for limited housing supports to be weighed against each other in the prioritization process conducted by the Coordinated Entry Prioritization Team. The Composite Score is produced from data elements in HMIS and information provided by case managers at CoC Access Points. The elements of the Composite Score are weighed as follows:

Priority	Approximate % of Composite Score	Factors
Length of Time Homeless	11%	Length of time homeless based on HMIS
Living Situation	19%	Place not meant for human habitation
		Non-congregate shelter
		Emergency shelter
		Other/Institutionalization
		Rapid Rehousing
Sub-Population	28%	Families with children under 4 years old
		Families with children over 4 years old
		Older adults
		Unaccompanied Homeless Youth (UHY)
		Systems Connected Youth
		Veterans
		Returning Citizens
		Actively Fleeing DV/Human Trafficking
Most Needs	43%	Returns to Homelessness
		Multiple evictions
		Medical Needs
		Large family
		Mental health
		Developmental health
		Substance use
		Physical Disability
		Chronic Health Condition
		HIV/AIDS

Participants in the coordinated entry process are free to decide what information they provide during the assessment process. They will not be denied assessment or services if they refuse to provide certain pieces of information, unless the information is necessary to establish or document program eligibility per the applicable program regulations.

Coordinated Entry Prioritization Team Meetings/Referral Protocols

CoC leadership will keep Coordinated Entry staff up to date on the housing resources available within the Coordinated Entry system, including Supportive Housing, Supportive Services Only, and dedicated Housing Voucher programs. Coordinated Entry staff will coordinate with supportive housing program staff to identify openings in real time and provide referrals from the prioritization list as soon as an opening is identified.

The Prioritization Team determines whether potential participants meet project-specific requirements of the projects for which they are prioritized and to which they are referred. The process of collecting required information and documentation regarding eligibility occurs concurrently with the assessment, scoring, and prioritization processes. Eligibility information is not used as part of prioritization and ranking.

The Prioritization Team meets bi-weekly to review the prioritized list of homeless clients. The team is composed of representatives from ES, SSO, RRH, TH-RRH, and PSH providers, the VA, behavioral health providers, the SOAR team and Street Outreach. Prior to the bi-weekly meeting, notice is sent out that includes the minutes from the last meeting, placements made from the prioritization lists, and the current prioritized lists of homeless households.

During the bi-weekly meeting the Prioritization Team discusses individual clients and which program could best serve them. Resources from outside the CoC are discussed and linkages to them provided. The prioritization list for each type of housing is reviewed and the order of priority is confirmed by the Prioritization Team, with adjustments being made as necessary. Once the team confirms the prioritization lists, the households on the prioritization lists are essentially “pre-referred” for any eligible opening which is identified until the next Prioritization Team meeting.

At the time of referral to supportive housing, the referring Access Point will need to provide a verification of homelessness and some proof of legal residency in the United States to the supportive housing provider. Permanent Supportive Housing projects will also need the Access Point to provide the signed Verification of Chronic Homelessness form. If possible, the referring Access Point should also provide the following client documents to the supportive housing program:

- Birth Certificate for all household members
- Social Security cards for all adults
- Government-issued photo ID
- Proof of income
- Verification of homelessness
- DD-214 (for Veteran referrals)

Referral Rejection Policy

No client may be turned away from homeless dedicated housing due to lack of income, lack of employment, disability status, or substance use unless the project's primary funder requires the exclusion or a previously existing and documented neighborhood covenant/good neighbor agreement has explicitly limited enrollment to clients with a specific set of attributes or characteristics. Housing Providers restricting access to projects based on specific client attributes or characteristics will need to provide documentation to the CoC providing a justification for their enrollment policy.

Both CoC housing providers and program participants may deny or reject referrals. Referral rejections from housing providers should be infrequent and must be documented in HMIS with specific justification as prescribed by the CoC. Allowable criteria for denying a referral include:

- Client/household refused further participation (or client moved out of CoC area)
- Client/household does not meet required criteria for program eligibility
- Client/household unresponsive to multiple communication attempts
- Client resolved crisis without assistance
- Client/household safety concerns
- Property management denial (include specific reasons documented by property manager and validated under fair housing laws).

Grievance and Appeal Procedure

If a client or provider is dissatisfied with the decision of the Coordinated Entry Team, they must put their concern in writing and request a meeting with the CoC leadership. CoC leadership will review the written document to schedule a meeting with the client within 5 business days of receiving the request and will render a decision in writing within 5 business days of the meeting.

4. Housing Interventions and Prioritization

Housing First

Housing First is an approach to permanent housing which HUD strongly recommends, and which has been shown to improve the housing outcomes of homeless households and will reduce overall homelessness within a CoC's geographic area. As defined by HUD, the core elements of a Housing First approach are:

- Few to no programmatic prerequisites to permanent housing entry
- Low barrier admission policies
- Rapid and streamlined entry into housing
- Supportive services are voluntary, but can and should be used to persistently engage tenants to ensure housing stability
- Tenants have full rights, responsibilities, and legal protections
- Practices and policies to prevent lease violations and evictions
- Applicable in a variety of housing models

Move On Strategy

The purpose of Coordinated Entry is to connect homeless households with the least restrictive, least intensive intervention which will help them permanently resolve their housing crisis. Some households will need the most intensive ongoing supports in order to maintain their housing, but some households, even those who begin in the most intensive programs, will eventually stabilize and be able to maintain permanent housing without CoC supports and resources. All programs should work with their clients to assess whether the household could be moved to a less intensive program type, or even move on from CoC support and resources entirely. Coordinated Entry staff will work with program staff to routinely screen all CoC programs to identify participants living in a CoC PSH program and certified by the CoC as appropriate for transition from a high acuity level of support into other less intensive housing opportunities to create opportunities for placement of new high acuity admissions from the CoC Prioritization List.

Housing Vouchers

Set-aside Housing Vouchers made available to the CoC by the Prince George's County Housing Authority should be utilized judiciously to resolve housing crises for households who are ready to move on from the need for high acuity projects, or for literally homeless households who have unusual barriers which CoC supportive housing projects cannot overcome (for example a household with more members than can be served in CoC transitional housing programs). Housing Vouchers should be prioritized for households who:

- Have an extensive history of homelessness,
- Are expected to lack of sufficient financial resources to ever afford market rate housing,
- Have sufficient resources that the application of a Housing Voucher would permanently resolve their housing crisis,
- Can handle all activities of daily living including rent payment, utility payments, etc.
- Have the ability to communicate respectfully and responsibly with Rental Offices and Utility companies, so as not to put their voucher at risk,
- If possible, for households who are literally homeless but lack financial prospects without the voucher to make them good candidates for RRH, they may be enrolled in RRH with financial subsidy and case management as a bridge to self-sufficiency with the voucher in place,
- Are otherwise described and/or prioritized in CoC-HAP MOUs or Agreements associated with special voucher types.

Prioritization Standards

The CoC's order of priority ensures that those persons with the longest histories residing in places not meant for human habitation, in emergency shelters, and in safe havens and with the most severe service needs are given first priority in PSH that is dedicated or prioritized for chronic homelessness.

In PSH that is not dedicated or prioritized for chronic homelessness those persons who do not yet meet the definition of chronic homelessness but have the longest histories of homelessness and the most severe service needs and are therefore the most at risk of becoming chronically homeless, are prioritized.

The matching and referral linkage process utilizes these prioritization criteria for each project type and takes into account the severity of the needs, length of time homeless, subpopulation characteristics, use of emergency public safety services and other criteria depending on the specific project type.

Rapid Rehousing

Rapid Re-housing (RRH) provides Prince George's County residents who are homeless with short-term housing subsidies allowing them to quickly achieve stable housing and become sustainably re-housed. RRH financial subsidy will generally be provided on a declining basis and all participants will be reassessed monthly to determine individual subsidy levels based on need and progress towards goals. Assistance will cease as soon as the participant is determined to be stable but may be provided for a period of no more than twelve (12) months. See the Prince George's County Continuum of Care: Rapid Re-Housing Policies and Procedures, incorporated herein by reference.

An applicant shall be eligible to receive RRH assistance if they:

1. Are a resident of Prince George's County, and,
2. Are currently literally homeless as defined by HUD (which includes having a primary nighttime residence that is a publicly or privately operated shelter or transitional housing facility designed to provide temporary living accommodations; or a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings), and,
3. Are referred by the Coordinated Entry Prioritization Team, and,
4. Have no other housing option (must be validated by the CoC).

Given that there will be more eligible applicants for RRH funds then limited resources can support, additional criteria will be considered by the HSP's Coordinated Entry Steering Committee and priority will be given to candidates who demonstrate the current capacity (or well-planned, potential capacity) to quickly achieve stable housing, **AND** who meet at least one of the following conditions:

- Homelessness status was a result of a *one-time* crisis – financial, health, domestic violence – for whom it can reasonably be assumed will become self-sustaining once the crisis is resolved.
- Reasonable expectation for career advancement or increased income as indicated by tenure in current employment, expected completion of education/vocational programs, achievement of skills and training certifications, or pending military, retirement or social security benefits.
- Documented opportunity of receiving subsidized housing or an assisted living placement within approximately twelve (12) months.
- Referred and case managed by one of the County's problem-solving courts (re-entry, drug, veterans, family and youth).
- Defined as Unaccompanied Homeless Youth, elderly, Domestic Violence survivor, or having a diagnosed disability (including HIV).

Joint Transitional-Rapid Rehousing

An applicant shall be eligible to receive Transitional-Rapid Rehousing if they:

1. Are a resident of Prince George's County, and,

2. Are currently literally homeless as defined by HUD (which includes having a primary nighttime residence that is a publicly or privately operated shelter or transitional housing facility designed to provide temporary living accommodations; or a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings) , and,
3. Are referred by the HSP's Coordinated Entry Prioritization Team, and,
4. Have no other housing option (must be validated by the CoC).

Given that there will be more eligible applicants for TH-RRH then limited resources can support, additional criteria will be considered by the HSP's Coordinated Entry Steering Committee and priority will be given to candidates who demonstrate planned, potential capacity to achieve stable housing, **AND** who meet at least one of the following conditions:

- Defined as Unaccompanied Homeless Youth or Domestic Violence survivor.
- Reasonable expectation for career advancement or increased income as indicated by tenure in current employment, expected completion of education/vocational programs, achievement of skills and training certifications, or pending military, retirement or social security benefits.
- Referred and case managed by one of the County's problem-solving courts (re-entry, drug, veterans, family and youth).

Permanent Supportive Housing

All admissions into PSH must come through Coordinated Entry and be accompanied by the CoC's *Verification of Chronic Homelessness Documentation Checklist and Summary* (addendum a). Because many of the CoC's PSH units are shared 2- or 3-bedroom apartments, Access Point case managers should work to identify other chronically homeless individuals with whom a person may be compatible. Prince George's County CoC has adopted the provisions and requirements set out in the HUD Notice CPD-14-012 for the Prioritizing Person's Experiencing Chronic Homeless and Other Vulnerable Homeless Persons in Permanent Supportive as the baseline written standards for operations of Permanent Supportive Housing Programs within the CoC.

PSH Dedicated or Prioritized for PSH

Order of Priority 1: A household should be prioritized first in dedicated or prioritized PSH if all of the following are true:

- Individual or head of household meets the definition of chronically homeless per 24 CFR 578.3; and,
- The length of time the individual or head of household has been homeless is at least 12 months continuously or over a of at least four occasions in the past 3 years where the total length of time homeless totals at least 12 months; and,
- The individual or head of household has been identified as having severe service needs (as outlined in Section 2 of this Policy).

Order of Priority 2: A household should be prioritized second in dedicated or prioritized PSH if all of the following are true:

- Individual or head of household meets the definition of chronically homeless per 24 CFR 578.3; and,
- The length of time the individual or head of household has been living in a place not meant for human habitation, a safe haven, or in an emergency shelter is at least 12 months continuously or over a period of at least four occasions in the past 3 years where the total length of time homeless totals at least 12 months; and,
- The individual or head of household has NOT been identified as having severe service needs; and,
- There are no chronically homeless households within the CoC's geographic area that meet the criteria under Order of Priority 1 for dedicated or prioritized PSH.

Order of Priority 3: A household should be prioritized third in dedicated or prioritized PSH if all of the following are true:

- Individual or head of household meets the definition of chronically homeless per 24 CFR 578.3; and,
- The length of time the individual or head of household has been living in a place not meant for human habitation, a safe haven, or in an emergency shelter is at least four occasions in the past 3 years where the total length of time homeless totals less than 12 months; and,
- The individual or head of household has been identified as having severe service needs; and
- There are no chronically homeless households within the CoC's geographic area that meet the criteria under Order of Priority 1 and 2 for dedicated or prioritized PSH.

Order of Priority 4: A household should be prioritized fourth in dedicated or prioritized PSH if all of the following are true:

- Individual or head of household meets the definition of chronically homeless per 24 CFR 578.3;
- The length of time the individual or head of household has been living in a place not meant for human habitation, a safe haven, or in an emergency shelter is at least four occasions in the past 3 years where the total length of time homeless totals less than 12 months; and,
- The individual or head of household has NOT been identified as having severe service needs; and
- There are no chronically homeless households within the CoC's geographic area that meet the criteria under Order of Priority 1, 2, and 3 for dedicated or prioritized PSH.

PSH that is not dedicated or prioritized for Chronically Homeless:

Order of Priority 1: A household should be prioritized first in non-dedicated and non-prioritized PSH if the following are true:

- The household is eligible for CoC Program-funded PSH meaning that there is a household member with a disability, and they are coming from a place not meant for human habitation, a safe haven, or in an emergency shelter. This includes persons exiting an institution where they have resided for 90 days or less but were living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter immediately prior to entering the institution; and
- The household has been identified as having severe service needs.

Order of Priority 2: A household should be prioritized second in non-dedicated and non- prioritized PSH if all of the following are true:

- The household is eligible for CoC Program-funded PSH meaning that there is a household member with a disability, and they are coming from a place not meant for human habitation, safe haven, or emergency shelter. This includes persons exiting an institution where they have resided for 90 days or less but were living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter immediately prior to entering the institution; and,
- The household has been living in a place not meant for human habitation, a safe haven, or in an emergency shelter for at least 6 months or has experienced three occasions in the past 3 years of living in one of these locations; and,
- The household has NOT been identified as having severe service needs; and,
- There are no eligible households within the CoC's geographic area that meet the criteria under Order of Priority 1 for non-dedicated or non-prioritized PSH.

Order of Priority 3: A household should be prioritized third in non-dedicated and non-prioritized PSH if all of the following are true:

- The household is eligible for CoC Program-funded PSH meaning that there is a household member with a disability, and they are coming from a place not meant for human habitation, safe haven, or emergency shelter. This includes persons exiting an institution where they have resided for 90 days or less but were living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter immediately prior to entering the institution; and,
- The household has NOT been identified as having severe service needs AND has been living in a place not meant for human habitation, a safe haven, or in an emergency shelter for less than six months or has experienced less than three occasions of living in one of these locations in the past 3 years; and,
- There are no eligible households within the CoC's geographic area that meet the criteria under Order of Priority 1 and 2 for non-dedicated or non-prioritized PSH.

Order of Priority 4: A household should be prioritized fourth in non-dedicated and non- prioritized PSH if the following is true:

- Any household that is eligible for CoC Program-funded PSH meaning that there is a household member with a disability, and they are coming from transitional housing where they entered directly from a place not meant for human habitation, emergency shelter, or safe haven.
- There are no eligible households within the CoC's geographic area that meet the criteria under Order of Priority 1, 2, and 3 for non-dedicated or non-prioritized PSH.

Addendum A: Verification of Chronic Homelessness Documentation Checklist and Summary

Verification of Chronic Homelessness Documentation Checklist and Summary

An applicant must be chronically homeless to be considered for PSH. To be considered chronically homeless, the Head of Household (HoH) must meet at least one of the specific elements of each of the following criteria:

1. **Housing Status**
    a. Currently homeless and has been continuously homeless for one year or longer
    b. Currently homeless and has experienced four or more occasions of homelessness, totaling 12 months or more, in the past three years
    c. Has been residing in an institutional care facility for fewer than 90 days and his/her housing status was either a. or b. before entering that facility
2. **Disability**
    a. Developmental Disability
    b. HIV or AIDS
    c. Physical, mental, or emotional impairment that meets all of the following criteria:
        i. Is expected to be of long-continuing or indefinite duration, and
        ii. Impedes the individual's ability to live independently, and
        iii. Is such that the ability to live independently could be improved with more suitable housing

To confirm program eligibility, please complete this form in its entirety.

Head of Household Name: _____ Date: _____

Referring Staff & Organization: _____ VI-SPDAT Score: _____

Disability – as defined by section 401(9) of the McKinney-Vento Homeless Assistance Act (43 U.S.C. 11360(9)).

Third Party Documentation is required. Please indicate the type of verification supplied and attach to this form.

☐ Written verification from a ***licensed professional*** certifying that the disability is expected to be long-continuing or of indefinite duration and substantially impedes the individual's ability to live independently

☐ Written verification from the ***Social Security Administration***

☐ Receipt of a **disability check**

☐ *Temporary Option – Staff Observations of a disability can be used for program entry, but must be confirmed by one of the above written standards within 90 days of program entry.*

Current Living Situation – To be considered chronically homeless, the individual must meet one of the following homeless conditions the night before entering the program.

Documentation and Details must be provided by completing the *Chronic Homeless Summary* (attached).

☐ Lives in a place not meant for human habitation or an emergency shelter.

☐ Has been residing in an institutional care facility for fewer than 90 days and met the homelessness criteria above before entering the facility (including but not limited to jail, substance abuse or mental health treatment facility or hospital).

Homeless History – To be considered chronically homeless, the individual must meet one of the following two homeless history conditions. (Documentation and Details must be provided by completing the *Chronic Homeless Summary* (attached)).

The individual must have been living in a place not meant for human habitation, or an emergency shelter:

☐ **Continuously for at least 12 months,** without a break of 7 or more consecutive nights

☐ **On at least 4 separate occasions in the last 3 years,** where the combined occasions equal at least 12 months

Notes: Stays in institutional care facilities for fewer than 90 days do not constitute a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was residing in an emergency shelter or place not meant for human habitation immediately before entering the institutional care facility.

A single encounter in a month is sufficient to consider the household homeless for the entire month unless evidence of a break.

Criteria for Documentation of Homeless History: You do not need to complete this page. It is for reference only.

Notes to Providers:

- At least 9 of the 12 months of homelessness or 3 of the 4 incidents of homelessness must be certified by third-party documentation. Three months or one incident can be self-certified.
- A single encounter in a month is sufficient to consider the household homeless for the entire month unless evidence of a break.
- In extreme cases self-certification of homelessness for more than 3 of 12 months or 1 of 4 incidents of homelessness is allowable if third-party documentation cannot be obtained.
    - Attempts to obtain 3rd party documentation must be thoroughly documented along with the reasons why 3rd party documentation was not obtained; and
    - This is limited to rare circumstances. No more than 25% of households served in a program during an operating year can be self-certified.

Current Living Situation	Suitable Documentation
Streets or other place not meant for human habitation	• **Written Third Party** (one or more of the following) o HMIS record of calls to Hotline and/or street outreach contacts o Signed letter on letterhead from street outreach or homeless service provider o Signed letter on letterhead from referral sources including: feeding centers, churches, somatic and behavioral health providers, crisis response, police, and libraries. OR • **Self-Declaration** (both of the following): o Signed declaration of homelessness o Written explanation by staff of attempts to secure 3rd party verification
Emergency Shelter (includes hypothermic, church-based, domestic violence and County shelters)	• **Written Third Party** (one or more of the following) o HMIS record of shelter stay o Signed letter on letterhead from the shelter provider OR • **Self-Declaration** (both of the following): o Signed declaration of homelessness o Written explanation by staff of attempts to secure 3rd party verification
Hospital, Jail, or Other Institution If the client's stay was 90 days or less and the client was in shelter or on the streets prior to entry, the time at the institution is counted as time homeless. If the client's institutional stay is over 90 days it is counted as a break in homelessness.	• **Written Third Party** (one or more of the following) o Letter or discharge paperwork from hospital or other institution, including admission and discharge dates o Referral from Dept of Corrections, Offender Reentry Program or one of the County's Specialty Courts o Record of institutional stay pulled from institutional database *AND*, to document homelessness, at least one of the types of documentation required for streets or shelter homelessness related to the client's housing status immediately prior to stay in the institution, or identification as homeless upon intake at the institution.

Chronic Homelessness Summary: Please complete this form in its entirety.

In the table below, chart the HoH's housing situation for one year or three years, depending on the category by which s/he is being qualified. Attach sufficient documentation for each change in housing situation. Up to 3 months (or one episode) can be documented through self certification.

The HoH is eligible because s/he has experience (check one)

☐ Continuous homelessness on the streets or in shelters for 1 year or longer (document a least the past 1 year)

☐ 4 or more occasions of homelessness totaling 12+ months on the streets or in the shelters in the past 3 years (document the past 3 years)

	Start Date	End Date	Duration	Location (Type)	Location (Provider name or location description)	Documentation	Attached
Episode 1				☐ Place not meant for habitation ☐ Emergency Shelter ☐ Institution< 90 days		☐ HMIS or Institutional record ☐ Housing/ Service Provider ☐ Outreach/ Referral Provider ☐ Client Self-Certification	☐ Yes ☐ No
Episode 2				☐ Place not meant for habitation ☐ Emergency Shelter ☐ Institution< 90 days		☐ HMIS Institutional record ☐ Housing/ Service Provider ☐ Outreach/ Referral Provider Client Self-Certification	☐ Yes ☐ No
Episode 3				☐ Place not meant for habitation ☐ Emergency Shelter ☐ Institution< 90 days		☐ HMIS Institutional record ☐ Housing/ Service Provider ☐ Outreach/ Referral Provider ☐ Client Self-Certification	☐ Yes ☐ No
Episode 4				☐ Place not meant for habitation ☐ Emergency Shelter ☐ Institution< 90 days		☐ HMIS Institutional record ☐ Housing/ Service Provider ☐ Outreach/ Referral Provider ☐ Client Self-Certification	☐ Yes ☐ No

Certifications

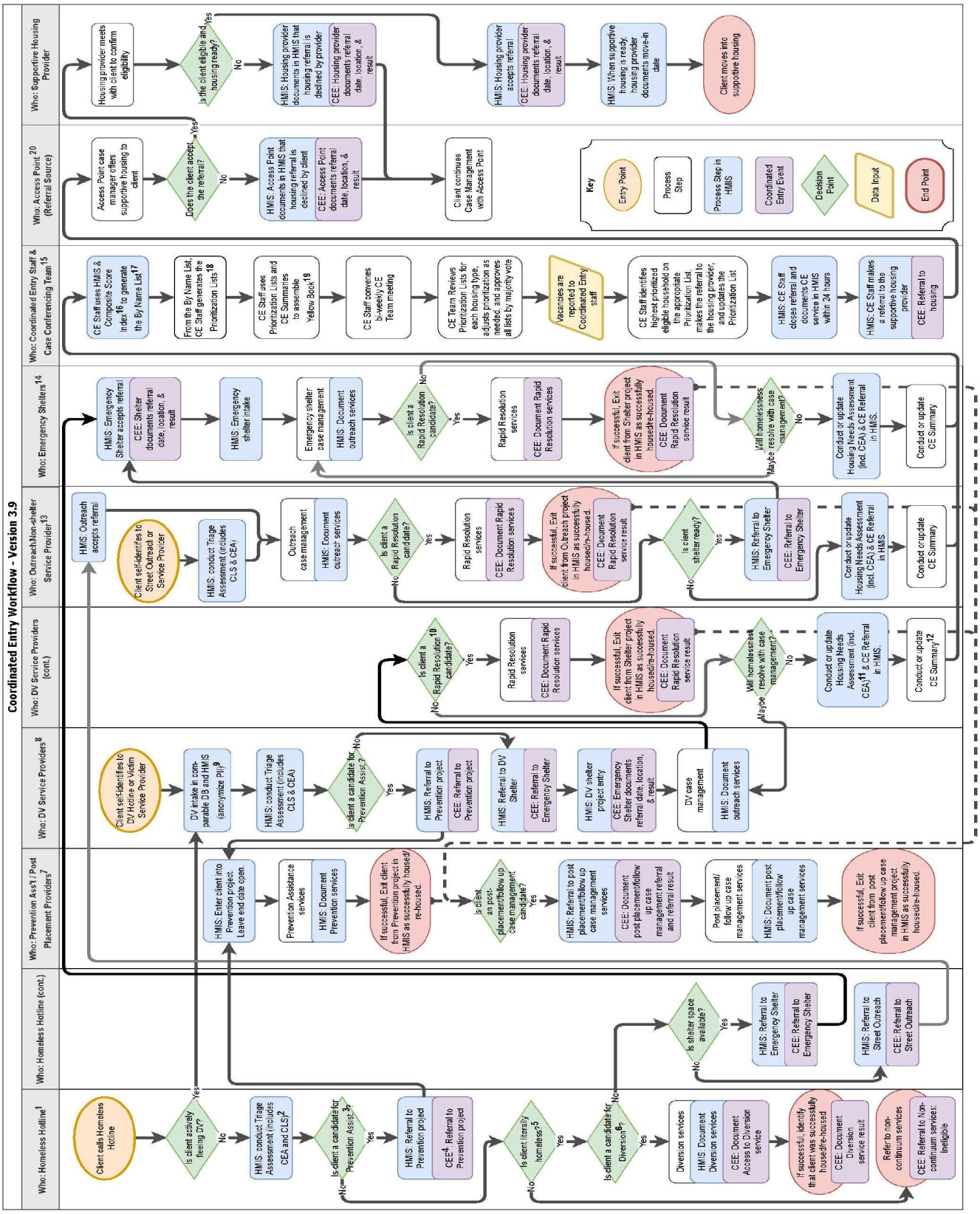
I, the Head of Household named below, certify that the timeline documented above is accurate to the best of my recollection.

Head of Household Name (printed): _____ Signature: _____ Date: _____

I, the Staff named below, certify that the timeline documented above is accurate as the HoH described it during the interview(s) conducted on the following date(s): _____

Staff Name (printed): _____ Signature: _____ Date: _____

Addendum B: Coordinated Entry Workflow (version 3.9)



Coordinated Entry Workflow - Version 3.8

Who: Homeless Hotline	Who: Homeless Hotline (cont.)	Who: Prevention Ass't / Post Placement Providers	Who: DV Service Providers	Who: DV Service Providers (cont.)	Who: Outreach/Non-shelter Service Provider	Who: Emergency Shelters	Who: Coordinated Entry Staff & Case Conferencing Team	Who: Access Point (Referral Source)	Who: Supportive Housing Provider
[1] The Prince George's County Homeless Hotline (1-888-731-0999) is the central information and access point for homeless services including emergency shelter. The Hotline screens for Domestic Violence, Human Trafficking, Sexual Assault, Veteran status, and Transition Age Youth status to screen callers to appropriate services. [2] The Prince George's County Triage Assessment is a universal intake and assessment tool which captures the data elements required for all clients in HMIS. It assesses a clients eligibility for referral to special programs (Veteran, TAY, DV, Chronic, etc.) and incorporates the Crisis Needs Assessment, Current Living Situation, and Coordinated Entry Event Sub-assessments for Coordinated Entry. [3] Homeless Prevention Assistance is for households who are at risk of homelessness within 14 days due to an external event. [4] A Coordinated Entry Event (CEE) is any referral or result of referral which is tracked in HMIS for the the Coordinated Entry System. [5] Eligibility for programs in Prince George's County may depend on program requirements. See https://bit.ly/2E7RZmZ for more details about the four categories of homelessness defined by the McKinney-Vento Act, or consult the Coordinated Entry Policy. [6] Diversion is a strategy that prevents homelessness for people seeking shelter by helping them identify immediate alternate housing arrangements and, if necessary, connecting them with services and financial assistance to help them remain in or return to permanent housing.		[7] Post placement/follow up case management services are CoC funded and available to households leaving a CoC project for a permanent housing solution.	[8] DV Service Providers who can perform intake into the DV Service System of the Prince George's County CoC include members of the Prince George's County DV Coalition. [9] Information on clients experiencing domestic violence, human trafficking, or sexual assault (collectively referred to as DV) cannot have Personally Identifying Information (PII) entered into HMIS, per the Violence Against Women Act of 1994 (VAWA). Client information including PII is maintained in a Comparable Database. Information necessary for the clients' referral to Coordinated Entry is entered into HMIS with the PII anonymized. See Prince George's County Domestic Violence Policy for more details. [10] Rapid Resolution is an intervention designed to prevent immediate entry into homelessness or immediately resolve a household's homelessness once they enter shelter, transitional housing or an unsheltered situation. [11] The Housing Needs Assessment is a Coordinated Entry Assessment (CEA) used to assess a household to determine the best fit among available permanent housing solutions. [12] The Coordinated Entry Summary is created when an Access Point case manager puts Case Conferencing information into a CE created Google Form. The CE Summary collects all CE information that is not already contained in HMIS.		[13] Outreach and non-shelter service providers are projects or programs within or outside of the CoC which serve unsheltered homeless individuals and have the ability to perform assessments and make referrals in HMIS. This includes DSS Street Outreach, the Bridge Center at Adam's House, homeless drop-in centers, the Healthcare Alliance, PGC Department of Corrections, and others.	[14] Emergency Shelters provide shelter for people experiencing homelessness and includes case management which is documented in HMIS.	[15] The CE Case Prioritization Team (CE Team) is made up of representatives of the defined Access Points, CoC Supportive Housing Providers, and is chaired by the Coordinated Entry Program Manager (CEPM). The CE Team meets bi-weekly to review and approve the Prioritization Lists. [16] The Composite Score Index produces a vulnerability score from questions and data elements in HMIS. [17] The By Name List is made up of all homeless individuals in the CoC who are unsheltered, meet the HUD definition of Chronically Homeless, and/or are referred to Coordinated Entry because their homelessness is not expected to resolve through routine case management. Chronic homelessness has been defined by HUD as a single individual (or head of household) with a disabling condition who has either experienced homelessness for longer than a year (living in a shelter, safe haven, or a place not meant for human habitation) or experienced at least 12 months of homelessness in four or more instances in the last three years. [18] The Prioritization Lists are made up of the highest vulnerability clients on the By Name List and are case conferenced and considered for referral to supportive housing resources by the Coordinated Entry Team. [19] The "Yellow Book" is the resource used at the Coordinated Entry Bi-weekly Meeting to prioritize clients. It is made up of the Prioritization List of clients and a summary sheet for each client on the list derived from the CE Summary Google Form. It's called the "Yellow Book" because the original resources were placed in yellow report covers.	[20] Access Points are service providers who encounter unsheltered homeless individuals or households and can make referrals to the Prioritization List. They are the primary point of case management for clients who have not yet been placed in supportive housing. At this writing the Prince George's County CoC Access Points are: • ACIS • Chronic Homelessness Workgroup • Department of Corrections • DSS Street Outreach • Domestic Violence Workgroup • Family Emergency Shelter • Housing Initiative Partnership • LARS • Mission of Love Charities Day Center • PG Plaza Day Center • Prince George's House • Promise Place • QCI • Safe Passages • Senior Homelessness Workgroup • Shepherd's Cove • SOAR • Veteran Homelessness Workgroup • VOA • Warm Nights • Youth Homelessness Workgroup	