Prince George's County CoC Coordinated Entry Policy and Order of Priority

1. Introduction

The CoC Interim Rule defines several responsibilities of the Continuum of Care (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. Prince George's County Continuum of Care (CoC) has developed the following Coordinated Entry Written Standards for providing assistance using McKinney-Vento Homeless Assistance funds in accordance with the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) 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 (CES).

A coordinated entry/assessment system is defined to mean a coordinated process designed to coordinate program participant intake, assessment, and provision of referrals. The basic minimum requirements for the Continuum's coordinated assessment system includes:

- Covers the entire geographic area of the County,
- Is easily accessed by individuals and families seeking housing or services,
- Is well advertised,
- Includes 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.

CES 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 System (CES) 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. CES 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 CES:

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.

Key elements of CES include:

- A designated coordinated entry team that makes housing referrals within the CoC
- The use of standardized assessment tools to assess consumer needs – Housing Prioritization Tool (HPT) and Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT).
- Prioritization of consumers 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.
- Documentation of VI-SPDAT scores, ranking on the priority housing list, referrals, etc in HMIS or other shared database to ensure transparency.
- Regular – bi-weekly – Coordinated Entry meetings that includes representatives from ES, RRH, TH, and PSH providers, Behavioral Health, Street Outreach and other interested parties.
- A Coordinated Entry Steering Committee (meets quarterly, or more often when necessary) that is responsible for establishing policies, procedures and performance benchmarks, measuring performance and identifying system gaps, resolving conflicts and coordinating funding resources. This is a relatively small group of executive-level decision-makers from the major providers and/or funders of housing or services.

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.

3. CES in Prince George's County

Coordinated entry in the county consists of several components which are described in detail below.

Initial Contact and Engagement
Street Outreach
Street homeless will be linked with an outreach team who will triage the case and ensure the consumer's basic needs are being met as completely as possible. They will facilitate obtaining identification, access to behavioral health providers, food and clothing, and remain in contact with the consumer until a housing plan can be implemented. Street Outreach team members will enter consumer 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 will help gather information to prove chronicity and disability.

Homeless Hotline
All potential consumers will be screened and assessed utilizing the Housing Prioritization Tool (HPT) to determine if they are homeless or at risk of imminent homelessness. All consumers will be assisted in being linked to mainstream resources resources outside the Homeless Services System including: Social Services, Energy Assistance, Somatic and Behavioral Health, SOAR, Employment Programs, Food Pantries, etc. Basic consumer information will be entered into HMIS, along with any service transactions provided.

Special populations will be identified at this point and appropriate referrals made:

Veterans	→	VA and SSVF providers
Domestic Violence	→	Family Crisis Center, DASH, CAFY, Still I Rise
Unaccompanied Youth	→	Promise Place, MMYF
Returning Citizens	→	Adams House, Welcome Home, American Justice Reentry & Rehabilitation
Chronically Homeless Behavioral Health	→	Street Outreach Team, QCI, Crisis Services

If a consumer meets the criteria for being homeless or at imminent risk of homelessness, efforts will be made to divert the household from entering the sheltering system through mediation, emergency rental assistance, and/or rapid re-housing. If 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 individual/family will be referred and contact information provided to the CE team.

Screening and Assessment
Screening and assessment collects information to guide referrals for emergency rental assistance, rapid re-housing, transitional housing, subsidized and unsubsidized housing, and permanent supportive housing based on consumer need, program eligibility and services offered. Prince George's County utilizes two assessment tools.

Housing Prioritization Tool (HPT)
The HPT is an initial screening tool used to assign a color code – green, yellow, orange or red – to a household. These colors provide guidance on the appropriateness of certain housing options and indicate what further interventions, if any, may be offered.

Green Color Code
A green color code indicates few barriers to housing. People in these households should be linked to mainstream resources, provided tools to self-resolve their homelessness, and, when appropriate, provided with security deposit and/or first month rent assistance or longer term rapid re-housing.

Yellow, Orange, or Red Color Code
All persons with scoring yellow, orange or red will be assessed using the VI-SPDAT

VI-SPDAT
In order to maintain consistency and transparency, VI-SPDATs are conducted by trained members of the CE team who are not direct employees of sheltering or housing programs within the CoC. VI-SPDATs are conducted on the individual/family within 3 days of the referral being made by the Hotline or Street Outreach whenever possible. If the person has been placed in emergency shelter the assessment will take place in the shelter. If the person is on the street and/or was not placed in ES because of lack of space, the CE team will conduct the assessment at a mutually agreed upon location.

All VI-SPDATS are entered into HMIS within a week. Case managers will use the information provided by the VI-SPDAT to tailor case management and supportive services options. Additionally the VI-SPDAT score identifies which housing intervention, if any, is best suited to the household.

While the VI-SPDAT score is used to determine appropriate housing intervention (as detailed in the VI-SPDAT score chart) Prince George's County has developed an order of priority for housing placement that ensures alignment with Open Doors, the Federal Plan to End Homelessness, and the County's 10 year plan to prevent and end homelessness.

Order of Priority for Housing
1) Chronically Homeless Veterans
2) All other Chronically Homeless Persons and Families
3) Veterans
4) Unaccompanied Homeless Youth

5) Families who are victims of Domestic Violence or have a Behavioral Health diagnosis and/or physical disabilities
6) All other Families
7) Singles who are victims of Domestic Violence, Singles with a Behavioral Health diagnosis and/or physical disabilities, Retuning Citizens
8) All other singles

VI-SPDAT Score	Housing Intervention	Notes
0 - 4	Family and/or landlord mediation. Assistance with security deposit and 1st month rent.	Linkages to mainstream services and supports. Case management focuses on increasing household income, money management, family relationships, and helping the household to self-resolve.
5 – 9	Transitional Housing Housing Vouchers Rapid Re-housing	Transitional Housing is prioritized for Unaccompanied Homeless Youth and Families fleeing Domestic Violence. HV and RRH resources are extremely limited. Households should be assisted in self-resolving whenever possible. Other housing options and mainstream supports must be pursued.
10 - 20	Housing Vouchers Permanent Supportive Housing	Because many of the CoC's PSH units are shared 2 or 3 bedroom apartments, street outreach and case management should work to identify other CH individuals with whom the person maybe compatible. Non-chronic households can be considered for PSH that is not dedicated or prioritized for the chronically homeless.

The VI-SPDAT tool allows the CoC to quickly identify which consumers have the most barriers to returning to housing so they can be prioritized for a housing intervention. While each housing intervention has its own standards for entry (detailed in Section: 4) in addition to the VI-SPDAT score some of the criteria used to determine a consumer's placement on the priority list for an intervention 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.

The priority list is updated weekly and is kept as a shared Google document that is utilized by the CE team and available to members of the CoC, and the broader Homeless Services Providers

group. Beginning November 1, 2016, the CoC will require the VI-SPDAT assessment to be entered into HMIS, subsequently the priority list and all coordinated entry referrals will be managed in HMIS.

Coordinated Entry Team Meetings/ Referral Protocols

The Coordinated Entry Team meets bi-weekly to review the prioritized list of homeless consumers and match them to current and upcoming openings within the CoC. The CE team is composed of representatives from ES, RRH, TH, and PSH providers, the VA, behavioral health providers, the SOAR team, and Street Outreach. Prior to the meeting notice is sent out that includes the minutes from the last meeting, the current prioritized list of homeless households, and any current housing openings within the CoC.

During the bi-weekly meeting the CE team discusses individual consumers and which program could best serve them. Resources from outside the CoC are discussed and linkages to them provided. Matches are made in priority order from the priority housing list to TH, RRH, and PSH providers. Once the decision is made a referral is completed to the receiving program and the consumer's Housing Navigator arranges a warm hand-off.

Housing Navigators serve as the main point of contact for each individual targeted for a housing intervention. When the consumer is located in a shelter their case manager is their de facto navigator. If the person is living in a place not meant for human habitation a Street Outreach worker, SOAR specialist or Community Health worker can act as their housing navigator. Navigators provide referrals, offer coordination, or provide in-person support to clients for their mental health, physical health, entitlement enrollment, and other service needs. The level of support provided is based on a client's independence; at a minimum, the housing navigator will serve as the main point of contact for the individual and help collect all documents needed to be placed in housing.

Basic documents to be considered "housing ready" include: 1. Birth Certificate 2. Social Security card 3. Government issued photo ID 4. Proof of any income or zero income statement 5. Verification of homelessness 6. DD-214 if the person is a Veteran.

Referral Rejection Policy

No consumer may be turned away from homeless designated 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 providers and program participants may deny or reject referrals. All service denials should be infrequent and must be documented in HMIS with specific justification as prescribed by the CoC. Allowable criteria for denying a referral includes:

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

4. Prioritization Standards

The matching and referral linkage process takes into account a set of prioritization criteria for each project type. The CoC has established priority for each project type based on the severity of the needs, length of time homeless, subpopulation characteristics, use of emergency public safety services and other criteria depending on the specific CoC component type.

Rapid Rehousing
Rapid Re-housing (RRH) provides Prince George's County households who are homeless and demonstrate the current capacity (or well-planned, potential capacity) to quickly achieve stable housing with short-term housing subsidies allowing them to become sustainably re-housed. RRH assistance will 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 he/she:

1) Is a resident of Prince George's County.
2) Is currently 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;
3) Is referred by the HSP's Coordinated Entry Sub-committee,
4) Has a documented VI-SPDAT score between 5 and 9, **AND**
5) Has 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 sub-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 UHY, elderly, Domestic Violence survivor, disabled (including HIV).

Transitional Housing
An applicant shall be eligible to receive Transitional Housing if he/she:

1) Is a resident of Prince George's County.
2) Is currently 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;
3) Is referred by the HSP's Coordinated Entry Sub-committee,
4) Has a documented VI-SPDAT score between 5 and 9, **AND**
5) Has no other housing option (must be validated by the CoC).

Given that there will be more eligible applicants for TH then limited resources can support, additional criteria will be considered by the HSP's Coordinated Entry sub-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 UHY 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).

PSH
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 Housing (PSH) and Recordkeeping requirements for Documenting Chronic Homeless Status as the baseline written standards for operations of Permanent Supportive Housing Programs within the CoC.

The Order of Priority for Permanent Supportive Housing is as follows:

- Those who meet the definition of chronically homeless AND have the longest histories of homelessness AND have the highest service needs;

- Those who meet the definition of chronically homeless AND have the longest histories of homelessness;
- Those who meet the definition of chronically homeless AND have the highest service needs;
- All other chronically homeless individuals and families;

If no chronically homeless individuals or families are on the waiting list that meet the criteria of the program or unit available then placement will be made from the homeless registry in the following order of priority

- Homeless individuals and families with a disability AND the highest service needs;
- Homeless individuals and families with a disability and the longest histories of homelessness;
- Homeless individuals and families with a disability; AND
- Individuals and Families with a disability who are residing in Transitional Housing who were unsheltered, residing in shelter or fleeing domestic violence immediately prior to entering Transitional Housing.