



**System Operations Manual**

**TX – 700 Continuum of Care**

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

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

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

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

(September 2015)



# TX – 700 Continuum of Care

## Coordinated Access System Operations Manual

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## I. Purpose and Background

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

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

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

The *Coordinated Access System* is designed to:

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

- ❖ Ensure clarity, transparency, consistency and accountability for homeless clients, referral sources and homeless service providers throughout the assessment and referral process;
- ❖ Facilitate exits from homelessness to stable housing in the most rapid manner possible given available resources;
- ❖ Ensure that clients gain access as efficiently and effectively as possible to the type of intervention most appropriate to their immediate and long-term housing needs;
- ❖ Ensure that people who have been homeless the longest and/or are the most vulnerable have priority access to scarce permanent supportive housing resources.

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

- ❖ A **uniform and standard assessment process** to be used for all those seeking assistance and procedures for determining the appropriate next level of assistance to resolve the homelessness of those living in shelters, on the streets, or places not meant for human habitation;
- ❖ Establishment of **uniform guidelines** among components of homeless assistance (Transitional Housing, Rapid Re-housing, and Permanent Supportive Housing) regarding: eligibility for services, priority populations, expected outcomes, and targets for length of stay;
- ❖ Agreed upon **priorities for accessing homeless assistance**;
- ❖ **Referral policies and procedures** from the system of coordinated access to homeless services providers to facilitate access to services;
- ❖ The **policies and procedure manual** contained herein and detailing the operations of the *Coordinated Access System*.

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

## II. Definitions

Terms used throughout this manual are defined below:

### **Chronically Homeless (HUD Definition):**

(1) *An individual who:*

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

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

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

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

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

### **Disability (HUD Definition):**

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

**Developmental Disability** *Defined in §102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 USC 15002). Means a severe, chronic disability that is attributable to a mental or physical impairment or combination AND is manifested before age 22 AND is likely to continue indefinitely AND reflects need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. An individual may be considered to have a developmental disability without meeting three or more of the criteria listed previously, if Individual is 9 years old or younger AND has a substantial developmental delay or specific congenital or acquired condition AND without services and supports, has a high probability of meeting those criteria later in life.*

**HIV/AIDS Criteria** *Includes the disease of acquired immunodeficiency syndrome (AIDS) or any conditions arising from the etiologic agent for acquired immunodeficiency syndrome, including infection with the human immunodeficiency virus (HIV).*

**Literally Homeless (HUD Homeless Definition Category 1):**

*(1) Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) Has a primary nighttime residence that is a public or private place not meant for human habitation; (ii) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or (iii) Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution*

**At imminent risk of homelessness (HUD Homeless Definition Category 2)**

*Individual or family who will imminently lose their primary nighttime residence, provided that: (i) Residence will be lost within 14 days of the date of application for homeless assistance; (ii) No subsequent residence has been identified; and (iii) The individual or family lacks the resources or support networks needed to obtain other permanent housing*

**Homeless under other Federal statutes (HUD Homeless Definition Category 3)**

*Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who: (i) Are defined as homeless under the other listed federal statutes; (ii) have not had a lease, ownership interest, or occupancy agreement in permanent housing at any time during the 60 days immediately preceding the date of application for homeless assistance; (iii) Have experienced persistent instability as measured by two moves or more during the 60-day period immediately preceding the date of applying for homeless assistance; and (iv) can be expected to continue in such status for an extended period of time due to special needs or barriers*

**Fleeing domestic abuse or violence (HUD Homeless Definition Category 4)**

*Any individual or family who: (i) Is fleeing, or is attempting to flee, domestic violence; (ii) Has no other residence; and (iii) Lacks the resources or support networks to obtain other permanent housing*

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

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

## **Vulnerability Index**

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

### **Singles VI**

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

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

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

### **Rapid Re-housing Next Step Assessments**

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

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

6. Criminal background history
7. Mental health history

### **Homeless Management Information System**

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

The U. S. Department of Housing and Urban Development (HUD) and other planners and policymakers at the federal, state, and local levels use aggregate HMIS data to obtain better information about the extent and nature of homelessness over time. Specifically, HMIS can be used to produce an unduplicated count of homeless persons, understand patterns of service use, and measure the effectiveness of homeless programs.

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

### **III. Staffing Roles and Expectations**

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

- Help create integrated, community-wide strategies and plans to prevent and end homelessness;

- Provide coordination among the numerous regional organizations and initiatives that serve the homeless population, and
- Create the region's single, comprehensive grant application to HUD for McKinney-Vento funding.

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

- Creating and widely disseminating materials regarding services available through the *Coordinated Access System* and how to access those services;
- Designing and delivering training at least annually to all key stakeholder organizations, including but not limited to the required training for *Coordinated Access Staff*;
- Ensuring that pertinent information is entered into HMIS for monitoring and tracking the process of referrals including vacancy reporting and completion of assessments;
- Managing case conferences to review and resolve rejection decisions by receiving programs and refusals by clients to engage in a housing plan in compliance with receiving program guidelines;
- Managing an eligibility determination appeals process in compliance with the protocols described in this manual;
- Managing manual processes as necessary to enable participation in the *Coordinated Access System* by providers not participating in HMIS;
- Designing and executing ongoing quality control activities to ensure clarity, transparency, and consistency in order to remain accountable to clients, referral sources, and homeless service providers throughout the coordinated access process;
- Periodically evaluating efforts to ensure that the *Coordinated Access System* is functioning as intended;
- Making periodic adjustments to the *Coordinated Access System* as determined necessary;
- Ensuring that evaluation and adjustment processes are informed by a broad and representative group of stakeholders;
- Updating policies and procedures
- Managing all PR requests related to the *Coordinated Access System*.

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

- Serving as point person and lead to all workgroups and transition teams
- Providing Coordinated Access training to participating agencies
- Database administering
- Report generating
- Communicating to user agencies and outreach coordinators
- Deactivating/reactivating client records
- Responding to requests for client deletion
- Responding to email generated questions
- Monitoring system performance (Coordinated Access Staff, Database, Providers, etc.).

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

Housing Assessors – see Policies & Procedures

Housing Navigators – see Policies & Procedures

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

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

#### **IV. Target Population**

The *Coordinated Access System* is open to all households who meet the HUD definition of homeless, as outlined in the new HEARTH Act regulations, and have incomes below 50% of the Area Median Income. The system uses vulnerability indices (described in Definitions) to rank Applicants in order of vulnerability, with the most vulnerable households ranked at the top.

More directly, applicants may be offered housing regardless of vulnerability score, but the more vulnerable persons will likely be offered housing before non-vulnerable.

## V. System Overview and Workflow

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

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

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

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

- **Step 2: Housing Assessment** – *Housing Assessors* are available at Assessment Hubs, the call center, and through community outreach teams to conduct the *Coordinated Access Housing Assessment* with households in need. The assessment is completed using HMIS. An additional *Vulnerability Index Assessment* is generated in HMIS for all households identified as a match for Permanent Supportive Housing and to prioritize referrals. Additional next step assessments are generated in HMIS for all households identified as a match for Rapid Re-housing and to prioritize referrals. Households must be re-assessed if more than 90 days have passed since the previous assessment.
- **Step 3: Housing Match** – Information gathered from the assessment is used to determine which housing intervention is best suited to end the household's homelessness (Permanent Supportive Housing or Rapid Re-housing). HMIS automatically matches households to a particular housing intervention and then a specific housing program based on program eligibility.
- **Step 4: Housing Referral** – Once the recommended intervention and eligible programs have been identified in HMIS and the household individuals have decided which programs they are interested in, an electronic referral to the provider can be completed and the following two options are available to the *Housing Assessor*:

- a. A reservation can be made to pull the unit from HMIS; or
  - b. The household can be added to the waitlist if no open units are available
- **Step 5: Housing Navigation** – After being referred to a housing provider, households will be connected with a *Housing Navigator*. This connection can be made in real time or by pulling from the *Coordinated Access Waitlist*. The *Housing Navigator* can be one of the following: the original referring Case Manager, the original Coordinated Access referring Outreach Worker, or a designated *Coordinated Access Housing Navigator*. The *Housing Navigator* begins the process of securing the identified unit. This process may include but is not limited to the following activities: obtaining ID, obtaining social security cards, obtaining homeless verification documents, obtaining a security deposit, obtaining application fees, and providing transportation to tour available units. **The process form referral to move in should be completed within 30 days.**

Below is an illustration of the CA Workflow:



## VI. Coordinated Access Policies and Procedures

### 1. Connecting to the Coordinated Access System

- 1.1. Locations & Hours – Assessments are conducted at designated *Assessment Hubs*. A future call center will also be established at one of the *Assessment Hubs*. Current Assessment Hub locations and assessment hours can be found on the Coalition for the Homeless of Houston/Harris County's website [www.homelesshouston.org](http://www.homelesshouston.org).
- 1.2. Eligibility – The *Coordinated Access System* is intended to facilitate access to the most appropriate housing intervention for each household's immediate and long-term housing needs and ensure that scarce permanent housing resources are targeted to those who are most vulnerable and/or have been homeless the longest. The *Coordinated Access System* uses the following criteria to accurately match needs to the appropriate housing intervention:

## Permanent Supportive Housing

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

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

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

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

## Rapid Re-Housing

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

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

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

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

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

## Transitional Housing

Time-limited housing where individuals that are homeless may stay and receive supportive services, that are designed to enable individuals to move into permanent housing.

Program Description	Essential Program Elements	Time Frame	Population	Desired /Expected Outcomes
<p>Short-term housing and supportive, wrap-around services (up to 2 yrs.) to prepare individuals that are homeless to secure and maintain permanent housing at exit.</p> <p>Intended to rapidly house and stabilize without barriers to enrollment (i.e., eligibility requirements such as income, sobriety, child care, rental history).</p>	<p><b>Case Management</b></p> <ul style="list-style-type: none"> <li>• Housing focused</li> <li>• Linkage mainstream resources and other supports as needed</li> <li>• Not mandatory for continued housing</li> <li>• Tailored to participant needs not to program and does not prescribe a standard “program” for every household.</li> </ul> <p>Domestic Violence Specific Considerations:</p> <ul style="list-style-type: none"> <li>• Access to crisis intervention services</li> <li>• Safety planning</li> <li>• Legal advocacy</li> </ul> <p><b>Housing</b></p> <ul style="list-style-type: none"> <li>• Provision of or formalized partnership to housing referrals and placement services</li> <li>• Primary responsibility of program is to locate permanent housing</li> <li>• Must be licensed or have licensed oversight if substance use, mental or physical health oriented.</li> </ul> <p><b>Harm Reduction and Housing First</b></p> <ul style="list-style-type: none"> <li>• Incorporate proven best practices and evidence-based practices.</li> <li>• Program agreement does not include “zero tolerance” policies (with the exception of physical violence or threats) for attainment or retention of housing.</li> <li>• Comply with Fair Housing Laws (no single-gender programs or arbitrary caps on ages, numbers or genders of children)</li> <li>• Comply with HUD Equal Access Rule</li> </ul>	<p>Up to 2 years of housing subsidy and case management</p> <p>Up to 6 months of follow-up services provided after exit</p>	<ul style="list-style-type: none"> <li>• Youth who cannot sign a lease (under 18 years), those fleeing domestic violence, those interested in substance use treatment and/or recovery support, and recently released from institutions, those seeking licensed medical or mental health housing</li> <li>• May be used as bridge to PSH for enrolled clients awaiting housing location or approval</li> </ul> <p>Helping those who are not chronically homeless, or who could be served by rapid re-housing and who are experiencing a transition in life (substance abuse recovery, unaccompanied minors, mental or physical health crisis and domestic violence) and could benefit from quickly accessing low barrier but program rich housing and services.</p>	<p><b>Outcome: Exiting households will secure and maintain permanent housing.</b></p> <p><b>Indicators:</b></p> <p>Threshold: 80% of households exit to permanent housing.</p> <p>Threshold: 40% of all participants have employment income.</p> <p>Threshold: 10% of all participants have non-employment income.</p> <p>Threshold: 56% of participants obtain mainstream benefits.</p>

## Hostel

Non-time limited, self-pay housing option for individuals. Payment is by the day, week or month. Sleeping may be dorm-style or private rooms. Supportive services are not available, nor are there programmatic aspects of this housing. Shared amenities are available such as laundry, lavatory, kitchen, phone, computer, lounge and locked storage space.

Program Description	Essential Program Elements	Time Frame	Population	Desired /Expected Outcomes
<p>Very low barrier, bunk or cot-style housing option for working poor. Offers amenities to be shared by all residents. Designed to be affordable and flexible in order to accommodate a range of individuals.</p>	<p><b>Low-cost, low-barrier housing</b></p> <ul style="list-style-type: none"> <li>• Basic check-in requirement that does not assess for criminal background, mental health, disability status or sobriety.</li> <li>• May require acceptance of limited rules geared toward safety of all residents.</li> <li>• Absence of curfews/check-in times to accommodate for varying employment schedules (including 3<sup>rd</sup> shift)</li> <li>• Payment for bed is due daily, weekly or monthly.</li> </ul> <p><b>Amenities</b></p> <ul style="list-style-type: none"> <li>• Shared kitchen, laundry, showers, lounge, phone, charging stations and computers are available for resident use.</li> <li>• Foot lockers for storage of personal items are available.</li> </ul>	<p>No time limits</p>	<ul style="list-style-type: none"> <li>• Adults with income who may not qualify for traditional rental opportunities</li> </ul>	<p><b>Outcome: Residents will not enter the community homeless response system.</b></p>

1.3 Marketing/Advertising – As needed, the *Coordinating Entity* will send information & updates regarding the *Coordinated Access System* via email to stakeholders, the 211 hotline, and the general public. The *Coordinating Entity* also distributes flyers and brochures and maintains information available on its website [www.homelesshouston.org](http://www.homelesshouston.org).

## 2. The Housing Assessment Process

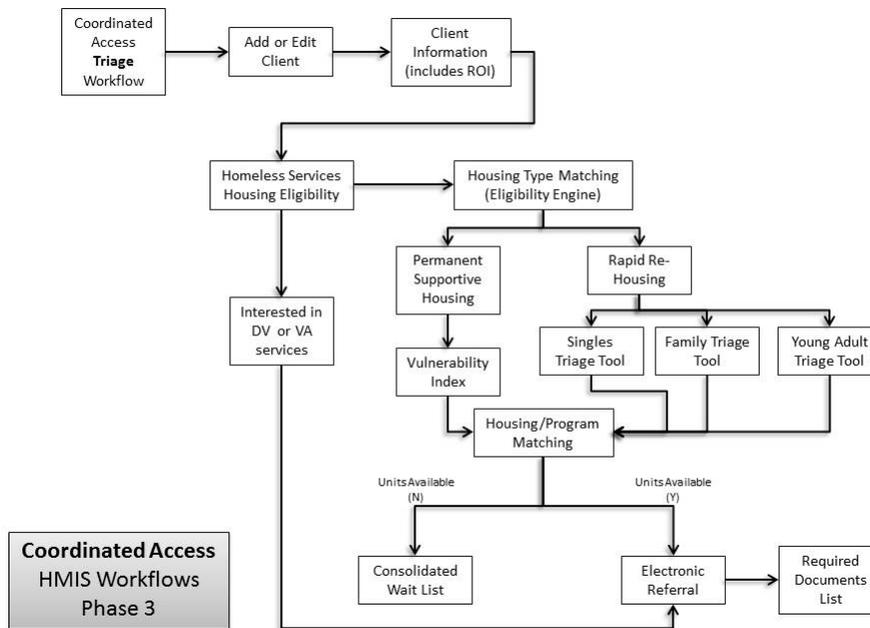
### 2.1 Housing Assessors

2.1.1 Roles and Responsibilities - *Housing Assessors* are staff from designated community agencies. *Housing Assessors* may office out of *Assessment Hubs*, be designated as the Assessor for his/her agency, or may be part of a community outreach team. All *Housing Assessors* are required to complete a HMIS intake and *Housing Assessment* with individuals in need of housing and pull, from HMIS, “housing matches” available to each individual. The *Housing Assessor* will then pass the referrals to the individual’s Case Manager or a *Housing Navigator*. *Housing Assessors’* responsibilities include, but are not limited to the following:

- Operating as the initial contact for the *Coordinated Access System*
- Conducting *Housing Assessments* and VI’s, and Next step assessments
- Client notification of *Eligibility and Referral Decisions*
- Submission of referrals to the *Receiving Program* through HMIS
- Collecting and uploading all documents available at assessment
- Participation in case conferences
- Responding to requests by the *Coordinating Entity*

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

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



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

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

2.6. Timeline - The *Housing Assessor* notifies the client of his/her eligibility and referral decision immediately. Once a referral is made, the *Receiving Program* has 24 business hours to acknowledge receipt of the referral. The *Receiving Program* must then enroll or deny the referral within seven (7) days. The *Receiving Program* can reject or deny the referral if the assigned case manager has been unable to contact the household after seven (7) days. If a household shows up at the *Receiving Program* after the seven (7) days have expired, the case manager will assist the household in reentering the system through the *Coordinated Access System*. All of this information is tracked in HMIS.

### 3. Housing Matching

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

#### 3.2. Housing Navigators

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

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

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

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

3.4. Unit Availability/Vacancy Posting – All Rapid Re-housing, and Permanent Supportive Housing Programs are required to post vacancies in HMIS within twenty-four (24) business hours of unit/bed availability. If providers know of an impending vacancy, they are required to post the anticipated availability date up to fourteen (14) days before unit vacancy. Programs must update vacancy information in HMIS within twenty-four (24) business hours of a unit/bed being filled. This information is crucial in determining what resources are available and where to send a client needing housing.

## 4. Housing Referral

- 4.1. Waitlist – There are separate waitlists for Permanent Supportive Housing and Rapid Re-housing. The waitlists consist of the following:
- 4.1.1. Permanent Supportive Housing clients are prioritized based on their VI score.
  - 4.1.2. Rapid Re-housing clients are prioritized by their household type (youth, families, singles) followed by their next step assessment score in each.
  - 4.1.3. Assessors pull the waitlist daily.
  - 4.1.4. If the waitlist indicates an opening for either Permanent Supportive Housing or Rapid Re-housing, the Assessors create a referral to the program with the opening.
  - 4.1.5. If the referral was made to a Permanent Supportive Housing program, then the Assessors will also create a reservation for the open unit to remove it from that program's inventory.
  - 4.1.6. If the program to which the referral was made is one that requires a Navigator, then the Assessor will also create a referral to the appropriate Navigator.
  - 4.1.7. Navigators or Case Managers Attempt to make contact with the client for seven (7) business days.
  - 4.1.8. If the client cannot be contacted within that time frame, then staff move on to the next client on the list.
  - 4.1.9. Once staff makes contact with the client, the client must decide immediately whether to accept or decline the unit.
  - 4.1.10. If the client accepts the unit, he/she moves forward in the next steps toward move in.
  - 4.1.11. If the client declines the unit, then the next client on the waitlist is contacted and the client that refused is moved down to the bottom of the appropriate waitlist based on their VI or next step assessment score.
- 4.2. Receiving Program Responsibilities – Once a referral is made, the *Receiving Program* has twenty-four (24) business hours to acknowledge receipt of the referral. The *Receiving Program* must then enroll or deny the referral within seven (7) days. The *Receiving Program* can reject or deny the referral if the assigned case manager has been unable to contact the house hold after seven (7) days. If a household shows up at the *Receiving Program* after the seven (7) days have expired, the case manager will assist the household in reentering the system through the *Coordinated Access System*. All of this information is tracked in HMIS.

4.2.1. Document Requirement Updates - *Receiving Programs* make eligibility determination decisions within one (1) business day of the intake interview (or when all required application materials are complete). The *Receiving Program* orally reviews the intake decision notification with the client to ensure that the client understands the decision, and applicable next steps, including the client's right to appeal the decision. An intake decision notification includes at a minimum:

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

4.2.2. Reasons for denial – *Receiving Programs* may only decline households found eligible for and referred by the *Housing Assessor* under limited circumstances including:

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

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

4.2.3. Client Choice – Clients may decline a referral because of program requirements that are inconsistent with their needs or preferences. There are no limitations

on this decision. For example, clients may decline participation in programs requiring sobriety.

4.2.4. Client Appeal – All clients have the right to appeal eligibility determinations issued by either the *Coordinating Entity* or any *Receiving Program*. Instructions for submitting an appeal are provided to clients at the time that an intake decision is made by the *Receiving Program*. *Housing Assessors* and *Housing Navigators* are responsible for assisting clients in filing eligibility determination appeals, including but not limited to drafting a written appeal on behalf of the client. All appeals of decisions by *Receiving Programs* should be made in writing and submitted to the *Coordinating Entity*.

4.3. Move-In – If the household is accepted, the *Receiving Program* must document that acceptance in HMIS and arrange for move-in within 30 days. If the client does not move-in as scheduled or within three (3) business days of the original move-in date, the *Receiving Program* must notify and refer the client back to the *Housing Navigator* so that the outcome is documented in HMIS.

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

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

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

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

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

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

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

4.5.2 Veterans – When a homeless or at-risk individual is identified by the *Coordinated Access System* to be a Veteran, additional questions concerning service era, length of service, and discharge status will be asked. If eligible for VA services, the Veteran will be given the option of being referred to the VA Drop-In Center. If the Veteran chooses that option, then that individual is referred to the VA Drop-In Center immediately. If the VA Drop-In Center determines that the individual seeking veteran specific services is not eligible for VA services, the *Housing Assessor* at the VA Drop-In Center will complete the CA Assessment in HMIS and will either refer the household to an available unit, or add the household to the appropriate waitlist in accordance with the process outlined in this manual.

## 5. Case Conferences

5.1. The *Coordinating Entity* will require a case conference to review and resolve rejection decisions by *Receiving Programs*. The purpose of the case conference will be to resolve barriers to the household receiving the indicated level of service. Such a case conference will be held in all instances in which a household is declined by a *Receiving Program*. Case conferences will be held in all instances in which a household has declined more than two placements.

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

In cases in which a household is facing program termination, the *Receiving Program* will notify the *Coordinating Entity*. The *Coordinating Entity* may then require a case conference to review and determine next steps. The purpose of the case conference will be to discuss interventions used to date and resolve barriers to securing permanent housing including plans to have the household re-assessed for a more suitable housing program.

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

## **VII. Fair Housing, Tenant Selection Plan, and Other Statutory and Regulatory Requirements**

The *Coordinating Entity* takes all necessary steps to ensure that the *Coordinated Access System* is administered in accordance with the Fair Housing Act by promoting housing that is accessible to and usable by persons with disabilities. The *Coordinated Access System* complies with the non-discrimination requirements of the Fair Housing Act, which prohibits discrimination in all housing transactions on the basis of race, national origin, sex, color, religion, disability status and familial status. This also includes protection from housing discrimination based on source of income. Additional protected classes under state law include sexual orientation (including gender identity), marital status, military discharge status, age (40+). Agencies cannot preference any protected class unless allowed by statute/regulation, or written waiver from their funding or regulatory body (i.e. U.S. Department of Housing and Urban Development).

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

The *Coordinating Entity* will request from each Authorized User Agency their tenant selection plan and any funding contract that requires or allows a specific subpopulation of persons to be served. For instance, Housing Opportunities for Persons with AIDS (HOPWA) programs will show funding contract, a single-gender program must produce its HUD waiver. It is further recognized that the Fair Housing Act recognizes that a housing provider may seek to fulfill its “business necessity” by narrowing focus on a subpopulation within the homeless population.

The *Coordinated Access System* may allow filtered searches for subpopulations while preventing discrimination *against* protected classes.

## **VIII. Evaluating and Updating Coordinated Access System Policies and Procedures**

The implementation of the *Coordinated Access System* necessitates significant, community-wide change. To help ensure that the system will be effective and manageable for homeless and at-risk households and for the housing and service providers tasked with meeting their needs, particularly during the early stages of implementation, the Houston/Harris County Continuum of Care anticipates adjustments to the processes described in this manual. To inform those adjustments, the *Coordinated Access System* will be periodically evaluated, and there will be ongoing opportunities for stakeholder feedback, including but not limited to Referral and Receiving Program work groups convened and managed by the *Coordinating Entity*. Specifically, the *Coordinating Entity* is responsible for:

- Leading periodic evaluation efforts to ensure that the *Coordinated Access System* is functioning as intended; such evaluation efforts shall happen at least annually.
- Leading efforts to make periodic adjustments to the *Coordinated Access System* as determined necessary; such adjustments shall be made at least annually based on findings from evaluation efforts.
- Ensuring that evaluation and adjustment processes are informed by a broad and representative group of stakeholders
- Ensuring that the *Coordinated Access System* is updated as necessary to maintain compliance with all state and federal statutory and regulatory requirements

Evaluation efforts shall be informed by metrics established annually by the *Coordinating Entity*, in conjunction with the *CoC Steering Committee* and *Coordinated Access Workgroup*. These metrics will be displayed on dashboards located on the *Coordinating Entity's* website and shall include indicators of the effectiveness of the functioning of the *Coordinated Access System* itself, such as:

- Wait times for initial contact
- Extent to which expected timelines described in this manual are met
- Number/Percentage of referrals that are accepted by receiving programs
- Rate of missed appointments for scheduled assessments
- Number/Percentage of persons declined by more than one (1) provider
- Number/Percentages of *Eligibility and Referral Decision* appeals
- # of program intakes not conducted through *Coordinated Access System*
- Completeness of data on assessment and intake forms

These metrics shall also include indicators of the impact of the *Coordinated Access System* on system-wide Continuum of Care outcomes, such as:

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

## **IX. Termination**

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

## **X. Appendices**

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Client Name \_\_\_\_\_

Last Four of Social Security Number \_\_\_\_\_

### Coordinated Access Housing Intervention Assessment

What is your housing goal? (Do not read the options; ask as an open-ended question)

Check all that apply.

- Find a housing unit that you can afford
- Get help to pay a couple of months of rent until you have income
- Get help to pay back rent or utility bills

Are you a veteran?  Yes  No

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

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

Are you interested in access VA services?  Yes  No

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

Are you homeless because someone is hurting you?  Yes  No

Are you interested in accessing DV services?  Yes  No

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

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

#### A. History of Homelessness

1. Where did you stay last night?

Literally Homeless

- Street
- Shelter
- Transitional Housing
- Place not meant for human habitation

Not Literally Homeless

- Friend or Family
- Own Housing/Permanent Housing
- Motel
- Other \_\_\_\_\_

2. When were you last housed?

\_\_\_\_\_

3. Where were you last housed?

\_\_\_\_\_

Client Name \_\_\_\_\_

Last Four of Social Security Number \_\_\_\_\_

### Coordinated Access Housing Intervention Assessment

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

Dates:

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

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2. How long has this person been homeless?

Years \_\_\_\_\_

Months \_\_\_\_\_

3. Number of documentable episodes of homelessness in the past 3 years \_\_\_\_\_

#### B. Health History

1. Have you been diagnosed with any of the following?

*Check all that apply.*

Substance use disorder

HIV/AIDS

Serious mental illness

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

Developmental disability

Chronic physical illness or disability that limits

your ability to work or perform

daily activities

## Coordinated Access Housing Intervention Assessment

### C. Employment & Income

1. Please describe your current employment situation or income received

- |   |   |
|---|---|
| <input type="checkbox"/> Currently Employed<br><br><input type="checkbox"/> Lost job within the last 3 months<br><br><input type="checkbox"/> Lost job 4-6 months ago<br><br><input type="checkbox"/> Lost job over 6 months ago<br><br><input type="checkbox"/> Not able to work due to enrollment in an educational/vocational training program | <input type="checkbox"/> Currently Employed<br><br><input type="checkbox"/> Lost job within the last 3 months<br><br><input type="checkbox"/> Lost job 4-6 months ago<br><br><input type="checkbox"/> Lost job over 6 months ago<br><br><input type="checkbox"/> Not able to work due to enrollment in an educational/vocational training program |
|---|---|

### D. Criminal History

1. How many times have you been incarcerated/in jail in the past 2 years?	
2. Do you have a past felony conviction(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you or anyone who will live with you been convicted of a violent or dangerous crime, e.g. felony arson, homicide, manslaughter, felony assault?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you or anyone who will live with you been convicted of a sexual offense?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you or anyone who will live with you been convicted of manufacturing or production of methamphetamine?	<input type="checkbox"/> Yes <input type="checkbox"/> No

## Proposed Community-Wide Prioritization Standards for Coordinated Access

If we follow Federal Priorities:

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

**AND**

If we agree that all Youth and Chronics are vulnerable

If we say PSH is for:

- Chronics
- Youth (Chronic or 19-26 Score)
- Families (Chronic or 11-21 Score)

**AND**

If we say RRH is for:

- Youth (Non-Chronic and 0-18 Score)
- Families (Non-Chronic and 0-10 Score)
- Singles (Non-Chronic)

**AND**

If we say we are not doing any specific subpopulation carve-outs because we don't have enough resources,

**THEN...**

We prioritize as follows:

Housing Intervention	Prioritization	Subpopulation	Secondary Prioritization
<b>PSH</b>	<b>1</b>	Chronic Youth	1. Veteran
			2. Prioritization Score
			3. Length of Homelessness
			4. Date of Assessment
	<b>2</b>	Chronic Families	1. Veteran
			2. Prioritization Score
			3. Length of Homelessness
			4. Date of Assessment
	<b>3</b>	Chronic Singles	1. Veteran
			2. Prioritization Score
			3. Length of Homelessness
			4. Date of Assessment
	<b>4</b>	Non-Chronic 19 - 26 Score Youth	1. Veteran
			2. Prioritization Score
			3. Length of Homelessness
			4. Date of Assessment
	<b>5</b>	Non-Chronic 11 - 21 Score Families	1. Veteran
			2. Prioritization Score
			3. Length of Homelessness
			4. Date of Assessment

	<b>6</b>	Non-Chronic High Scoring Singles	1. Veteran
			2. Prioritization Score
			3. Length of Homelessness
			4. Date of Assessment
<b>RRH</b>	<b>1</b>	Non-Chronic and 0-18 Score Youth	1. Veteran
			2. Prioritization Score
			3. Length of Homelessness
			4. Date of Assessment
	<b>2</b>	Non-Chronic and 0-10 Score Families	1. Veteran
			2. Prioritization Score
			3. Length of Homelessness
			4. Date of Assessment
	<b>3</b>	Non-Chronic Singles	1. Veteran
			2. Prioritization Score
			3. Length of Homelessness
			4. Date of Assessment

# Vulnerability Index Survey Consent Form

## Consent for Interview

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We are here today to talk to you about your housing and service needs. If you give us permission, we will ask you some questions today for about 10 minutes and take a picture of you so we can identify you at a later date. These questions are about your health and housing and we will also ask for your social security number. By participating in the interview you give permission to Community Solutions and Coalition for the Homeless of Houston Harris County to provide your information to authorized agencies for the purpose of furthering services and housing in this community. Some of the questions we ask might make you feel uncomfortable or be upsetting. If you feel uncomfortable or upset during the interview, you may ask the interviewer to take a break or to skip any of the questions. The information that you tell us during the interview will be stored in a secure database and also be shared with outreach workers and case managers who will follow up with you for services. All of your information will be kept secure and individuals who will see it have signed confidentiality waivers and will not share your information. You can skip any questions you do not want to answer, end the interview at any point, or choose to not have your picture taken. At anytime you can request that your information be removed from the database. We will give you a \$5 food card at the end of the interview to thank you for your time. No one will be upset or angry if you decide not to be interviewed today.

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### SIGN BELOW IF AGREEING TO BE INTERVIEWED

Your signature (or mark) below indicates that you have read (or been read) the information provided above, have gotten answers to your questions, and have freely chosen to be interviewed. By agreeing to be interviewed, you are not giving up any of your legal rights.

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Date

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Signature (or Mark) of Participant

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Printed Name of Participant

Please sign below if you also agree to have your picture taken

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Signature (or Mark) of Participant

Identifier:
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<b>1. INTERVIEWER'S NAME</b>		<b>2. TEAM #</b>	
		<input type="checkbox"/> STAFF <input type="checkbox"/> VOLUNTEER	
<b>3. DATE</b>	<b>4. TIME</b>	<b>5. LOCATION</b>	
<b>6. In what language do you feel best able to express yourself?</b>			
<b>7. FIRSTNAME</b>		<b>8. LASTNAME</b>	
<b>9. NICKNAME</b>		<b>10. DOB</b>	
<b>11. Social Security Number</b>		<b>12. Has Consented to Participate:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	

Identifier:
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**OK, first I'm going to ask you a few questions about your housing history...**

13. What is the total length of time you have lived on the streets or shelters?	# of years:
	# of months:
14. In the past three years, how many times have you been homeless and then housed again?	
15. Where do you sleep most frequently? (check one)	
<input type="checkbox"/> Shelters <input type="checkbox"/> Streets <input type="checkbox"/> Car/Van/RV <input type="checkbox"/> Subway/Bus <input type="checkbox"/> Beach/Riverbed <input type="checkbox"/> Other (specify) _____	
<i>(This question cannot be changed. If you have an additional location please use OTHER. In the database you will have the opportunity to type in that location if OTHER is selected)</i>	
16. Where did you live prior to becoming homeless? (check one)	
<input type="checkbox"/> This city <input type="checkbox"/> This region <input type="checkbox"/> Other part of the State <input type="checkbox"/> Somewhere else (specify) _____	
<i>(This question will be tailored specifically for your region. Use the link at the end of this survey to make the changes )</i>	

**OK, now I'd like to ask you a few questions about your health...**

17. Where do you usually go for healthcare or when you're not feeling well?	
<input type="checkbox"/> Hospital <input type="checkbox"/> Clinic <input type="checkbox"/> VA <input type="checkbox"/> Other (Specify) _____	
<input type="checkbox"/> Does not go for care	
<i>(This question will be tailored specifically for your region. Use the link at the end of this survey to make the changes )</i>	
18. How many times have you been to the emergency room in the past three months? _____	
19. How many times have you been hospitalized as an inpatient in the past year? _____	
20. Do you have now, have you ever had, or has a healthcare provider ever told you that you have any of the following medical conditions?	
a. Kidney disease/ End Stage Renal Disease or Dialysis.....	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused
b. History of frostbite, Hypothermia, or Immersion Foot .....	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused
c. History of Heat Stroke/Heat Exhaustion.....	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused
d. Liver disease, Cirrhosis, or End-Stage Liver Disease .....	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused

Identifier:
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- e. Heart disease, Arrhythmia, or Irregular Heartbeat.....  Yes  No  Refused
- f. HIV+/AIDS.....  Yes  No  Refused
- g. Emphysema .....  Yes  No  Refused
- h. Diabetes .....  Yes  No  Refused
- i. Asthma .....  Yes  No  Refused
- j. Cancer.....  Yes  No  Refused
- k. Hepatitis C.....  Yes  No  Refused
- l. Tuberculosis.....  Yes  No  Refused
- m. **DO NOT ASK:** Surveyor, do you observe signs or symptoms of serious physical health conditions?.....  Yes  No

- n. Have you ever abused drug/alcohol, or been told you do? .....  Yes  No  Refused
- o. Have you consumed alcohol everyday for the past month? .....  Yes  No  Refused
- p. Have you ever used injection drugs or shots? .....  Yes  No  Refused
- q. Have you ever been treated for drug or alcohol abuse?.....  Yes  No  Refused
- r. **DO NOT ASK:** Surveyor, do you observe signs or symptoms of alcohol or drug abuse?.....  Yes  No

- s. Are you currently or have you ever received treatment for mental health issues?..  Yes  No  Refused
- t. Have you ever been taken to the hospital against your will for mental health reasons? .....  Yes  No  Refused
- u. **DO NOT ASK:** Surveyor, do you detect signs or symptoms of severe, persistent mental illness?.....  Yes  No

- v. Have you been the victim of a violent attack since you've become homeless? .....  Yes  No  Refused
- w. Do you have a permanent physical disability that limits your mobility? [i.e., wheelchair, amputation, unable to climb stairs]? .....  Yes  No  Refused
- x. Have you had a serious brain injury or head trauma that required hospitalization or surgery? .....  Yes  No  Refused

**21. What kind of health insurance do you have, if any?** (check all that apply)  
 Medicaid  Medicare  VA  Private Insurance  None  Other (specify): \_\_\_\_\_

*(This question cannot be changed. If you have an additional location please use OTHER. In the database you will have the opportunity to type in that location if OTHER is selected)*

Identifier:
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**Alright, now I've just got a few more questions...**

22. Have you ever served in the US Military?.....  Yes  No  Refused
23. If yes, which war/war era did you serve in?.....  Korean War (June 1950-January 1955)  
 Vietnam Era (August 1964-April 1975)  
 Post Vietnam (May 1975-July 1991)  
 Persian Gulf Era (August 1991-Present)  
 Afghanistan (2001-Present)  
 Iraq (2003-Present)  
 Other (Specify)  Refused
24. If yes, what was the character of your discharge?.....  Honorable  Other than Honorable  
 Bad Conduct  Dishonorable  Refused
25. Have you ever been in jail? .....  Yes  No  Refused
26. Have you ever been in prison? .....  Yes  No  Refused
27. Have you ever been in foster care? .....  Yes  No  Refused

**28. How do you make money? (choose as many as apply)**

- |  |                                      |  |
|--|--------------------------------------|--|
| <input type="checkbox"/> Work, on-the-books  | <input type="checkbox"/> Food Stamps | <input type="checkbox"/> Pension/Retirement      |
| <input type="checkbox"/> Work, off-the-books | <input type="checkbox"/> Sex Trade   | <input type="checkbox"/> None of the Above/Other |
| <input type="checkbox"/> SSI                 | <input type="checkbox"/> Drug Trade  | _____  |
| <input type="checkbox"/> SSDI/SSA            | <input type="checkbox"/> Recycling   |  |
| <input type="checkbox"/> VA                  | <input type="checkbox"/> Panhandling |  |
| <input type="checkbox"/> Public Assistance   | <input type="checkbox"/> No Income   |  |

*(This question cannot be changed. If you have an additional location please use OTHER. In the database you will have the opportunity to type in that location if OTHER is selected)*

**29. What is your gender?**

- Male  Female  Transgender  Other  Decline to State

Identifier:

**30. What is your ethnicity?** (choose as many as apply)

- African American/ Black
- Asian
- Native Alaskan
- Native Hawaiian or Other Pacific Islander
- Latino/a
- Native American
- White
- Mixed Race
- Decline to State
- Unknown
- Other \_\_\_\_\_

*(This question cannot be changed. If you have an additional location please use OTHER. In the database you will have the opportunity to type in that location if OTHER is selected)*

**31. What is your citizenship status?**       Citizen     Legal Resident     Undocumented     Refused

**32. What is the highest grade in school you completed?**

- K-8     Some high school     High School Graduate     GED     Some College
- College Graduate     Post Graduate     Decline to State     Other

**OK, now I'm going to ask you some questions about your community**

**33. Is there a person/outreach worker that you trust more than others?**       Yes     No     Refused

**34. If yes, do you know their name and/or what agency they work for?**

**OK, now I'd like to take your picture. May I do so?**

## Singles RRH Next Step Assessment

		Answer	Score
1	Do you have a disabling condition?	Yes	1/Logic
2	Where did you stay last night?	Homeless	Logic
3	How long have you currently been homeless?	>12 mos	Logic
4	Have you been homeless before (HUD Definition)?	Yes	1
5	How many times have you been homeless in the past 3 years?	>4	Logic
6	What is your total monthly cash income?	<\$800/month	1
7	Are you currently employed?	No	1
8	How many jobs have you lost in the past 12 months?	3 or more or none	1
9	Are you currently pregnant?	Yes	1
10	Were you in Special Education or Resources Classes when you were in school?	Yes	1
11	Do you have a Diploma or GED?	No	1
12a	Do you currently use drugs or alcohol?		0
12b	How many times per week are drugs or alcohol used?	>3 times/week	1
13	Have you experienced any of the following in the past 6 months:		
	Arrest		1
	Prostitution		1
	Domestic Violence		1
	Sex Offense		1
14	Who can you count on for financial support? (If you had a small bill that needed to be paid and you were out of money for the month is there anyone that usually helps you out?)	<1 person	1

VI: 0-8 Prioritization

0-15 = Next Step (0-5 referrals to Employment)

# Family Housing Triage Tool

		Answer	Score
1	Does any adult in your household have a disabling condition?	Yes	1/Logic
1a	Do any children in your household have a disabling condition?	Yes	1
2	Where did you stay last night?	Homeless	Logic
3	How long have you currently been homeless?	>12 mos	Logic
4	Have you been homeless before (HUD Definition)?	Yes	1
5	How many times have you been homeless in the past 3 years?	>4	Logic
6	What is your total household monthly cash income?	<\$800/month	1
7	Are you or any adults in your household currently employed?	No	1
8	How many jobs have you or other adults in your household lost in the past 12 months?	3 or more or none	1
9	Do you currently have or have you had an open CPS case in the past 2 years?	Yes	1
9a	Do you have any children currently in CPS or someone else's custody?	Yes	1
10	Are you or is any adult in your household currently pregnant?	Yes	1
11	How many minor children are currently living with you?		
		1	1
		2	2
		3	3
		4	4
		5+	5
12	Were you in Special Education or Resources Classes when you were in school?	Yes	1
13	Do you have a Diploma or GED?	No	1
14a	Do you or any of the adults in your household currently use drugs or alcohol?		0
14b	How many times per week are drugs or alcohol used?	>3 times/week	1
15	Has your household experienced any of the following in the past 6 months:		
	Arrest		1
	Prostitution		1
	Domestic Violence		1
	Sex Offense		1
16	Who can you count on for financial support? (If you had a small bill that needed to be paid and you were out of money for the month is there anyone that usually helps you out?)	<1 person	1

11-21 or Chronic = PSH

0-1- & Non-Chronic = RRH (0-5 Referrals to Employment)

# Young Adult Housing Triage Tool

		Answer	Score
1	Where did you stay last night?	Homeless	1/Logic
2a	Have you been diagnosed with any of the following: (Bipolar, Schizophrenia, Major Depression, Conduct Disorder, Oppositional Defiant Disorder, or a Substance Use Disorder)	Yes	1
2b	Are you receiving any mental health treatment?	No	1
3	How many jobs have you lost in the past 12 months	3 or more or none	1
4	Do you have any children in your custody and/or do you have an open CPS cases?	Yes	1
5	Have you ever left a home or become homeless because you are LGBTQ?	Yes	1
6	Are you currently pregnant?	Yes	1
7a	Were you in Special Education or Resources Classes when you were in school?	Yes	1
7b	Do you have a Diploma or GED?	No	1
8a	Have you ever used marijuana?		0
8b	At what age was the first time you used marijuana?	<12	1
9a	Do you currently use drugs or alcohol?		0
9b	How many times per week do you use drugs or alcohol?	>3 times/week	1
9c	Has your drug or alcohol use ever resulted in any of the following:		
	Arrest		1
	Living in a shelter or on the street		1
	Prostitution		1
	Theft		1
	Domestic Violence		1
	Loss of employment		1
10	Have you ever left a transitional housing program?	Yes	1
11a	Do you have any felony convictions?	Yes	1
12b	Are you a registered sex offender?	Yes	logic
13	Do you have a case worker with any of the following systems:	Yes	0
	Probation/Parole	Yes	1
	MHMRA	Yes	1
	CPS	Yes	1
	Drug and Alcohol	Yes	1
	Any other Case Managers	Yes	1
14	Who can you count on for emotional support? (On the days when you are so down and you don't know what to do is there an adult that you visit with or call?)	<1 person	1
15	Who can you count on for financial support? (If you had a small bill that needed to be paid and you were out of money for the month is there an adult that will usually help you out?)	<1 person	1

18-26 or Chronic = PSH

0-18 & Non-Chronic = RRH



600 Jefferson, Suite 920

Houston, Texas 77002

713-739-7514

Fax 713-739-8038

[www.homelesshouston.org](http://www.homelesshouston.org)

Coalition for the Homeless of Houston/Harris County  
Department of Housing and Urban Development (HUD)  
Continuum of Care (CoC) Program  
Coordinated Access System

Memorandum of Understanding (MOU) between the **Coalition for the Homeless Houston/Harris County (CFTH)**, and \_\_\_\_\_ **(Project Applicant)**

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## PURPOSE

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

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

## GENERAL PROVISIONS

### (CFTH) will:

- 1) Serve as the Lead Agency in the Continuum of Care (COC);
- 2) Maintain the Homeless Management Information System (HMIS), including the CAS Workflow;
- 3) Coordinate the system of homeless and homelessness prevention services in the Harris and Fort Bend County continuum area;
- 4) Provide lead staff to guide the CAS Workgroup and any relevant subgroups;
- 5) Coordinate, integrate, and leverage resources to maximize impact of services for individuals who are experiencing homelessness;
- 6) Develop and implement policies and procedures on how the CAS will be operated;



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Houston, Texas 77002

713-739-7514

Fax 713-739-8038

[www.homelesshouston.org](http://www.homelesshouston.org)

- 7) Provide guidance and supervision to CAS staff;
- 8) Evaluate performance and progress of the CAS and make adjustments as necessary.
- 9) Oversee the Case Conferences and Appeals process as necessary.

**Project Applicant will:**

- 1) Comply by business rules developed for the CAS;
- 2) Accept client referrals for PSH and/or RRH services through the CAS only;
- 3) Enter and maintain timely client data in HMIS;
- 4) Updated all CAS referrals within 24 hours;
- 5) Name a designated staff contact for the CAS.

**CONFIDENTIALITY**

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

**EQUAL OPPORTUNITY**

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



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Fax 713-739-8038

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**TERMS OF AGREEMENT**

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

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

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

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

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**By:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Title:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**COALITION FOR THE HOMELESS OF  
HOUSTON/HARRIS COUNTY**

**By:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Title:** \_\_\_\_\_

**Date:** \_\_\_\_\_