



**Homeless Solutions Policy Board
Chairpersons**

Charles R. Meadows, Community Leader
John Paddock, Rector, Christ Episcopal Church

451 W. Third Street, 9th floor
Dayton, OH 45422-3100
937- 225-4695 (Fax) 937-496-7714

Front Door Assessment & Referral Process Policies & Procedures Manual

The Homeless Solutions Policy Board has initiated a process to improve the delivery of housing and shelter services to families and individuals who are homeless or at great risk of homelessness throughout Dayton and Montgomery County. This process, the *Homeless System Front Door Assessment Process*, institutes consistent and uniform assessment processes to determine the most appropriate response to each individual or family's immediate and long-term housing needs.

The Front Door Committee, a planning body of the Homeless Solutions Policy Board, has instituted this process with a set of guiding principles that inform the design, implementation, and oversight of the system of care for persons experiencing a housing crisis in Montgomery County. The Homeless Solutions Policy Board members and homeless assistance providers will work to:

- Rapidly exit people from their homelessness to stable housing
- Ensure that the hardest to serve are served
- Serve clients as efficiently and effectively as possible
- Be transparent and accountable throughout the referral and assessment process

FRONT DOOR ASSESSMENT PARTNERS: ROLES AND EXPECTATIONS

All households who enter any of the community's gateway shelters (Daybreak, St. Vincent Apple Street, Gettysburg Gateway for Men, Daybreak, and the YWCA) or who are homeless and on the street (MVHO PATH) are assessed using the same Front Door Assessment tool.

Objective: Front Door Assessment providers will work collaboratively with clearly defined roles and expectations that guide the day-to-day operations of the Front Door assessment and referral process.

Front Door Assessment Providers

- ✓ Complete initial and comprehensive Front Door Assessments within timeframe guidelines.
- ✓ Make a referral in ServicePoint to program type appropriate for each client based on housing barriers and assessment (see Referral Decision Process).
- ✓ If client rejected by two referrals, initiate Case Conference Meeting (see Case Conference Meeting section).
- ✓ If client is placed in a program and it is determined that the client needs to go to another program option, the provider that originally referred the client to the program and the agency currently serving the client will jointly update the Comprehensive Assessment and Barriers Screen.

- ✓ One representative from each Front Door Assessment provider participates in regular Assessment Process Management meetings to discuss referral operations and specific referral cases and make recommendations for system refinements.
- ✓ Participate in Case Conference Meetings as appropriate.

Program Receiving Referrals

- ✓ Send vacancy information to County Homeless Solutions staff.
- ✓ Review Front Door referrals and conduct any additional screening processes (client interview, case review, etc.)
- ✓ Make determination to accept or reject referral within 7 days of receiving electronic referral from Front Door Assessment provider. For PSH this maybe a conditional acceptance pending final eligibility determination as required for LIHTC, Section 8 and Shelter+Care.
- ✓ Provider must accept 1 of every 4 referrals. Detailed documentation of reason for rejection is maintained in ServicePoint.
- ✓ Participate in Case Conference Meetings as appropriate.

County, City and HMIS Staff

- ✓ Manage waiting list for transitional housing, permanent supportive housing and Safe Haven programs.
- ✓ Receive program vacancy notifications
- ✓ Identify top ranked clients for referral to vacancy
- ✓ Participate in Case Conference Meetings as appropriate.
- ✓ Participate in Assessment Process Management Meetings as appropriate.

REFERRAL DECISION PROCESS

Front Door Assessment providers will use established program referral criteria to determine the type of program appropriate for each client. The referral decision is based on a set of housing barriers and assessment filters associated with each program type. (See Program Referral Criteria below). *In some cases the unique characteristics of the household or available housing resources may require flexibility in referral decision. (ex. A pregnant head of household receiving Rapid Rehousing while waiting for PSH referral to ensure the baby is not born in shelter)!

Program Referral Criteria

| Program Type | Program Referral Criteria (Housing Barriers & Assessment Filters) |
|------------------------|--|
| Rapid Rehousing | <ul style="list-style-type: none"> • Regular income or recent work history • Can be used as a bridge to permanent subsidy. • ILS score<35 •Low or Medium on barriers • May need supportive services if there is substance abuse diagnosis and is not connected to mainstream treatment •May need rent subsidy once income is established •May need referral to employment program •Large family needing 3+ bedrooms |

| Program Type | Program Referral Criteria (Housing Barriers & Assessment Filters) |
|--|--|
| Transitional Housing | <ul style="list-style-type: none"> • No income or inadequate income • ILS score ≥ 35 • Early recovery, pregnant, transitioning from DV, young adults (18-24) with children • At least medium on housing barriers • Low to medium on housing barriers, young adults 18-24 with children |
| Permanent Supportive Housing Scattered Site | <ul style="list-style-type: none"> • ILS score ≥ 35 • Documented disability that impeded ability to live independently • At least medium on housing barriers • If family, more than 2 children |
| Permanent Supportive Housing Facility Based | <ul style="list-style-type: none"> • ILS score ≥ 35 • Documented disability that impeded ability to live independently • Medium to high housing barriers • Has not succeeded in Scattered Site PSH • High user of hospitals/ER |
| Safe Haven- Single Adults ONLY | <ul style="list-style-type: none"> • Severe mental illness • Unable/Unwilling to engaged in mental health treatment • ILS score ≥ 35 • At least medium on housing barriers |
| Supportive Services- Doors | <ul style="list-style-type: none"> • If going to scattered housing PSH, has behavioral health diagnosis and is not connected to mainstream treatment |

MAKING REFERRALS

- ✓ Complete *Client Intake, Comprehensive Assessment, and Housing Barriers Screen* and enter all information into ServicePoint. (St. Vincent staff complete client profile, identify household members, complete all other universal data elements.) Please note for **Rapid Rehousing** the Client Intake is completed **only** then indicate the referral.
- ✓ Rapid Rehousing Client Intake only then indicate referral.
- ✓ Review the **Program Criteria** for each program type and align the client's barriers and characteristics with the program type designed to address those specific barriers and circumstances. Front Door Assessment providers will identify a single program type to which the client will be referred.
- ✓ Make a program referral in ServicePoint to Homeless Solutions.
- ✓ Once a program opening is identified for a client on the centralized waiting list, County Homeless Solutions staff will notify the Front Door Liaisons for the Assessment provider for that client and the agency with the vacancy that a referral is now ready to be made.
- ✓ If the referral is rejected by the 'Referred to' provider, the provider will notify the agency working with the client, and County Homeless Solutions staff that the client has been rejected and that the next scoring client needs to be referred.

RECEIVING REFERRALS

- ✓ All transitional housing, permanent supportive housing and Safe Haven programs must fill all vacancies through the Front Door. Requests for referrals should be made if:
 - For programs with multiple partners, both agencies agree to request referral.
 - The unit is still occupied if agency is certain the unit will be vacant and available on a specific date. If the current tenant is in eviction process or their move out status is uncertain then do not ask for a referral until the unit is vacant.
 - The unit has passed HQS inspection if required.
- ✓ When an email about a referral is received, log on to ServicePoint and review the client in HMIS using the client name and ID number, look up the clients **Intake, Comprehensive Assessment, and Housing Barriers Screen** information. Conduct any additional screening processes (client interview, case review, etc.)
- ✓ Make determination to accept or reject referral within 7 days of receiving electronic referral from Front Door Assessment provider. For PSH this may be a conditional acceptance pending final eligibility determination as required for LIHTC, Section 8 and Shelter+Care. Providers may schedule client interviews to collect additional data and assess for program fit. Interview must be conducted within 7 days of receipt of referral.
- ✓ If receiving agency accepts the referral the provider contacts the Front Door Assessment provider that has contact with the client to establish move in date and arrange logistics. For programmatic shelter and transitional housing move in to be completed within seven days of accepting referral.

REFERRAL PRIORITIZATION

Objective: Front Door Assessment providers will refer homeless persons for limited beds and resources based on criteria that prioritize individuals that have historically been the hardest to serve and those individuals and families that have been waiting the longest for housing.

Clients will be referred to available housing and service slots for Permanent Supportive Housing and Safe Haven based on the following set of ranked prioritization criteria:

1. Clients who meet the definition of chronic homeless and those that are at risk of becoming chronically homeless (as documented by providers that the person has a disabling condition and 4 episodes of homelessness in a three year period).
 - Those with longest history or homelessness and most severe service needs
 - Those with the longest history of homelessness
 - Those with the most severe service needs
 - Other chronic households
2. Unsheltered/Street Homeless with referral/recommendation from PATH when weather is life threatening
3. Large family households (5 or more members) without other placement options or family with pregnant woman in her final trimester.
4. Clients with chronic and/or debilitating health conditions or fragile health conditions based on Vulnerability Index scores.
5. Clients with the longest cumulative length of stay homeless (as documented by providers and HMIS of 200+nights)
6. Unsheltered/Street Homeless with referral/recommendation from PATH (non-life threatening)

7. Young adults 18-24
8. Clients who are 60 years of age and older with no option for senior housing.
9. Clients that have been reassessed by PSH/Safe Haven by the move-up assessment.

REFERRAL MANAGEMENT PROCESS

Objective: Front Door Assessment providers will assess client characteristics, needs, and housing barriers, and refer clients to the most appropriate housing option available using an intentional and rational management approach.

Vacancy Notification

All agencies with transitional housing, permanent supportive housing and Safe Haven programs will send information about vacancies when they occur to County Homeless Solutions staff.

Centralized Waiting List

A centralized waiting list by program type for transitional housing, permanent supportive housing and Safe Haven will be maintained by County Homeless Solutions staff.

Referral Procedures

If there are no programs with vacancies, client is put on the waiting list for that program type. (Reporting will track both the program type client scored for as well as program type that client was referred to, to identify gaps in the system.) If the client is in a priority category, client will access the next available vacancy or be placed at the top of the centralized waiting list based on the *Referral Prioritization Criteria*.

SECONDARY ASSESSMENTS

Re-Assessment at Gateway Shelter

If a single or family are still at the gateway shelter and more information is obtained which would change barriers to housing placement, an updated assessment can be completed by the Assessor to determine if a level of care change needs to occur.

If a single or family is still residing in shelter for more than 6 months, an updated assessment will be completed to determine if a level of care change needs to occur.

Mid-System Re-Assessment

If a client is placed in a program and it is determined that the household has barriers that were not identified in the original assessment which are supported by new documentation, the agency currently serving the client will update the Intake, Comprehensive Assessment, and Barriers screen. If the client scores for another program type, the Program will call the County Homeless Front Door to make the referral. The client will not have to return to a Gateway Shelter to complete the Mid-system assessment.

If client moves to permanent housing from programmatic shelter or transitional housing, that program can make a referral for Supportive Services to support their transition to permanent housing.

Moving On Assessment

For tenants ready to move on from PSH to another subsidy program or housing in the open market, the Housing Barriers Screen will be updated and a new referral made in HMIS if necessary.

Lateral Move

If a client housed at a facility based PSH program is determined to need less supportive services and /or would benefit from scattered site placement, a lateral move can be made, as long as the client meets the receiving program requirements. If a client is housed in a PSH scattered site program and is not succeeding (with evidence that attempts have been made to assist the client in maintaining current housing), and it is determined that the client would benefit from facility based housing in order to not return to homelessness, a lateral move can be made as long as the client meets the receiving program requirements. **All** lateral moves must be case conferenced with supportive services staff, landlords(if applicable), and Homeless Solutions Staff to determine if a lateral move is appropriate and will prevent the client from returning to homelessness.

FRONT DOOR ASSESSMENT MONITORING

Objective: To support transparent operations of the referral process, the Homeless Solutions staff will review HMIS data, monitor the effectiveness of the referral process, and engage in case conferencing to problem solve individual referral and linkage problems as necessary.

Assessment Process Management Meetings

Assessment Process Management meetings are designed to allow transparent and systematic review of Front Door Assessment functioning. All system providers are welcome to attend. Participation is required for at least one representative from each Front Door Assessment provider and County Homeless Solutions, City, or HMIS staff.

A typical Assessment Process Management Meeting agenda will include the following:

1. Status of the Centralized Waiting List
2. Review of referral process functioning
3. Review of System Management Report from HMIS (clients served, length of stay, outcomes, etc.)

Case Conference Meetings

Case conferences will be provided as needed. Montgomery County Staff will initially participate in these meetings via telephone and in person as schedule allows. Case conferences will review the following cases:

- Two providers reject the same client
- Provider rejects four referrals in a row
- Involuntary termination¹

¹ If a client is to be involuntarily terminated from a program, the agency must notify the County Homeless Solutions staff. Case conferences will be held to discuss appropriate placement and follow up. In cases where the client poses an immediate threat to self or others, the provider will seek emergency removal as needed to ensure safety. In cases where the client will not be

Case Conferences will assess the housing planning (placement options) for clients with most difficult/challenging barriers and the accuracy of the assessment process in making an appropriate referral. Case Conferences will include:

- Referring agency
- Receiving agency
- Montgomery County staff

Front Door Assessment Monitoring Meetings

The Front Door Committee will serve as the general oversight body for the Front Door Assessment and Referral process. The Committee will meet to review the System Management Report, discuss any assessment and referral updates to barriers, and identify major programmatic and policy questions, changes or potential impacts.

returned to the program, the County and Front Door Assessor will be notified of the removal within 24 hours and the case will be referred for case conferencing.