River Valleys Continuum of Care Coordinated Entry System: Housing Provider Procedures

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Coordinated Entry Terms and Definitions

Board and Lodge	Board and Lodge is a type of housing for individuals that provides a room or place to stay. Some Board and Lodge facilities are considered Lodging Establishments with Special Services. Each Board and Lodge facility can look very different. Board and Lodge facilities vary in size, with five or more people living together. Some Board and Lodge facilities look like houses, while others are like apartment buildings, depending on the number of people living there. Bedrooms may be individual or shared, depending on the facility. Other spaces, such as living rooms, dining rooms, or cafeterias, are shared. *If someone that is being assessed is in a Board and Lodge you will select, "Residential project or halfway house with no homeless criteria" as the location.
Chronically Homeless	**HUD's definition:** Chronically homeless means: (1) A "homeless individual with a disability," as defined in Section 401(9) of the McKinney-Vento Homeless Assistance Act, who: i. Lives in a place not meant for human habitation, a Safe Haven, or an emergency shelter; AND ii. Has been homeless continuously for at least 12 months or on at least four separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in (i) above.
Case Conferencing	Local process for CE staff to coordinate and discuss ongoing work with persons experiencing homelessness in the community, including the prioritization or active list. The goal of case conferencing is to provide holistic, coordinated, and integrated services across providers, and to reduce duplication.
Continuum of Care (CoC)	Group responsible for the implementation of the requirements of HUD's CoC Program interim rule. The CoC is composed of representatives of organizations, including nonprofit homeless providers, victim service providers, faith-based organizations, governments, businesses, advocates, public housing agencies, school districts, social service providers, mental health agencies, hospitals, universities, affordable housing developers, law enforcement, organizations that serve homeless and formerly homeless veterans, and homeless and formerly homeless persons.
Continuum of Care (CoC) Program	HUD funding source to (1) promote communitywide commitment to the goal of ending homelessness; (2) provide funding for efforts by nonprofit providers, and state and local governments to quickly rehouse homeless individuals and families while minimizing the trauma and dislocation caused to homeless individuals, families, and communities by homelessness; (3) promote access to and effect utilization of mainstream programs by homeless individuals and families; and

	(4) optimize self-sufficiency among individuals and families experiencing homelessness.
Coordinated Entry (CE)	Coordinated Entry in the River Valleys CoC Region is a collaborative initiative designed to create a more effective and efficient homeless response system. A coordinated entry system is defined as a coordinated process designed to coordinate program participant intake, assessment, and provision of referrals, which covers the entire geographic area. It must be easily accessed by individuals and families seeking housing or services, well-advertised, and include a comprehensive and standardized assessment tool.
Coordinated Entry (CE) Assessment	The River Valleys CE Assessment includes the Greater MN Step 1: Coordinated Entry Diversion/Triage and Greater MN Step 2: Eligibility Supplement.
Disability/Disabling Condition (HUD)	HUD defines a disability as: an impairment of long-continued and indefinite duration, and substantially impedes the ability to live independently. A "disabling condition" is a diagnosable • substance abuse disorder, • serious mental illness, • developmental disability, • PTSD, • cognitive impairments resulting from a brain injury, or • chronic physical illness or disability, including co-occurance of two or more of these conditions.
Emergency Shelter	Short-term emergency housing available to persons experiencing homelessness.
GPD TIP Subsidy	Grant and Per Diem Program Transition in Place. Program for Veterans that provides temporary rental subsidy to tenants whose amount decreases over time as greater levels of financial independence are achieved. This program ensures the Veteran is connected to the broad cross section of health services within the VA and other community based providers.
Homeless Management Information System (HMIS)	Local information technology system used by a CoC to collect participant-level data and data on the provision of housing and services to homeless individuals and families and to persons at risk of homelessness. Each CoC is responsible for selecting an HMIS software solution that complies with HUD's data collection, management, and reporting standards. Institute for Community Alliances (ICA) is the State System Administrator for HMIS. ICA provides technical assistance and training support for providers using HMIS in MN.
Host Homes (emergency and non-crisis)	A Host Home is a private residence where the unrelated caregiver provides persons with housing, meals, assistance and supervision.
Housing Choice Voucher	The housing choice voucher program (Section 8) is the federal government's major program for assisting very low-income families, the elderly, and the disabled to afford decent, safe, and

	sanitary housing in the private market. Housing choice vouchers are administered locally by public housing agencies (PHAs).
Housing Problem Solving (HPS)	An approach that is client-centered, housing-focused, and exploratory conversation that should happen with everyone regardless of perceived needs and barriers. The goal of HPS is to explore creative, flexible, safe, and cost-effective solutions to quickly resolve the housing crisis — even if just temporarily — with limited or no financial support.
High Priority Homeless (HPH)	Households prioritized for permanent supportive housing by the Coordinated Entry system.
HUD	United States Department of Housing and Urban Development (HUD)
MN Long Term Homelessness	Persons including individuals, unaccompanied youth, or families with children who lack a permanent place to live continuously for a year or more or at least four times in the past three years. Time spent in an institutional care or correctional facility shall be excluded when determining the length of time a household has be homeless except in the case where an individual was in a facility for fewer than 90 days and was homeless at entry to the facility. **Doubled Up/Couch Hopping:** Doubled up or couch hopping is considered an episode of homelessness if a household is doubled up with another household (and duration is less than one year) and couch hops as a temporary way to avoid living on the streets or in an emergency shelter. **Transitional Housing (TH):** Time spent in transitional housing is a neutral event. It is not considered time housed or time homeless when determining LTH eligibility. **Institutions**: Time spent in an institutional care (treatment, hospital, foster care, etc.) or correctional facility (jail or prison) is a neutral event. It is not considered time housed or time homeless except in the case where an individual was in a facility for fewer than 90 days and was homeless at entry to the facility. That time can be considered time homeless. Evaluate the housing history prior to and after TH or an institutional stay to determine if it meets the state's LTH definition. **NOTE:** Minnesota's definition does not require that the person have a disabling condition
Projects for Assistance in Transition from Homelessness (PATH)	Substance Abuse and Mental Health Services Administration (SAMHSA)–funded program to provide outreach and services to people with serious mental illness (SMI) who are homeless, in shelter or on the street, or at imminent risk of homelessness.
Public housing authority (PHA) or Housing and Redevelopment Authority (HRA)	Local entity that administers public housing and Housing Choice Vouchers (HCV) (aka Section 8 vouchers).
Permanent supportive housing (PSH)	Permanent housing with indefinite leasing or rental assistance paired with supportive services to assist homeless persons with

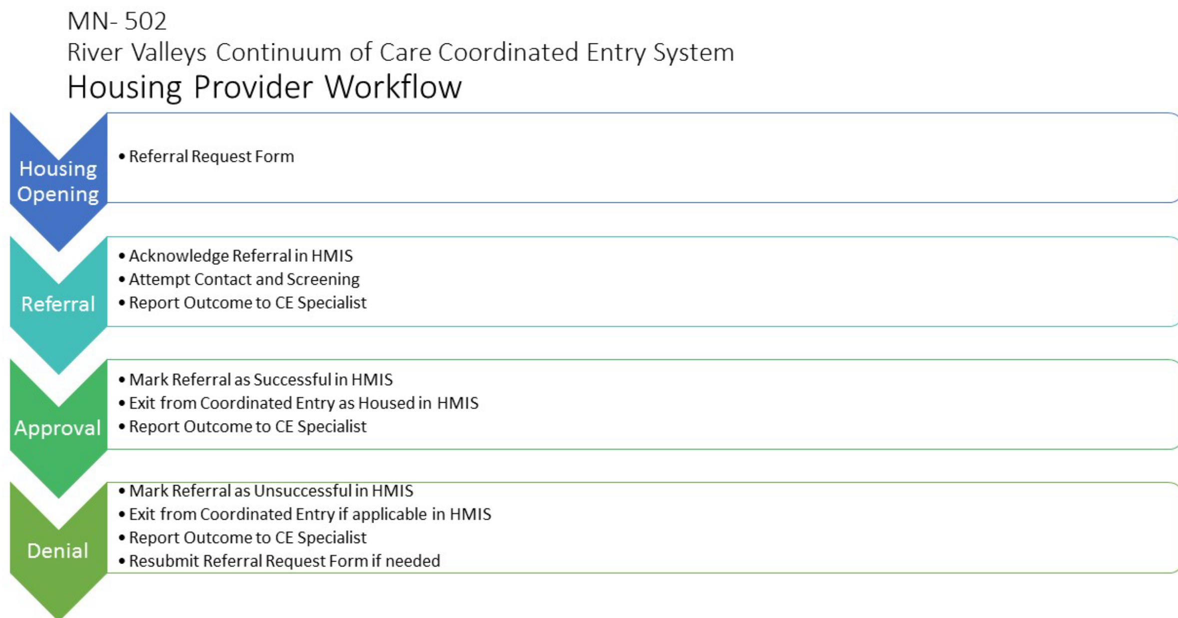
	a disability or families with an adult or child member with a disability achieve housing stability.
Rapid re-housing (RRH)	Program emphasizing housing search and relocation services and short- and medium-term rental assistance to move homeless persons and families (with or without a disability) as rapidly as possible into permanent housing.
Release of Information (ROI)	Written documentation signed by a participant to release his/her personal information to authorized partners.
Safe Haven (HUD)	Safe Havens serve as refuge for people who are homeless and have a serious mental illness. A safe haven is a form of supportive housing that serves hard-to-reach homeless persons with severe mental illness who are on the street and have been unable or unwilling to participate in supportive services. We do not have any Safe Havens in our CoC. It is very unlikely you would select Safe Haven as someone's location in the CE Assessment
Serious and Persistent Mental Illness (SPMI)	A condition with a diagnosis of mental illness that meets at least one of the following: • The member had two or more episodes of inpatient care for mental illness within the past 24 months • The member had continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the past 12 months • The member has been treated by a crisis team two or more times within the past 24 months • The member has a diagnosis of schizophrenia, bipolar disorder, major depression or borderline personality disorder; evidences a significant impairment in functioning; and has a written opinion from a mental health professional stating he or she is likely to have future episodes requiring inpatient or residential treatment unless community support program services are provided • The member has, in the last three years, been committed by a court as a mentally ill person under Minnesota statutes, or the adult's commitment as a mentally ill person has been stayed or continued • The member was eligible under one of the above criteria, but the specified time period has expired • The member was eligible as a child with severe emotional disturbance, and the member has a written opinion from a mental health professional, in the last three years, stating that he or she is reasonably likely to have future episodes requiring inpatient or residential treatment of a frequency described in the above criteria, unless ongoing case management or community support services are provided
Severe Mental Illness (SMI)	Defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. The burden of mental illnesses is particularly concentrated among those who experience disability due to SMI.
Transitional Housing (TH)	Program providing homeless individuals and families with the interim stability and support to successfully move to and maintain permanent housing. Transitional housing funds may be used to cover the costs of up to 24 months of housing with accompanying supportive services. Program participants must have a lease (or sublease) or occupancy agreement in place when residing in transitional housing.

VASH	HUD- Veterans Affairs Supportive Housing (VASH) program combines Housing Choice Voucher (HCV) rental assistance for homeless Veterans with case management and clinical services provided by the Department of Veterans Affairs (VA). VA provides these services for participating Veterans at VA medical centers (VAMCs) and community-based outreach clinics.
Victim Service Provider	Government-based program or a nonprofit program offering safety planning, counseling, support or advocacy related to domestic violence, harassment, sexual assault, or stalking.

Introduction

This document outlines procedures for those Housing Providers that use Coordinated Entry to fill open units, vouchers, slots, etc. for their program. Housing Programs that use Coordinated Entry to fill openings include but are not limited to HUD CoC projects, Minnesota Housing Homeless Programs, Minnesota Department of Human Services Office of Economic Opportunity Homeless Assistance Programs, Emergency Solutions Grants, and Housing Support (formerly GRH).

The workflow below outlines the basic steps for Housing Providers using Coordinated Entry.



Requesting and Receiving Referrals

Referral Request Form

When there is an opening in a program the River Valleys CES Referral Request Form should be filled out to request referrals from the CE Specialist. Once the form has been filled out a confirmation email will be sent stating that the request has been submitted. Requests submitted after 4:00pm will count as the next business day. The CE Specialist will then send the referrals via email within 2 business days. For larger requests for the same program (over 10 referrals), it may take up to 3 business days.

Referral Amount

In most cases there will be two referrals per opening unless there are other circumstances that warrant more referrals per opening or less referrals per opening. An example where more referrals might be given would be if the program has had difficulties filling a unit and there have been many referral requests for the same unit. If the program has kept the CE Specialist informed about pending referrals, then it could be arranged to receive more than two referrals for the opening. If a program has requested more referrals and updates have not been given for past referrals then the referrals may be withheld until updates are given to the CE Specialist.

Referral Spreadsheet

Once the referral request has been submitted, the CE Specialist will email the referrals within 2 business days. The referral spreadsheet will always be protected with a password that the CE Specialist will assign the first time referrals are requested by the program. The password will always remain the same.

There might be 2 tabs on the spreadsheet; a tab for past referrals by the program and a tab for active referrals for the program. The current referrals being requested will be located on the Active Referrals Tab under the date the referrals were sent. See picture below.

Referrals will almost always be listed by HMIS Client ID or non- HMIS Unique ID. See picture below.

03ARA0704	**Non- HMIS Unique ID**
1037361	**HMIS ID**
1130395	**HMIS ID**

For referrals that have an outcome there will be a yellow, red, green, or blue highlight. The color codes mean the following:

Yellow: Referral is still pending

Red: Referral has been declined

Green: Referral has been housed with the program

Blue: Priority Referral (for scattered site RRH and/or TH programs only)

In some cases a referral might be working with a CE Housing Navigator. If that is the case then there will be a note by the HMIS Client ID or non- HMIS Unique ID stating who the Navigator is and their contact information. See instructions below for contacting and working with the CE Housing Navigator.

Acknowledging the Referral in HMIS

For those referrals that are from the HMIS Priority List, the referral will need to be acknowledged in HMIS using the Housing Provider Data Entry Instructions. The instructions can also be found here: https://www.hmismn.org/coordinated-entry.

Contacting Referrals

Attempting to contact referrals that have been received should begin within 1-2 business days after receiving the referral, depending on the number of referrals. If a referral is received who is working with a CE Housing Navigator, then contact the Navigator first for more information regarding the referral. There should be at a

minimum 3 attempts of contact made to the referral within 5 business days. A valid attempt of contact is defined as one business day of reaching out to the referral, alternative contacts, case managers, and CE assessor (e.g., business day 1; contact referral and alternate contacts, business day 2; contact referral, assessors, and case manager, etc.). Due diligence should be used to attempt all means of contact including reaching out to CE Assessor, case managers, shelters, and/or outreach worker for those staying in a place not meant for habitation.

Documenting Contact Attempts

Housing providers can use the contact log provided or another method of their choice for logging contacts. The important factor is making sure the attempts have been documented in case it needs to be referenced by either the Housing Provider or the CE Specialist. If the minimum attempts have been completed then the referral can be returned.

No Contact Information

If there is not contact information listed for the referral, contact the Assessor to see if there has been contact. If the referral is in a place not meant for habitation, contact any outreach workers, drop-in centers, or local free food resources as applicable to see if there has been contact. If contact cannot be made and they have been assessed in the last three months then the referral can be returned but should remain on the priority list. If contact cannot be made and the referral was assessed over three months ago then the referral can be returned and removed from the priority list.

Reporting Updates

Once the outcome of the referrals is known then update the CE Specialist with the status. Updates can be provided by either emailing the contact log, emailing the referral spreadsheet with outcomes, or putting the outcomes in an email. The referral should then be marked successful or unsuccessful in HMIS and if it is appropriate, exiting the referral from CE.

Referral Screening

Determining Eligibility

Once contacting referrals has begun, the goal should be to determine eligibility as soon as possible with the understanding that it may take longer depending on the program. It will be up to the housing provider to determine eligibility and collect the needed documentation based on the program. The only exception is if the Referral has already been working with a CE Housing Navigator.

Duration Guidelines for Pending Referrals

The referral can be kept by the Housing Provider as long as the Referral is engaged and they still want to work with the Housing Provider and there is progress towards housing the Referral.

Enrollment

When it has been determined that the Referral has met eligibility for the program and they will be enrolled (but not necessarily housed yet), then the referral should be marked as successful in HMIS and the program should do any other steps that are necessary for their enrollment process.

Housing Referral

Once a housing date has been determined or they have been housed then the referral should be marked as successful in HMIS and exited from CE (if this has not been done already at enrollment). The outcome should then be reported to the CE Specialist.

Some programs use the Coordinated Entry Receipt for the Referral's file to show that the Referral has been referred through CE. If the Coordinated Entry Receipt is needed or other documentation for the Referral file then contact the CE Specialist.

Declining Referrals

Reasons for Declining Referrals

- Referral does not meet the program's eligibility criteria.
- Referral cannot be reached within 5 business days of the referral being made to the program (see Contacting Referrals above)
- Referral has not been in contact with the housing provider or cannot be contacted after initial contact.
- Program does not have the capacity or expertise to meet a participant's disability needs and service partnership is not currently available
- Referral declines housing due to location or other reason
- Referral is already housed (self- resolved)
- Program has staff turnover after receiving referrals or other capacity reasons
- Program realizes there were not enough funds available and had already received referrals

Declining Referral and Returning to CE

If a Referral falls under one of the reasons stated above, "Reasons for Declining Referrals," then provide an update to the CE Specialist and mark the Referral as unsuccessful under the CE Entry in HMIS.

Reasons for Returning Referral to CE (and NOT exiting from CE)

- Referral is still without housing
- Referral has only had one attempt to contact (see Contacting Referrals above)
- Referral does not meet eligibility criteria
- Referral declines progam

Declining Referrals and not Returning to CE

If a Referral falls under one of the reasons stated above, "Reasons for Declining Referrals," then provide an update to the CE Specialist and mark the Referral as unsuccessful under the CE Entry in HMIS and exit the Referral from HMIS.

Reasons for **NOT** returning Referral to CE (and exiting from CE)

- Referral has self- resolved
- If CE Specialist informs Housing Provider that this is the 2nd contact attempt by another Housing Provider then Referral can be exited from CE
- Referral will be in an institutional setting for more than 3 months
- Referral wants to be removed from CE
- Referral has moved outside of the CE

Updating the CE Assessment

When a referral is going to be declined and will be returned to CE, the CE Assessment should be updated to reflect any changes that may have occurred from the time of CE Assessment to Housing Referral. Updates that typically need to be made are shown below. Please refer to the Minnesota Coordinated Entry Assessor Instructions for updating CE Assessment Data.

All updates will be made in the Entry/Exit tab of HMIS under the SE CoC CE Assessment Provider. **Hint:** make sure SEC is in the Provider name if there are multiple entries under the Entry/Exit tab. It is important to note that an Interim Review should be created when making updates in the CE Assessment.

If the Housing Provider does not have access to HMIS, use the Update Form to note any changes that need to be made to the CE Assessment. When providing a referral update to the CES Specialist, attach the Update Form to the email and the CE Specialist will make the appropriate changes in the Referral's CE Assessment.

Household Type

Any household composition and size updates should be completed here:

Field	Value
Household Type	-Select- G
Household Size: Total # of Persons	G
Household Size: Total # of Adults (18+)	G
Household Size: Total # of Children (17 and under)	G

Current Living Situation

If the Referral's location has changed since Assessment it should be updated in two locations:

SECTION 2. Eligibility

Current Living Situation

Start Date *	End Date	Current Living Situation	Is client going to have to leave their current living situation within 14 days?
Add			

AND

Assessing Chronic Homelessness (HUD)

Note, HUD does not factor in doubled up/couch hopping episodes when assessing chronic homelessness.

If you are asked to complete Approximate Date Homelessness Started below, have the client look back to the date of the last time the client had a place to sleep that was not on the streets, ES, or SH and enter that date.

Field	Value
Prior Living Situation	-Select- G
Length of Stay in Previous Place	-Select- G

The location must be updated in both areas of the CE Assessment so the most accurate information shows on the Priority List Report. If the wrong location is listed on the report it may drastically affect what Housing Program the Referral is referred to.

***Please note:** For the purposes of CE, Prior Living Situation (pictured above) really means where the Referral is now- not where they were before the current location.

Housing Summary

Update any new episodes (i.e., treatment and shelter stays, doubled- up episodes) in the Household Summary Sub assessment:

Please provide list of previous living experiences in the subassessment below to help determine an appropriate placement.

Housing Summary

Move-In Date	Move-Out Date	Residence Type	County (MN Only)
Add			

If they are doubled- up or in another temporary situation, and it has been less than a week (or 90 days if in an institutional setting), then ask if they were on the streets prior to current situation.

If they were on the streets prior to current situation, ask for the date the literally homeless situation started, how many times in the past 3 years they have been literally homeless, and then the total number of months in the last 3 years they have been literally homeless.

County Preferences

There does not need to be five counties, but at least one should be entered. If a Referral requests to be placed on the Priority List in another CoC see instructions for Adding a Referral to Another CoC's CE.

Please rank up to five counties that you would prefer to find housing in:

Client Choice 1 (County)	-Select- G
Client Choice 2 (County)	-Select- G
Client Choice 3 (County)	-Select- G
Client Choice 4 (County)	-Select- G
Client Choice 5 (County)	-Select- G

Contact Information

Current contact information should be updated below:

SECTION 4. Contact Information

Phone number where you can be reached or where a message can be left	G
Email where you can be reached or where a message can be sent	G
Alternative Contact #1 Name	G
Alternative Contact #1 Relationship	G
Alternative Contact #1 Phone	G
Alternative Contact #1 Email	G
Alternative Contact #2 Name	G
Alternative Contact #2 Relationship	G
Alternative Contact #2 Email	G
Alternative Contact #2 Phone	G

Navigation

Navigator Role

CE Housing Navigators assist targeted participants between assessment and housing referral to increase participant likelihood of getting housed and help housing programs with documenting eligibility.

Households Served

Highest Priority Households

Highest priority households for housing (most barriers to obtaining housing and vulnerability, longest histories of homelessness) who are not yet pending for housing.

Lower Barrier Households

Lower barrier households where rapid referral for homeless-designated housing is unlikely and mainstream resources may be most effective in quickly resolving housing crises.

Households Fleeing Domestic Violence

Households that are residing in domestic violence shelters or fleeing domestic violence, but not in shelter.

For more information about the role of CE Housing Navigators, please refer to the Coordinated Entry Housing Navigator Role Document.

Working with Navigators

Contacting Navigator

If the Housing Provider has received a referral that is working with a Navigator then the Housing Provider should contact the Navigator prior to reaching out to the Referral. The Navigator is likely to have more information about the Referral and how to reach them best. The Navigator can also facilitate contact between the Housing Provider and the Referral if the Navigator feels that approach would work better.

Collecting Documentation

In some cases the Navigator may have documentation that the Housing Provider will find useful in determining eligibility. The Navigator will have the Referral sign a release of information so the needed documentation can be shared with the Housing Provider. If the Navigator does not have documentation for the Referral then the Housing Provider and the Navigator may work together as needed to collect what is needed for eligibility.

Procedures for Other Situations

Multiple Openings

Opening with the same program but different location

If a Housing Provider has an opening with the same program but a different location and the referral is interested in the other location then contact the CE Specialist for confirmation of referral transfer to the other location.

Opening with the same program but different funding source/program

If a Housing Provider has multiple openings with different funding sources/programs and the Housing Provider is pulling referrals at the same time, then the referrals received can be swapped if needed between the funding sources/programs. Situations such as this should still be provided to the CE Specialist to document.

Referral is in Another County or State

If the referral is in another county or state at the time of contact and they are willing to relocate, the Housing Provider should discuss with the referral to determine if there is transportation or other resources available to relocate them to the area.

Referral is in an Institutional Setting at Time of Contact

If at the time of contact the referral is in an institutional setting like treatment or jail, then continue to work with them as able, or as time allows based on the availability of unit, voucher, subsidy, etc. If the referral is going to be in the institutional setting for over three months (confirmed by individual or roster) then the referral can be returned and exited from CE.

Adding a Referral to Another CoC's CES

If the participant reports that they want to be in a county outside of the CoC, the Housing Provider should contact the CE Specialist to confirm that they can be added to that CoC's CES. If the Referral is not eligible for the selected CoC's CES then it is up to the Housing Provider to follow- up with the Referral and let them know.

Referral Re- engages with Housing Provider

If there is a referral who could not be reached and has been returned to CE ends re- engaging with the Housing Provider, then the CE Specialist should be contacted to see if they can be a referral again. In most cases this is acceptable, but confirmation is necessary before proceeding. The CE Specialist will make sure that the referral is not pending with another Housing Provider, etc.

Adding Another Member to the Household for Housing Support (LTH) Programs

If there is interest to add another member to a household already enrolled in Housing Support (who was referred through CE), and the added household member will also receive Housing Support and does not meet the county exemption, then a CE Assessment should be completed. The Housing Support provider should contact a CE Assessment site and communicate with the CE Specialist about the CE Assessment being completed. Once it is confirmed that the participant has been assessed and is active on the CE Priority List Report, they will then be referred to the Housing Support Program and further screening will be completed to determine eligibility and enrollment.

Client is Exiting the program into homelessness

If there is a participant that is exiting the Housing Program into homelessness, that Housing Provider should use due diligence to ensure that the Client is assessed again for CE and added to the priority list.

Prioritization

Referrals are pulled based on prioritization for each program type; Permanent Supportive Housing, Rapid Rehousing, Transitional Housing, and Joint Rapid Rehousing/Transitional Housing. Prioritization for each program type is determined by the River Valleys Continuum of Care. Please see the CE Policy related to the Orders of Priority for each program type.

Transfers

Types of Transfers

Voluntary

If an opening in an equal program type becomes available within the River Valleys CoC region, and a participant is eligible and is requesting a transfer. For example, there is a need to relocate to another county due to employment or school.

Involuntary

When a non-emergency housing program designated for homeless persons is closing and participants If a non-emergency housing program designated for homeless persons is closing and participants affected were referred via CES (or would have been had CES been in place when they entered the program), currently enrolled clients may be transferred to another program.

Increased Service Need

If the current level of service is not enough to meet the needs of a participant and there would be more success in more intensive program, a program transfer can be requested to a more intensive program. Once the current case manager has confirmed the clients wish to transfer, the PSH Transfer Assessment should be completed, and contact made to the CE Specialist to discuss possible transfer options.

Emergency

When there is an immediate need to relocate the household due to domestic violence, dating violence, sexual assault, and stalking.

Transfer Steps

If there is a participant that falls under one of the above transfer types, first contact the CE Specialist to discuss possible options for the transfer. In cases where a transfer may not be successful, the household should have their CE Assessment updated and re-added to CE. If they have never had a CE Assessment because they were housed before CE was implemented, then they should have a CE Assessment completed and be added to CE.

HUD Chronic Homeless Openings

Occasionally, a circumstance may arise when a Housing Provider cannot identify a HUD Chronic household for their vacancy though CE referrals. In this situation the CE Specialist should be contacted with the HMIS ID or non- HMIS ID of the referral who has been the next prioritized but does not meet the HUD chronic definition. The CE Specialist will provide a letter or email documenting the CE policy and HUD guidance allowing the vacancy to be filled with a non- chronic household. The letter or email should be kept with the client file. Additionally, there may be a need to explain the reason for the non- chronic household being housed when the project completes the Annual Performance Report (APR). For the purpose of the APR, the CE Specialist may also provide sample narrative language at the time the approval letter or email is sent.

Priority Referrals

Please note: Priority Referrals are only for Scattered Site Rapid Rehousing and/or Transitional Housing Providers

Requirements

If a Participant has secured housing, then the rest of the following conditions must be met to proceed with a Priority Referral Request:

- The participant must have been assessed (CE Assessment) and placed on the coordinated entry priority list, and
- the agency requesting the referral has within the last 6 months, pulled 90% of their referrals from CE, and
- the participant has shown confirmation of the rental, e.g., letter of intent from the landlord or lease, or
- the participant has disclosed that they are fleeing violence and it is the cause of their current homeless situation.

Making the Request

Each RRH or TH provider will be given link to a Google spreadsheet with the number of referrals and priority referral requests from the last 6 months. If the percentage is 90% or above then a request can be made if all other criteria from above are met. If a Client has secured housing and has met the above conditions then fill out the Priority Referral Request Form. Just like referral requests, a confirmation email will be sent after the form has been submitted and the CE Specialist will respond within 1-2 business days.

Priority Referral Approval and Denial

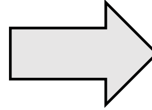
Approval

After 1-2 business days the CE Specialist will email with either approval or denial of the Priority Request. If the request has been approved the referral will be added to the program's referral spreadsheet and will be highlighted blue. The referral will then need be acknowledged in HMIS following the Housing Provider Data Entry Instructions. All other procedures remain the same: contacting the referral, updating the CE Specialist with the outcome, and data entry into HMIS.

Denial

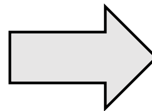
After 1-2 business days the CE Specialist will email with either approval or denial of the Priority Referral Request. If the request has been denied there is no other action required and additional resources should be explored with the client to find other options.

"Where am I on the list?" OR
"What is going on, I have not heard anything?"



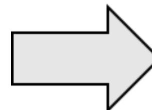
Coordinated entry is not a waitlist. We don't know how long it will take to match you with the right housing program. Housing referrals are made based on availability and individual needs. If it looks like you are eligible for an opening, you will be contacted by the housing provider directly.

"Can I be added to another priority list? I want to live in another county outside of the area (CoC)."



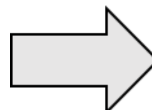
Each area of Minnesota has different eligibility for accessing Coordinated Entry. We will check with the Coordinated Entry Specialist and the other CoC to see if you can be added to their Coordinated Entry list. If you are able to be added, you may get a call from another assessor in that area with more information. We will let you know if you are not able to be added.
***Assessor, make sure they still want to be on our CES list if they do not choose any counties in our CoC.**

When a household wants to be reassessed.



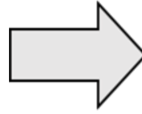
Unless your circumstances have changed significantly we do not have to complete a new assessment, but we can update your information if it is needed.

When a household does not meet the eligibility of a program.



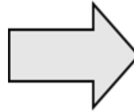
At this time you are not eligible for services through our program. I am going to update your information for coordinated entry to reflect your current situation so you can be referred for another program that you might be eligible for. Please update the assessing agency if your situation changes again so you are referred only to programs you may be eligible for.

When a household calls back after being contacted and they have missed housing opportunity.



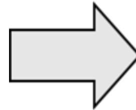
I am sorry I wasn't able to reach you in the time allowed to contact someone for an opening. I can update your information for coordinated entry so that you have the opportunity to get referred again for housing.

When a household is not able to secure housing in the time allotted.



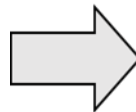
At this time, I will have to return your name back to coordinated entry, so you have the opportunity to be referred to another program. Another program might have additional housing options for you.

When a household was a referral and was returned to CE, but they have now secured housing.



*If there is no more funding available: I am sorry at this time we no longer have any funding.
*If there is still funding or the unit is still open: I will check the Coordinated Entry Specialist to see if your name can be referred to our program again.

When a household has secured their own housing and does not want to be assessed (this would also apply if they have not secured housing but they have not been assessed), or they are calling to see if there is assistance/funding available.



Our program (or many programs) require(s) coordinated entry to access housing assistance. Without being assessed, we will not be able to provide assistance. If privacy is a concern, you can refuse any question you do not want to answer.
*If they still refuse assessment: let them know they can come back if they change their mind and refer to other resources.

River Valleys Continuum of Car Coordinated Entry System
Referral Contact Log

***Once three attempts have been made within five days, please fill out form with final outcome and submit to CESReferrals@threeriverscap.org**

Staff Name (First and Last Name)	Agency	Date Referred from CE	HMIS ID or Unique ID	Date of Attempted Contact	Type of Contact Phone # and email used, talk to assessor, etc.	Result of Contacts
Final Outcome:						

Staff Name (First and Last Name)	Agency	Date Referred from CE	HMIS ID or Unique ID	Date of Attempted Contact	Type of Contact Phone # and email used, talk to assessor, etc.	Result of Contacts
Final Outcome:						

River Valleys Continuum of Care Coordinated Entry System: Update Form for Assessment Updates

Circle "Yes" or "No" depending on if the response has changed. If a response is the same as in the Step 2 CES Assessment or on the Contact Spreadsheet, you do not need to fill out all the questions- just the ones that have changed.

If not homeless (crisis resolved) – follow instructions for exiting the referral or contacting the CE Specialist if it is a non- HMIS List entry.

Name: ______________________________ Organization: ______________________________

Name / HMIS ID #/Non- HMIS ID on CE Priority List: ___________________________________

1. **Household Type:** Same? YES NO
   - ☐ Family
   - ☐ Single
   - ☐ Youth- Single
   - ☐ Youth- Family

   Household Size: Same? YES NO
   Total # of Persons ______
   Total # of Adults ______
   Total # of Children (17 and under) ______

2. **If there are school- aged children, is the school district the same?** YES NO
   If it has changed, what is the new school district? _______________________

3. **Any new episodes to enter in the Housing Summary Sub assessment?** YES NO

Move-In Date Ex: 01/01/2001	**Move-Out Date** Ex: 03/01/2002	**Residence Type** Select from list in Step 2 Assessment	**State**	**City** (MN- Only)	**County** (MN- Only)	**Lease Holder**

4. **Current Location: Same?** YES NO
   - ☐ Place not meant for habitation
   - ☐ Emergency shelter, including hotel or motel paid for with Emergency shelter voucher
   - ☐ Foster care home or foster care group home
   - ☐ Hospital or other residential non-psychiatric medical facility
   - ☐ Jail, prison, or juvenile detention facility
   - ☐ Long-term care facility or nursing home
   - ☐ Psychiatric hospital or other psychiatric facility
   - ☐ Substance abuse treatment facility or detox center

- ☐ Hotel or motel paid for without emergency shelter voucher
- ☐ Owned by client, no ongoing housing subsidy
- ☐ Owned by client, with ongoing housing subsidy
- ☐ Permanent housing for formerly homeless persons
- ☐ Rental by client, no ongoing subsidy
- ☐ Rental by client, with VASH subsidy
- ☐ Rental by client, with GPD TIP subsidy
- ☐ Rental by client, with other ongoing subsidy
- ☐ Residential project or halfway house with no homeless criteria
- ☐ Staying or living in a family member's room, apartment, or house
- ☐ Staying or living in a friend's room, apartment, or house
- ☐ Transitional housing for homeless persons (including homeless youth)

Fill out the questions below only if they are:

- **doubled- up or in another temporary situation (not highlighted above), and it has been less than a week (or 90 days if in an institutional setting), and they were in a HUD homeless situation (shelter, streets) or they are now in a HUD homeless situation.**
  Approximate Date of most recent episode of HUD homelessness: ___________
  Regardless of where they stayed last night - Number of times the client has been on the streets, in ES, or SH in the past three years including today: ___________
  Total number of months homeless on the street, in ES or SH in the past three years:__________

5. **Is the disability information the same?** YES NO

Household Disability Information:

Relationship to Head of Household	**Disability Type (select from list to the right)**	**Date of Diagnosis**	**If yes to Drug Abuse, Alcohol Abuse, or Drug and Alcohol Abuse, currently receiving services or treatment?**	**Does your disability limit your ability to live independently?**	**Is the disability documented?**	**Disability Type:** Mental Health Problem, Physical, Developmental, Chronic Health Condition, Alcohol Abuse, Drug Abuse, Both Alcohol and Drug Abuse, HIV/AIDS,

6. **Are their county preferences the same?** YES NO

Counties of preference:

Participant Choice 1:
Participant Choice 2:
Participant Choice 3:
Participant Choice 4:
Participant Choice 5:

*If the participant selects a county outside of the CoC, let them know you will have to contact the List Manager to confirm that they can be added to that CoC's CES and you will let them know if they cannot be added.

7. **Is their contact information the same?** YES NO

Phone number where you can be reached or where a message can be left:
Email where you can be reached or where a message can be sent:
Alternative Contact #1 Name
Alternative Contact #1 Relationship:
Alternative Contact #1 Phone:
Alternative Contact #1 Email:
Alternative Contact #2 Name:
Alternative Contact #2 Relationship:
Alternative Contact #2 Phone:
Alternative Contact #2 Email:

8. Any other notes?

____
____
____
____
____

River Valleys Continuum of Care Coordinated Entry System: Transfer to Permanent Supportive Housing Assessment

Instructions

The Housing Case Manager should complete all sections of the assessment below. Then add up all scores in the 'participant score' column and write the total in the bottom. If the assessment subsection does not apply, please give 0 as the score, then write N/A and a brief explanation in the corresponding "Housing Case Manager Comment" column (Example: 0, N/A, not required to pay utilities). The Housing Case Manager may choose to score the Permanent Supportive Housing (PSH) participant higher or lower based upon professional discretion (Example: Connection to Community Supports subsection, score 0 given, participant has always been independent without community supports).

Participant Name:	**HMIS ID/Non- HMIS ID:**	**Date Assessment Completed:**
Staff Name:	**Staff Email:**	**Staff Phone Number:**
Date Entered Program:	**Date Needs to Exit Program:**	**Total (Actual) Household Size:**
Has an Extension been requested to the Funder?	**Does the Head of Household have verification of disabling condition?**	**Does the Household have verification of their homeless history?**
Are there any legal/criminal barriers to housing at a site- based PSH?	**Provide List of alternatives to housing and additional support service connections in the past 6 months:**	

Provide a narrative that describes the increased and/or sustained service need of participant:

River Valleys Continuum of Care Coordinated Entry System: Transfer to Permanent Supportive Housing Assessment

****Please note that this section is weighted different than the others****

Section 1: Wellness	Score 5	Score 4	Score 1	Score 0	Participant Score	Housing Case Manager Comment (If N/A or scoring guide deviation)
Substance Use Disorder Recovery and/or Harm Reduction	Participant has not been able to sustain recovery or consistently sustain recovery or followed Harm Reduction practices	For the past 0-6 months the participant had periods of sustained recovery or followed Harm Reduction practices	For the past 6- 12 months the participant sustained recovery or followed Harm Reduction practices	Participant has no current substance use disorder treatment needs OR has 24+ months of sustained recovery or Harm Reduction practices		
Mental Health Service Needs	For the past 0- 3 months the participant was able to keep mental health care appointments or did not have any engagement with mental health care providers	For the past 3- 6 months the participant was able to keep mental health care appointments	For the past 6-12 months the participant was able to keep mental health care appointments	Participant keeps mental health care appointments on a regular basis OR has no current behavioral health needs		
Connection to Health Care	Participant has not been connected to health care provider during the past 12 months	Participant is newly connected to a health care provider	Participant has been connected to a health care provider for the past 3 to 6 months	Participant has been connected to a health care provider for more than 6 months		

Section 1 Total:

River Valleys Continuum of Care Coordinated Entry System: Transfer to Permanent Supportive Housing Assessment

Section 2: Financial Responsibility and Income	Score 3	Score 2	Score 1	Score 0	Participant Score	Housing Case Manager Comment (If N/A or scoring guide deviation)
Utility Bills	Participant has paid utility bills on time 0-3 times in the past 12 months	Participant has paid utility bills on time 4-6 times in the past 12 months	Participant has paid utility bills on time 6-8 times in the past 12 months	Participant has paid utility bills on time 8-12 times in the past 12 months		
Outstanding Utility Bills	Participant has outstanding utility arrears and is not willing to set up a payment plan	Participant has less than $1,000 in utility arrears and has set up a payment plan or applied for resources	Tenant has less than $500 in utility arrears and is current on payment plans	Participant has no utility arrears		
Employment	Participant is not employed and not enrolled in an employment program.	Participant is currently in an employment development program, educational training program, or actively seeking employment.	Participant is employed, involved in a volunteer position, internship, or job mentoring program for less than 6 months.	Participant has been employed for at least 6 months or is receiving Social Security benefits.		
Current Debt and Financial Obligations	Participant has debt over 50% of their monthly income or is unable to consistently meet financial obligations	Participant has debt over 50% of their monthly income but is able to consistently meet financial obligations.	Participant has less than 10% of their monthly income in outstanding debt and is meeting financial obligations	Participant has no outstanding debt or financial obligations.		

Section 2 Total:

River Valleys Continuum of Care Coordinated Entry System: Transfer to Permanent Supportive Housing Assessment

Section 3: Housing	Score 3	Score 2	Score 1	Score 0	Participant Score	Housing Case Manager Comment (If N/A or scoring guide deviation)
Safe Living Environment	Participant has had over 5 contacts* with police and/or landlord complaints in the past 6 months regarding disruptive activities in the unit	Participant has had 3-5 contacts* with police and/or landlord complaints in the past 6 months regarding disruptive activities in the unit	Participant has had 1-2 contacts* with police and/or landlord complaints in the past 6 months regarding disruptive activities in the unit	Participant has not had any police visits or landlord complaints regarding disruptive activities in the unit		
Length of Time Housed in RRH/THP	Participant has less than 2 months left in the program	Participant has 3- 6 months left in the program	Participant has less than 7-12 months left in the program	Participant has over 12 months left in the program		
Housing Stability	Participant has had 3 or more involuntary lease terminations while in the program.	Participant has had 1-2 involuntary lease terminations while in the program, and circumstances were not mutual.	Participant has had 1 involuntary lease termination while in the program, but circumstances were mutual.	Participant has never received an involuntary lease termination while in the program.		
Outstanding Rent Arrears	Participant has outstanding rent arrears and is not willing to set up a payment plan	Participant has more than 6 months in current rent arrears and has set up a payment plan or applied for resources	Participant has less than 3 months in current rent arrears and is current on payment plans	Participant has no current rent arrears		

*Excludes contacts/complaints related to domestic violence

Section 3 Total:

River Valleys Continuum of Care Coordinated Entry System: Transfer to Permanent Supportive Housing Assessment

****Please note that this section is weighted different than the others****

Section 4: Supportive Services and Resources	Score 5	Score 4	Score 1	Score 0	Participant Score	Housing Case Manager Comment (If N/A or scoring guide deviation)
Connection to Community Supports*	Participant has no community supports outside of PSH project	Participant has 1-2 community supports	Participant has 3-4 community supports	Participant has 5 or more community supports		
Need for Housing Case Management	Participant will likely need housing case management services 3 or more times per month	Participant will likely need housing case management once a month	Participant will likely need housing case management services quarterly	Participant will not need housing case management services		
Transportation	Participant utilizes housing case manager to meet transportation needs 1 or more times per month	Participant has used housing case manager to meet transportation needs 1-2 times in the past 3 months	Participant has used housing case manager for assistance with transportation but has other ways of meeting this need	Participant transportation needs are met outside of the housing case manager		

*Examples of community supports are family, food shelves, drop-in centers, support groups, faith communities, volunteer activities, community center, etc.

Section 4 Total:	

Housing Case Manager Comments and Additional Considerations	Section	Total for Section
	Section 1: Wellness	
	Section 2: Financial Responsibility and Income	
	Section 3: Housing	
	Section 4: Supportive Services and Resources	
	Total Assessment Score:	