North Carolina
Balance of State Continuum of Care

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Regional Committee Veteran Plan

In *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness*, the US Interagency Council on Homelessness (USICH) outlines goals for Continuums of Care that include ending Veteran homelessness by 2015.[1] To assist communities in reaching this objective, the USICH also published *Achieving the Goal of Ending Veteran Homelessness: Criteria and Benchmarks*, which outlines how systems can achieve an effective end to Veteran homelessness. Effectively ending homelessness for Veterans means that communities have designed systems to quickly identify and house homeless Veterans.[2] The North Carolina Balance of State Continuum of Care (BoS CoC) has set a goal to meet the USICH criteria and benchmarks by December 2017.

Goal

The goal of the regional Veteran system is to meet the federal benchmarks and criteria in each of the 13 Regional Committees by establishing and continuing to maintain an optimized homeless assistance system that effectively and continually prevents and ends Veteran homelessness across the BoS CoC. To accomplish this goal, the BoS CoC and State and VA partners will create a regional Veteran system to quickly identify and house Veterans in all 13 Regional Committees.

Vision

The BoS CoC Plan to End Veteran Homeless identifies a primary SSVF grantee for each of the 13 regions who will provide outreach to homeless Veteran households, assess them for eligibility, and oversee their connection to housing. These SSVF grantees will act as system navigators for each identified Veteran, no matter the Veteran's VA eligibility status, to ensure data collection and connection to permanent housing as quickly as possible. The permanent housing placement may be provided by SSVF, HUD-VASH, CoC or ESG programs, or other community housing programs. If a Veteran is ineligible for SSVF assistance, the SSVF provider, as navigator, will connect the Veteran to the Regional Committee's coordinated assessment system to access community housing programs.

Contact Information

Regional Committee: The Region Three or the "Uni5 Region" committee members are:

Autumn Culver; 828-368-2106; autumn.d.culver@gmail.com

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Christopher Hoover; 828-432-5659; chris@meetingplacemission.org

[1] https://www.usich.gov/opening-doors
[2]https://www.usich.gov/resources/uploads/asset_library/Achieving_the_Goal_Ending_Veteran_Homelessness_v3_10_01_15.pdf

Jamie Brown; 828-256-5056; jamiebrown@sipesorchardhome.org

Chastity Rice; 828-433-0681; chastity.poteat@bcuw.org

Counties Served: Alexander, Burke, McDowell, Caldwell, Catawba

For the following questions please provide individual name, agency name and contact information.

Primary SSVF Provider: ABCCM Veterans Services of the Carolinas; 20 20th St Asheville, NC 28806; 855-243-3293 (Toll Free); 828-259-5314 (P); 828-259-5324 (F); VSC@abccm.org; Region 3 (Uni5) Veteran Committee Lead Curry Cromer ABCCM 980-201-8672 curry.cromer@abccm.org

Primary Authors of the Plan: Curry Cromer; ABCCM; 980-201-8672; curry.cromer@abccm.org

Regional Committee Lead: Autumn Culver; 828-368-2106; autumn.d.culver@gmail.com

Regional Committee Point of Contact for the Veteran System: Curry Cromer; 980-201-8672; curry.cromer@abccm.org

Other Key Partners in Veteran System: Community Link, 704-943-3594; Family Endeavors, 704-780-4950;

Criterion #1: The community has identified all Veterans experiencing homelessness.

Outreach

The goal of outreach is to immediately identify and engage unsheltered homeless Veterans and offer low-barrier shelter and permanent housing assistance to any homeless Veteran within the CoC. Outreach within Regional Committees will take two forms: passive and assertive.

Passive Outreach

With passive outreach, SSVF providers, with the help of regional leadership, will identify key community partners to aid in identifying homeless Veterans. SSVF providers will train these community partners on how to identify Veterans experiencing homelessness and how to make a referral to the primary SSVF agency in the region. Referrals will be made on an ongoing basis. In addition, each region will also be responsible for contacting the identified community partners a minimum of 2 times per month, whether in-person or by phone, to ask for potential referrals. Examples of agencies that should be considered for passive outreach include local service agencies (libraries, clothing closets, feeding programs), Veteran services (National Guards, Veteran Service Officers, VFWs), jails, etc.

Use the Appendix A tab to identify key partners who will be contacted for passive outreach efforts.

Describe how key community partners will be trained to identify Veterans, including who will provide training, how the trainings will be conducted (in-person, community meetings, etc.), the target dates for initial trainings, and the plan for future trainings to refresh current staff and initiate onboarding staff.

ABCCM will train key community partners on how to identify veterans in Burke, Caldwell, Catawba, and McDowell Counties. Community Link will conduct trainings for key partners in Alexander County. Trainings may occur on-site with an individual community partner or at county level or regional level community meetings. Online trainings may also be conducted. The target date to train each community partner will be within three weeks of the implementation of the Uni5 Regional Committee Veteran Plan. During the training process, each community partner will be encouraged to implement and adopt permanent processes that ensure veterans are being identified and referred to the primary SSVF provider. These permanent processes will help minimize gaps in service which might stem from staff turnover or oversight. Refresher trainings will occur at minimum annually. More frequent training will be provided when staff turnover has occurred, during the onboarding of new staff, or in other instances where the SSVF provider conducting bi-monthly outreach deems that refresher training is appropriate.

Once communities identify Veterans through passive outreach, describe the process for engaging the Veteran, including: who will engage the Veteran, timeframe for first point of contact, how an offer of shelter will be made, housing plan development, and how the Veteran's information will be added to the regional by-name list.
Veterans identified in passive outreach will be referred to the primary SSVF provider ABCCM. ABCCM will contact each veteran within 24 hours of the referral's receipt and will conduct an intial SSVF assessment via phone screening. If the veteran is unsheltered, then ABCCM will offer to connect the veteran to emergency shelter during the phone screening. Housing plan development will take place more concretely once the veteran begins SSVF participation or accesses an alternative housing resource. The veteran's information will be added to the by-name list within 24 hours of when consent is received.

Assertive Outreach

Assertive outreach will be the primary responsibility of the SSVF providers in each Regional Committee. Assertive outreach involves visiting and surveying sites where unsheltered homeless people sleep or frequent to identify homeless Veterans and to offer them shelter and housing. Through this approach, providers can continue to engage known Veterans and identify new Veterans who need assistance. SSVF providers will also work with community partners who already conduct outreach to train them in how to identify and refer Veterans.

Use the following chart to list all agencies (SSVF providers, faith-based organizations, shelters, etc.) completing assertive outreach in the region:

Agency	**Counties Served**	**How Often Outreach is Done Per Month**
ABCCM	Burke, McDowell, Caldwell, Catawba	Bi-monthly Minimum
Community Link	Alexander, Catawba	Bi-monthly Minimum
Family Endeavors	Catawba	Bi-monthly Minimum
Veterans Helping Veterans	Catawba	Weekly

If community agencies are doing assertive outreach, describe how they will be trained to identify Veterans, including who will be providing training, how the trainings will be done (in-person, community

meetings, etc.) the target dates for these trainings, and how staff turnover will be taken into account for future training.
When additional community partners conducting assertive outreach are identified, the SSVF providers will conduct training according to the passive outreach training plan listed above.

How will the region obtain information about potential unsheltered sites (law enforcement, librarians, etc.)?
The region will obtain information on unshletered sites utilizing contact with law enforcement, soup kitchens, crisis centers, and other community partners.

Once an unsheltered location is identified, how will the location be tracked by the region and how often will the locations be visited for ongoing engagement?
Once identified, unsheltered locations will be tracked at community meetings at both the county and regional level. In order to accomplish this, each community meeting should introduce a segment of the meeting agenda to discuss movements and developments among known unsheltered sites. Unsheltered sites will be visited monthly for outreach, provided potential safety concerns with visiting each site have been mitigated.

Once a Veteran is identified through assertive outreach, describe the process for engaging the Veteran, including: who will engage the Veteran, timeframe for first point of contact, how an offer of shelter will be made, housing plan development, and how the Veteran's information will be added to the regional by-name list.
When an SSVF provider identifies an unsheltered veteran during assertive outreach, that provider will make an immediate offer to connect the veteran to shelter. The SSVF provider will also begin screening the veteran for SSVF and other services and obtain the necessary consent to add the veteran's name to the by-name list. By-name list information obtained by the non-primary SSVF providers will be shared with the primary SSVF provider during biweekly list updates to ensure the veteran identified is represented on the region's by-name list. Unshelterd veterans will be offered shelter once a month at minimum by either the primary SSVF provider unless the veteran is enrolled with one of the secondary SSVF providers at which point a monthly offer of shelter will be made by the secondary SSVF provider.

Veterans identified in assertive outreach by other community partners will be referred to the primary SSVF provider ABCCM. ABCCM will contact each veteran within 24 hours of the referral's receipt and will conduct an initial SSVF assessment via phone screening. If the veteran is unsheltered, then ABCCM will offer to connect the veteran to emergency shelter during the phone screening. Housing plan development will take place more concretely once the veteran begins SSVF participation or accesses an alternative housing resource. The veteran's information will be added to the by-name list within 24 hours of when consent is received.

How will transportation be provided for unsheltered Veterans once identified?
SSVF providers may find it necessary to transport the veteran to shelter when identifying unsheltered veterans during assertive outreach. In some instances the SSVF provider may utilize other community partners to arrange transportation for the veteran. The provider might also direct the veteran to community resources that could facilitate transportation to shelter.

In-Reach

The primary SSVF provider will coordinate in-reach efforts to identify homeless Veterans in shelter and transitional housing programs that do not participate in coordinated assessment or the HMIS system. SSVF providers will train agency staff at non-participating agencies on how to identify Veterans and how to make a referral to the primary SSVF agency in the region.

Use the Appendix B tab to identify key agencies that provide shelter, transitional housing, or other services that do not currently participate in HMIS or coordinated assessment and will be contacted for in-reach efforts.

Describe how agencies that provide shelter and transitional housing and do not participate in HMIS or coordinated assessment will be engaged in the Veteran system, including: who will engage the agencies and a projected timeline.
ABCCM will train "in-reach" shelters and transitional housing providers on how to identify veterans in Burke, Caldwell, Catawba, and McDowell Counties. Community Link will conduct trainings for key partners in Alexander County. Trainings may occur on-site with an individual community partner or at county level or regional level community meetings. Online trainings may also be conducted. The target date to train each community partner will be within three weeks of the implementation of the Uni5 Regional Committee Veteran Plan. During the training process, each community partner will be encouraged to implement and adopt permanent processes that ensure veterans are being identified and referred to the primary SSVF provider. These permanent processes will help minimize gaps in service which might stem from staff turnover or oversight. Refresher trainings will occur at minimum annually. More frequent training will be provided when staff turnover has occurred, during the onboarding of new staff, or in other instances where the SSVF provider conducting bi-monthly outreach deems that refresher training is appropriate.

Describe how engaged community agencies will be trained to identify Veterans, including: who will be providing training, how the trainings will be done (in-person, community meetings, etc.), the target dates for these trainings, and how staff turnover will be taken into account for future training.
ABCCM and Community Link will train additional key community "in-reach" partners as listed above.

Once the community has identified Veterans through in-reach efforts, describe the process for engaging the Veteran, including: who will engage the Veteran, timeframe for first point of contact, how an offer of shelter will be made, housing plan development, and how the Veteran's information will be added to the regional by-name list.
Veterans identified during "in-reach" will be referred to the primary SSVF provider ABCCM. ABCCM will contact each veteran within 24 hours of the referral's receipt and will conduct an initial SSVF assessment via phone screening. If the veteran is unsheltered, then ABCCM will offer to connect the veteran to emergency shelter during the phone screening. Housing plan development will take place more concretely once the veteran begins SSVF participation or accesses an alternative housing resource. The veteran's information will be added to the by-name list within 24 hours of when consent is received.

Criterion #2: The community provides shelter immediately to any Veteran experiencing unsheltered homelessness who wants it.

Offer of Shelter

When an unsheltered Veteran is identified during outreach, SSVF providers will make an immediate referral to the coordinated assessment system. If the region's coordinated assessment system identifies an unknown Veteran, the provider completing the screen will make an offer of shelter and refer the Veteran to the primary SSVF provider in the region. For Veterans ineligible for VA programs, the SSVF provider will work with providers in the region's coordinated assessment system to ensure that shelter placement has been offered and the Veteran's information has been entered into HMIS.

Use Appendix C tab to identify shelter in the region that will be utilized to serve unsheltered Veterans.

For Veterans who decline an offer of shelter, the SSVF provider, acting as navigator, will routinely offer shelter in conjunction with the regional coordinated assessment system while also working to secure a permanent housing placement.

For regions that do not have shelter, an offer of emergency housing in a hotel or motel will be made.

Describe how unsheltered Veterans will be offered and connected to shelter once identified in outreach, including: how shelter bed(s) will be secured, how Veterans will be transported to shelter, etc.
Unsheltered veterans identified in outreach will be connected to shelter by an SSVF provider. The SSVF provider may find it necessarry to transport the veteran to shelter. In some instances the SSVF provider may utilize other community partners to arrange transportation for the veteran, or the provider might direct the veteran to resources that could facilitate transportation to shelter. If shelter is not readily available in the veteran's location, the SSVF provider will work to locate additional resources for shelter across the region. The SSVF provider may also contact individual shelters who might be at full capacity to assess whether special arrangements can be made to provide shelter to the unsheltered veteran.

If an unsheltered Veteran is identified in the region's coordinated assessment process through the Prevention and Diversion screen or the VI-SPDAT, describe how CoC agencies will make an offer of shelter and how Veterans will be connected to the primary SSVF provider to be added to the region's by-name list.
Veterans will be identified through the Coordinated Assessment Prevention and Diversion Screen and will be referred to ABCCM. ABCCM will then conact the veteran within 24 hours of the referral and begin assessment for SSVF. Upon completion of the Prevention and Diversion Screen unsheltered veterans will be directed to available shelter or placed on correspndonig shelter waiting lists if shelter is unavailable.

Describe how Veterans who decline an offer of shelter will be routinely offered shelter and how these offers will be tracked for the region.
SSVF staff members will periodically offer shelter to unsheltered SSVF participants who initially declined shelter. Offers of shelter will be documented through the internal records of individual SSVF providers.

Does your region utilize emergency housing, such as hotel/motel vouchers, if no shelter beds are available? ☐ Yes ☒ No
If so, please describe the process for accessing this emergency housing:

Please describe any known barriers for accessing emergency housing:
Alexander Co. does not have an emergency shelter; The other remainnig shelters require sobriety to enter shelter which presents a barrier.

Does your region need assistance with emergency housing and shelter? ☒ Yes ☐ No
If yes, please provide the name, email and phone number of the person to contact: Please contact members of the Regional Committee: Autumn Culver; 828-368-2106; autumn.d.culver@gmail.com
Teena Willis; 828-323-8084; twillis@partnersbhm.org
Christopher Hoover; 828-432-5659; chris@meetingplacemission.org
Jamie Brown; 828-256-5056; jamiebrown@sipesorchardhome.org
Chastity Rice; 828-433-0681; chastity.poteat@bcuw.org

Criterion #3: The community only provides service-intensive transitional housing in limited instances.

Transitional Housing

Though the BoS CoC does not have Grant Per Diem programs, service-intensive transitional housing programs funded through private sources are available to Veterans. Both the primary SSVF provider and the local agencies that serve as access points for the Regional Committee's coordinated assessment system will ensure Veterans are offered a choice of permanent housing assistance (e.g., SSVF) either prior to entering the transitional housing program or once identified in the transitional housing program.

Literally homeless Veterans referred to Grant Per Diem programs outside of the BoS CoC who originated from the BoS CoC will be welcomed back to their home counties, if they choose to return. SSVF providers are responsible for following up with Veterans while in Grant Per Diem programs and to develop housing plans for their return. For Veterans that entered Grant Per Diem programs without literal homeless status, SSVF providers will not accept referrals from Grant Per Diem programs until the program attempts a discharge into housing using the Veteran's support resources.

For each system, please describe how Veterans will be offered permanent housing and how that offer will be tracked prior to transitional housing referral.

Regional Coordinated Assessment System:
The Coordinated Assessment System will identify veterans during the Prevention and Diversion Screen and refer those veterans to the primary SSVF provider ABCCM. The primary SSVF provider will offer to connect the veteran to permanent housing either through SSVF or other available housing resources. If the veteran declines the offer of permanent housing and requests a referral for transitional housing, the declination will be acknowledged and documented on a Declaration of Housing Preference form. An offer of permanent housing will be made monthly, at minimum, to any veteran residing in transitional housing for non-clinical purposes. This offer of permanent housing will be routinely tracked by the primary SSVF provider.

Veteran Service System (SSVF Providers and VA Medical Centers):
The primary SSVF provider will offer to connect the veteran to permanent housing either through SSVF or other available housing resources. If the veteran declines the offer of permanent housing and requests a referral for transitional housing, the declination will be acknowledged and documented on a Declaration of Housing Preference form. An offer of permanent housing will be made monthly, at

minimum, to any veteran residing in transitional housing for non-clinical purposes. This offer of permanent housing will be routinely tracked by the primary SSVF provider.

If a Veteran is referred to a Grant Per Diem program outside of the BoS CoC and wishes to return to the BoS CoC for housing, please describe how SSVF providers will follow-up with the Veteran to create housing plans for their return to the region.
If a veteran in GPD outside the BoS CoC intends to return to housing within the region, it is expected that the veteran and the veteran's GPD Case Manager will formulate a successful housing plan for the veteran's return. In many instances forging a successful housing plan will be contingent on the veteran's ability to access resources and supports when entering housing in the region. There will also be some instances where the veteran and GPD Case Manager were unable to formulate a successful housing plan for the veteran to enter permananet housing in the region. In both of these cases the GPD program can make a referral to the primary SSVF provider on the veteran's behalf. When this takes place the primary SSVF provider will act as the System Navigator and Point of Contact for the GPD Case Manager. In doing so the primary SSVF provider will assist the GPD Case Manager in identifying community resources, supports, and (when necessarry) shelter for the veteran's return. In instances where transportation resources are available, the primary SSVF provider can connect the the GPD Case Manager and veteran to transportation resources to facilitate the veteran's return to the region. If the veteran in GPD is discharged into homelessness, the primary SSVF provider will make every effort to enroll that veteran in SSVF as part of the veteran's GPD discharge plan. Note that in many cases the veteran will have to physically reenter the region in order to be elligible for SSVF with specific providers. This would apply to veterans in GPD who are residing outside of the service areas of the region's SSVF providers. GPD referrals can be made to the primary SSVF providers main intake line as well as by fax or email. The primary SSVF provider will make contact with the referring GPD Case Manager within 24 hours of receipt of ther referral. The primary SSVF provider will be in contact with the referring GPD Case Manager as many times as is necessary for the successful development of the veteran's housing plan. If the veteran reenters the region into homelessness, the primary SSVF provider will regularly engage with the veteran to facilitate an appropriate housing intervention.

Criterion #4: The community has capacity to assist Veterans to swiftly move into permanent housing.

System Navigation

As communities identify homeless Veterans through outreach or in-reach activities, the primary SSVF provider will be notified. The primary SSVF provider will either meet with the Veteran or identify another SSVF provider who covers the region to contact the Veteran. Upon contact, the assigned SSVF provider will connect the Veteran to the local VAMC to determine Veteran eligibility for SSVF and HUD-VASH and add them to the Regional Committee's by-name list.

If the VAMC identifies the Veteran as eligible for VA-funded services, the primary SSVF provider will ensure a connection to either an SSVF or HUD-VASH program in the region to assist with permanent housing placement. If the Veteran is ineligible for VA benefits or does not want to participate in a VA program, the SSVF provider will connect the Veteran to the Regional Committee's coordinated assessment system for assessment and prioritization for CoC and other community housing programs.

Please use the following chart to list the staff from the VA Medical Centers (VAMC) who serve the region:

VAMC	Counties Served	Contact Name	Contact Information (email and phone)	Primary or Secondary staff
Hickory CBOC	Catawba	Tim Brulet	timothy.brulet@va.gov 828-431-5600 ext. 8053	☒Primary ☐Secondary
Charles George VA Medical Center	Alexander, Burke, McDowell, Caldwell, Catawba	HCHV Walk-In Line	828-298-7911 ext. 1198	☒Primary ☐Secondary
				☐Primary ☐Secondary
				☐Primary ☐Secondary

Please use the following chart to list the SSVF providers in the region:

Agency	Counties Served	Point of Contact	Contact Information (email and phone)	Primary SSVF Provider
ABCCM	Burke, McDowell, Caldwell, Catawba	Curry Cromer	curry.cromer@abccm.org 980-201-8672	☒Yes ☐No
Community Link	Alexander, Catawba	Branden Lewis	brandenl@communitylink-nc.org 704-943-3594	☐Yes ☒No
Family Endeavors	Catawba	Michelle Blanding	mblanding@familyendeavors.org 704-780-4950	☐Yes ☒No
				☐Yes ☐No

Describe how the primary SSVF provider will follow up with referrals as Veterans are identified in the region, including: the timeframe for follow-up and how Veterans will be added to the regional by-name list.

The primary SSVF provider will contact veterans identified in the region within 24 hours from receipt of referral and conduct an initial SSVF eligibility assessment through a phone screening. The veteran's information will be added to the by-name list within 24 hours of when consent is received.

If other SSVF provider(s) cover the region, describe how the primary SSVF provider will coordinate referrals and ensure that programs contact Veterans.

The primary SSVF provider ABCCM will receive all referrals for the region. Within 24 hours of the referral's receipt, ABCCM will conduct an initial SSVF eligibility assessment through a phone screening. Veterans located in Burke, Caldwell, and Mcdowell Counties will be staffed to ABCCM exclusively. Veterans located in Alexander County will be staffed to Commmunity Link exclusively. Veterans located in Catawba County will be staffed in a "round-robin" rotation between ABCCM, Community Link, and Family Endeavors. Bi-weekly meetings among the SSVF providers and regular by-name list updates will ensure that other SSVF programs have made contact with the corresponding veteran who was referred.

Describe how SSVF providers will coordinate with VA Medical Centers to assess Veterans for VA eligibility, including: transportation, timeframe, and determination of eligibility.
Connecting veterans to VA Health Care is a core service of SSVF and assessing the need to do so is among the initial assessments made in SSVF. SSVF providers will connect their participants to VA Health Care by assisting in the navigation of the "MyHealtheVet" online tool and "eBenefits.va.gov." When apropriate, providers will assist with transportation to VA medical centers to connect to VA Health Care in person. Providers may also refer participants to local VSO's to address more formidable barriers restricting access to VA Health Care. In cases where the veteran participant is not eligible for VA Health Care, providers will make efforts to connect the veteran to other health care resources in their community.

Describe how SSVF providers will assess eligibility for SSVF services, including: timeframe and how eligibility will be tracked.
ABCCM will assess initial eligibility for SSVF by conducting a phone screening within 24 hours of receipt of the veteran referral. If phone screening determines the veteran is initially eligible for SSVF, ABCCM will staff the veteran's case within 48 hours of that determination. Once staffed the SSVF provider will contact the veteran to schedule an SSVF intake to verify program eligibility. Total elapsed time between receipt of the initial veteran referral and SSVF program intake should not exceed 5-7 business days. SSVF eligibility will be tracked on the region's by-name list.

If eligible for SSVF and/or other VA housing programs, describe the process that will be used to connect Veterans to permanent housing within 90 days.
SSVF's core purpose is to connect veterans to permanent and stable housing within 90 days of program enrollment. SSVF can accomplish this independently or in concert with other VA housing programs such as HUD-VASH.

If ineligible for SSVF and/or other VA housing programs or the Veteran refuses VA-funded programs, describe how the SSVF provider will connect Veterans to the region’s coordinated assessment process.
When a veteran is found ineligible for SSVF or other VA housing programs or has refused a VA-funded program, the veteran will be connected to coordinated assessment through several methods and at varrying points of contact with the SSVF provider. If found ineligible during the initial eligibility phone screening assessment, the veteran will be provided information on where to connect to a coordinated assessment access point. During this time the primary SSVF provider may find it necessarry to assist the veteran in addressing logisitical obstcales that prevent connection to an access point. In these cases the primary SSVF provider will direct the veteran to resources that will address those obstacles. The primary SSVF provider may find it necessarry to send a referral to a coordinated assessment access point in cases where consent to do so has been obtained. SSVF providers interacting with veterans who have been found ineligible during assertive outreach may find it necessary to assist the veteran with transporation to a coordinated assessment access point. The primary SSVF provider will make additional contacts with the ineligible veteran to ensure connection to coordinted assessment.

Once a Veteran enters the region’s coordinated assessment system, describe how the Veteran will be tracked by regional leadership and SSVF providers to ensure housing placement.
The region's SSVF providers will utilize the region's by-name list to track each veteran's progress towards housing placement during their biweekly list update meetings. Regional leadership may participate in these list update meetings to participate in veteran tracking.

Describe the process by which the region will track housing plans on regional by-name lists.

The region will track housing plans on the regional by-name list through the biweekly list update meetings.

Please use the following chart to list the region's coordinated assessment access points:

Agency	Counties Served	Role in the Coordinated Assessment Process
Burke United Christian Ministires	Burke	☒ Prevention and Diversion ☐ VI-SPDAT
House of Refuge Ministries	Burke	☒ Prevention and Diversion ☒ VI-SPDAT
The Meeting Place Mission	Burke	☒ Prevention and Diversion ☒ VI-SPDAT
Dulatown Outreach Center	Caldwell	☒ Prevention and Diversion ☒ VI-SPDAT
Yokefellow Ministries	Caldwell	☒ Prevention and Diversion ☐ VI-SPDAT
McDowell Mission Ministries	McDowell	☒ Prevention and Diversion ☒ VI-SPDAT
Family Care Cente	Catawba	☒ Prevention and Diversion ☐ VI-SPDAT
		☐ Prevention and Diversion ☐ VI-SPDAT
		☐ Prevention and Diversion ☐ VI-SPDAT

Does the region currently have housing programs, including public housing authorities, with preferences for Veterans? ☒ Yes ☐ No

If so, please describe the each program and preferences.
Western Piedmont Council of Governments Regional Housing Authority priortizes veterans on their section 8 wating list. Applicants are scored for higher priority if they are a veteran. WPCOG serves Alexander, Burke, Caldwell and Catawba Counties.

Regional By-Name List

To track the BoS CoC's progress in meeting the goal of ending Veteran homelessness, key data will need to be tracked for each of the 13 regional Veteran systems. Each region should maintain a by-name list. This list will identify all homeless[3] Veterans within each region and will be updated at least monthly using the USICH template.

BoS CoC staff and SSVF providers will work jointly to maintain a current by-name list for each region. BoS CoC staff will pull regular reports from agencies that use HMIS to identify Veterans, place them on the list, and ensure that the primary SSVF provider for the region makes contact. SSVF providers will make bi-weekly contact with agencies not currently using HMIS to check if any Veteran currently accesses services in their programs.

[3] https://www.hudexchange.info/resources/documents/HEARTH_HomelessDefinition_FinalRule.pdf

Who will oversee the by-name list for the region?
ABCCM

What is the process the region will use to get consent from Veterans to be added to the by-name list?
The region's Prevention and Diversion Screen is the primary tool to obtain by-name list consent. SSVF providers may also obtain by-name list consent from veterans participating in SSVF that have bypassed the Prevention and Diversion Screen.

Please list all agencies that will have access to the list to add Veterans and/or update information and describe how MOUs will be established with these agencies.
ABCCM will be the sole custodians of the by-name list for the Uni5 region. ABCCM will provide the list to NCCEH. MOUs will be obtained as needed and required. MOUs between SSVF providers will be developed pending more detailed guidance from NCCEH.

Please describe the process for reviewing the list to ensure information remains current, including: how often, who will review, and in what format (in-person meeting, phone call, etc.)
The region's SSVF providers will routinely review the region's by-name list through biweekly list update meetings. These meetings will take place in person or remotely utilizing encrypted email. These meetings ensure that all by-name list information remains current.

Describe how the by-name list will be stored for the region, including technology used and how Regional Committees and other partners will be updated.
ABCCM will store the by-name list on an excel file utilizing the USICH master list tool. The Regional Committee and other partners will be updated through remote meetings utilizing encrypted email or during in-person regional meetings.

Is region currently being served by NC Serves? ☐Yes ☒No
If so, how will NC Serves information be incorporated into the by-name list?

Criterion #5: The community has resources, plans, and system capacity in place should any Veteran become homeless or be at risk of homelessness in the future.

Advertisement

Please explain the strategies that will be used to educate agencies and other community systems about the regional Veteran process. (Please attach any materials the Regional Committee uses in these efforts, like flyers, slides, posters, handouts, etc.)

Agencies and other community systems will receive training on the regional veteran process and plan as outlined in the outreach section listed above. Training will be conducted on site with community partners, at community events organized at the regional and sub-regional level, at the bi-monthly Uni5 regional meeting, and the bi-monthly Coordinated Assessment/Veterans Sub-Commmittee.

Please explain the strategies the Regional Committee uses to educate Veteran households who are risk of homelessness or experiencing homelessness about the regional Veteran process. (Please attach any materials the Regional Committee uses in these efforts, like flyers, slides, posters, handouts, etc.)

Veteran households will be educated on rapid re-housing and homeless prevention resources with ABCCM's Veterans Services of the Carolinas brochure. Brochures will be routinely provided to all outreach locations with physical and electronic copies. Through routine training and otureach as described above, community partners will be equipped to identify veteran households in need of housing assistance and can educate those households on how to connect to available housing resources.

Local Oversight

The regional Veteran process provides community-wide accountability for housing Veterans experiencing homelessness as quickly as possible. It is recommended that each Regional Committee have a Veteran subcommittee to oversee the system, report out to the Regional Committee, address system grievances, educate and provide outreach to non-participating agencies, and assist in maintaining the by-name list.

Please describe how the Regional Committee will be updated about progress towards ending Veteran homelessness, including: who will provide the update, how often, and in what venue(s) (Regional Committee meetings, email, etc.).

A representative from ABCCM will update the regional committee at the bi-monthly regional committee meetings and the bi-monhtly Coordinated Assessment sub-committee/Veterans sub-committee meetings.

Will the Regional Committee have a Veterans subcommittee to oversee the region's plan? ☒Yes ☐No

How will system gaps be identified and addressed?

System gaps can be identified and addressed internally by each SSVF provider. They can also be identified and addressed during the bi-monhtly regional committee meetings and the bi-monhtly Coordinated Assessment sub-committee/Veterans sub-committee meetings.

How will system issues be identified and addressed?

System issues can be identified and addressed internally by each SSVF provider. They can also be identified and addressed during the bi-monhtly regional committee meetings and the bi-monhtly Coordinated Assessment sub-committee/Veterans sub-committee meetings.

Grievances

Agency Grievance Policy

Please complete the following policy with details from your Regional Committee:

If a provider declines a client referral, that provider should work with the community to refer the client to the next appropriate housing provider and/or emergency shelter to ensure that the household has a safe place to sleep that night.

Providers are expected to submit a written reason for the denial to the referring agency as well as the Regional Coordinated Assessment Lead and Coordinated Assessment Lead. Providers may decline 1 out of 10 referrals in a month without a meeting. However, if a program declines more referrals than this, they will need to meet with Coordinated Assessment/Veterans Subcommittee to discuss the issue(s) that result in referrals being declined.

For all other grievances, providers must email a detailed grievance to the Regional Coordinated Assessment Lead and Coordinated Assessment Leads within 10 days of the adverse action/decision. The Coordinated Assessment Subcommittee will schedule a hearing within 3 to 5 business days of receiving the grievance and render a decision within 7 days following the hearing. If grievances cannot be resolved at the local level, an appeal will be submitted to the BoS CoC Veteran Subcommittee.

Individual Grievance Policy

Please complete the following policy with details from your Regional Committee:

If a household does not agree with a referral or the assessment process, the coordinated assessment site will attempt to make another appropriate referral based on the household's needs and the housing resources available.

If the household remains unsatisfied, they may file a grievance with the Regional Coordinated Assessment Lead, the Coordinated Assessment Lead, or the Coordinated Assessment/Veterans Subcommittee, either verbally or in writing, within 10 days of the attempted referral. The Regional Coordinated Assessment Lead, Coordinated Assessment Leads, or the Coordinated Assessment/Veterans Subcommittee will respond within 3 to 5 business days. If the household does not agree with this local decision, an appeal will be submitted to the BoS CoC Veteran Subcommittee.