North Carolina
Balance of State Continuum of Care

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North Carolina Balance of State Continuum of Care Coordinated Entry Written Standards

Overview

The North Carolina Balance of State Continuum of Care (NC BoS CoC) has developed these written standards to give specific guidelines for how best to operate regional coordinated entry systems to achieve the goal of making homelessness rare, brief, and non-recurring. These guidelines create consistency across the CoC's regions, protect our mutual clients by putting their needs first, and provide a baseline for holding all CoC coordinated entry systems to a specific standard of care.

The Department of Housing and Urban Development (HUD) requires every CoC to evaluate outcomes of projects funded under the Emergency Solutions Grants (ESG) Program and the CoC Program and report to HUD (24 CFR 578.7(a)7). In consultation with recipients of ESG Program funds within the geographic area, CoCs must establish and operate either a centralized or coordinated entry system that provides an standardized, comprehensive assessment of the needs of individual and families for housing and services.

- In consultation with recipients of ESG and CoC Program funds within the geographic area, CoCs must establish and consistently follow written standards for providing CoC assistance. At a minimum, these standards must include policies and procedures for evaluating individuals' and families' eligibility and determining the process for prioritizing eligible households for rapid rehousing and permanent supportive housing programs.
- Policies and procedures for coordination among emergency shelters, transitional housing programs, essential service providers, homelessness prevention programs, rapid rehousing programs, and permanent supportive housing programs.
- Definitions for participation in the CoC's Homelessness Management Information System (HMIS)or comparable database for victim service providers.

The NC BoS CoC has developed coordinated entry written standards to ensure:

- System accountability to individuals and families experiencing homelessness, specifically populations at greater risk or with the longest histories of homelessness
- System compliance with HUD regulations and priorities
- Consistency across regional coordinated entry systems
- Adequate staff competence and training, specific to the target population served

COORDINATED ENTRY

Coordinated entry systems allow CoCs to coordinate program participant intake, assessment, and provision of referrals. The system covers a set geographic area, can be easily accessed by individuals and families experiencing homelessness or at-risk of homelessness seeking housing and services, is well advertised, and includes a comprehensive and standardized assessment tool.[1]

Any community can implement a coordinated entry system regardless of geography, housing resources, service availability, or unique community makeup. Communities can successfully create and operate coordinated entry with patience, persistence, testing, and revisions.

Whether a CoC, community or region uses the terms "coordinated entry," "coordinated access," "centralized intake," or "coordinated intake," the substance behind the name remains the same: transitioning from a "first come, first served" mentality to one that prioritizes the most vulnerable individuals and families in a community for the available housing interventions and sets a course for housing and services that meets the needs of all individuals and families experiencing homelessness or at-risk of homelessness.

Coordinated entry, when implemented correctly, prioritizes individuals and families who need housing the most across communities. This type of system moves beyond programs to create a collaborative environment across all services and program types in the community that can provide an informed way to target housing and supportive services to:

- Divert people away from the system who have other safe options for housing
- Quickly move people from homelessness to permanent housing by connecting them to the most appropriate housing program available
- Create a more effective and defined role for emergency shelters and transitional housing
- Save time, effort, and frustration on the part of service providers through targeting and engagement efforts
- Focus on efforts to end homelessness as a community
- Reduce the length of time homeless by moving people quickly into the appropriate housing
- Increase the likelihood of housing stability by targeting the appropriate housing intervention to corresponding needs
- Provide a picture of current system gaps in the community that need to be filled in order to end homelessness for all households
- Be good stewards of limited resources

Traditionally, communities did not have an organized, transparent system for entry and referral to housing and supportive services. Individual programs served only people presenting themselves at their front doors, taking clients on a "first come, first served" basis. While many

[1] https://www.gpo.gov/fdsys/granule/CFR-2013-title24-vol3/CFR-2013-title24-vol3-part578/content-detail.html

communities still operate in this manner, years of research, re-thinking, and commitment to moving away from this linear approach, has shifted communities towards a collaborative systematic approach.[2] These changes include:

Historic Practice is Program-Centric	Coordinated entry is Client-Centric
Should we accept this person into our program?	What housing and service intervention is the best fit for each individual or family?
Clients must tell their information to every program that they enter for services	Standard forms, assessment, and intake processes across all programs in the community
Uneven knowledge about existing programs, eligibility, and purpose in communities	Accessible information about housing and service options in the CoC, community or region

Building a strong coordinated entry system builds on and enhances the strengths of the community's programs. When communities come together to implement coordinated entry, each program realizes success in multiple ways:

- *Programs receive eligible clients:* Programs receive appropriate referrals for participants whose needs and eligibility have already been determined.
- *Case managers can do case management:* When every program does their own intake, case managers often share most of this burden. When communities use a common assessment to share this workload, staff can realize real efficiencies in housing placement and case management.
- *Communities understand the resources they need most:* When communities coordinate the front door of their system, they begin to see who is accessing homeless and housing services and what their needs are. With this understanding, communities can begin to right-size their system to ensure that programs are there to meet the needs of households accessing the system.
- *Time, red-tape, and barriers are significantly reduced:* When community programs follow the same process and understand one another's roles, workload is reduced for everyone.

NC BALANCE OF STATE COC COORDINATED ENTRY GUIDING PRINCIPLES

Across the NC BoS CoC, all regionally designed and operated coordinated entry systems will be:

- *Sustainable:* Regional Committees identify the resources required to operate a coordinated entry system now and for the foreseeable future.
- *Flexible:* Communities customize their coordinated entry system based on community needs, resources, and services available.

[2] http://www.endhomelessness.org/library/entry/one-way-in-the-advantages-of-introducing-system-wide-coordinated-entry-for-

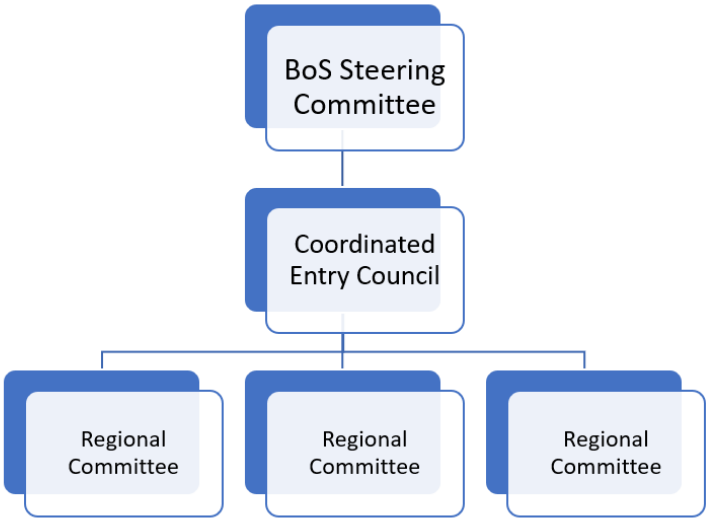
- *Transparent and accountable:* Participants understand what coordinated entry is doing and why. Agencies publish and make available their program rules and have a clear, fair grievance and appeals process for both participants and services agencies.
- *Housing-focused:* Individuals and families experiencing homelessness return to permanent housing within an average of 30 days, in compliance with HEARTH.
- *Client-focused:* The coordinated entry system is easily accessible, leaves no one behind, and accommodates participant choice and needs.
- *Collaboration-focused:* Regional Committees operate their systems with broad-based consensus and manage system responsibilities through strong partnerships where integrity is key and service providers hold one another accountable and exhibit a willingness to cooperate.
- *Easy-to-use:* System is well-advertised and known throughout the community. It does not inhibit providers from doing their job of ending homelessness.
- *Accessible:* The coordinated entry system is accessible to every individual and family experiencing homelessness or at-risk of homelessness, regardless of race, color, national origin, religion, sex, age, familial status, disability, or sexual orientation, gender identity or marital status.

GOVERNANCE

Commented [a1]: Governance: Updated the diagram from Coordinated Assessment Council to Coordinated Entry Council.

General Structure

Local Regional Committees will design and administer coordinated entry in their communities with standards and governance provided by the NC BoS CoC Steering Committee. The Steering Committee will appoint a standing Coordinated Entry Council (CEC) to approve new Regional Committee coordinated entry plans and significant ongoing changes. The CEC will have representatives from each of the regional CE systems and other state-level experts.



Role of the Coordinated Entry Council (CEC)
The NC BoS CoC Steering Committee defines membership of the Coordinated Entry Council through the CoC Governance Charter. The CEC provides oversight of the full CoC's coordinated entry system to ensure regional coordinated entry plans meet the standards set forth in this document. The CEC approves significant plan changes and provides ongoing oversight of the full system to meet CoC and HUD priorities and mandates.

Role of Regional Committees
Each Regional Committee will design and implement a local coordinated entry system within the parameters of the system standards provided. The standards give Regional Committees a supportive framework to use when implementing local systems as well as standardized assessment tools that will be uniform across the NC BoS CoC. These tools include: the Prevention and Diversion Screening Tool, the Homeless Assessment and Referral Tool (HART) , and the Case Management Tool. This document describes these assessments in the definitions section and demonstrates their use throughout the document.

Commented [a2]: Starting in this section: Updated all references to VI-SPDAT to HART (Homeless Assessment and Referral Tool).

DEFINITIONS
Acuity: When using the HART, acuity means the presence of a presenting issue based on the assessment score. Acuity on the assessment tool is expressed as a number with the higher score representing more complex, co-occurring issues likely to impact overall stability in permanent housing. When using the Case Management Tool acuity refers to the severity of the presenting issue and the ongoing goals to addressing these issues.

Case Management Tool: A standardized tool for case management to track participant progress in programs in the coordinated entry process. Housing programs administer this tool at program entry, housing entry, and every six months thereafter until program discharge. Upon discharge from the program, housing case managers administer the tool one final time 12 months later, when possible, to ensure the household continues to make progress.

Chronically Homeless: (1) an individual with a disability as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)) who: (i) lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and (ii) had been homeless and living as described in (i) continuously for at least 12 months or on at least 4 occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating occasions included at least 7 consecutive nights of not living as described in (i). Stays in institutional care facilities for fewer than 90 days will not constitute a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the care facility; (2) an individual who has been residing in an institutional care facility, including jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or (3) a family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in (1) or (2) of this definition, including a family whose composition had fluctuated while the head of household has been homeless. (24 CFR 578.3)

Comparable Database: HUD-funded providers of housing and services (recipients of ESG and /or CoC Program funding) who cannot enter information by law into HMIS (victim service providers as defined under the Violence Against Women and Department of Justice Reauthorization Act of 2005) must operate a database comparable to HMIS. According to HUD, "a comparable database . . . collects client-level data over time and generates unduplicated aggregate reports based on the data." The recipient or subrecipient of CoC and ESG Program funds may use a portion of those funds to establish and operate a comparable database that complies with HUD's HMIS requirements. (24 CFR 578.57)

Coordinated entry: "A centralized or coordinated process designed to coordinate program participant intake, assessment, and provision of referrals across a geographic area. The . . . system covers the geographic area (designated by the CoC), is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool" (24 CFR 578.3). CoCs have ultimate responsibility to implement coordinated entry in their geographic area.

Developmental Disability: As defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002): (1) A severe, chronic disability of an individual that (i) is attributable to a mental or physical impairment or combination of mental and physical impairments; (ii) is manifested before the individual attains age 22; (iii) is likely to continue indefinitely; (iv) results in substantial functional limitations in three or more of the following major life activities: (a) self-care; (b) receptive and expressive language; (c) learning; (d) mobility; I self-direction; (f) capacity for independent living; (g) economic self-

sufficiency; (v) reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. (2) an individual from birth to age 9, inclusive, who has a substantial developmental disability or specific congenital or acquired condition, may be considered to have a developmental disability without meeting three or more of the criteria in (1)(i) through (v) of the definition of "developmental disability" in this definition if the individual, without services or supports, has a high probability of meeting these criteria later in life. (24 CFR 578.3)

Disabling Condition: According to HUD: (1) a condition that: (i) is expected to be of indefinite duration; (ii) substantially impedes the individual's ability to live independently; (iii) could be improved by providing more suitable housing conditions; and (iv) is a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury; or a developmental disability, as defined above; or the disease of Acquired Immunodeficiency Syndrome (AIDS) or any conditions arising from AIDS, including infection with the Human Immunodeficiency Virus (HIV). (24 CFR 583.5)

Diversion: Diversion is a strategy to prevent homelessness for individuals seeking shelter or other homeless assistance by helping them identify immediate safe, alternate housing arrangements, and if necessary, connecting them with services and financial assistance to help them return to permanent housing. Diversion practices and programs help reduce the number of people becoming homeless and the demand for shelter beds.

Family: A family includes, but is not limited to the following, regardless of actual or perceived sexual orientation, gender identity, or marital status: (1) a single person, who may be an elderly person, displaced person, disabled person, near-elderly person, or any other single person: or (2) a group of persons residing together, and such group includes, but is not limited to: (i) a family with or without children (a child who is temporarily away from the home because of placement in foster care is considered a member of the family); (ii) an elderly family; (iii) a near-elderly family; (iv) a disabled family; (v) a displaced family; and (vi) the remaining member of a tenant family. (24 CFR 5.403)

Homeless:

Commented [a3]: Homeless: Updated Category 4 to reflect new HUD definition.

Category 1: an individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) an individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; (ii) an individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by Federal, State, or local government programs for low-income individuals); or (iii) an individual who exits an institution where he/she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution;

Category 2: an individual or family who will immediately lose their primary nighttime residence, provided that: (i) the primary nighttime residence will be lost within 14

days of the date of application for homeless assistance; (ii) no subsequent residence has been identified; and (iii) the individual or family lacks the resources or support networks (e.g. family, friends, faith-based or other social networks) needed to obtain other permanent housing; or

Category 4: any individual or family who: (i) is experiencing trauma or a lack of safety related to, or fleeing or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous, traumatic, or life-threatening conditions related to the violence against the individual or a family member in the individual's or family's current housing situation, including where the health and safety of children are jeopardized; (ii) has no other safe residence; and (iii) lacks the resources to obtain other safe permanent housing. (24 CFR 578.3)

Housing First: A national best practice model that quickly and successfully connects individuals and families experiencing homelessness to permanent housing without preconditions such as sobriety, treatment compliance, and service and/or income requirements. Programs offer supportive services to maximize housing stability to prevent returns to homelessness rather than meeting arbitrary benchmarks prior to permanent housing entry.[3]

Prevention and Diversion Screening Tool (aka Emergency Response Screening): A tool used to reduce entries into the homeless service system by determining a household's needs upon initial presentation to shelter or other emergency response organization. This screening tool gives programs a chance to divert households by assisting them to identify other safe, permanent housing options and, if needed, providing access to mediation and financial assistance to remain in housing.

Rapid Rehousing: A national best practice model designed to help individuals and families exit homelessness as quickly as possible, return to permanent housing, and achieve long-term stability. Like Housing First, rapid rehousing assistance does not require adherence to preconditions such as employment, income, absence of criminal record, or sobriety. Financial assistance and housing stabilization services match the specific needs of the household. The core components of rapid rehousing are housing identification/relocation, short- and/or medium-term rental and other financial assistance, and case management and housing stabilization services. (24 CFR 576.2)

Transitional Housing: Temporary housing for participants who have signed a lease or occupancy agreement with the purpose of transitioning participants into permanent housing within 24 months.

HART (Homeless Assessment and Referral Tool) An equity-based tool used by all regions in the NC Balance of State CoC to determine initial acuity and set prioritization and intervention for permanent housing placement.

ORDER OF PRIORITY FOR ESG and/or CoC-Funded Permanent Housing

Commented [a4]: Order of Priority: Updated to reflect the new order of priority for ESG and/or CoC-funded permanent housing.

First priority: Most severe service needs, as determined through HART acuity score.

Second priority: Highest HART acuity score and experiencing unsheltered homelessness.

Third priority: Highest HART acuity score and longest length of time homeless.

Fourth priority: Highest HART acuity score and disabling condition.

Fifth priority: Family with highest HART acuity score.

[3] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448313/pdf/0940651.pdf

Benchmarks

- *First Priority:* Individual or family with the most severe service needs (as found through the acuity score on HART).
- *Second Priority*: Individual or family with the highest HART acuity score AND experiencing unsheltered homelessness.
- *Third Priority:* Individual or family with highest HART acuity score AND longest length of time homeless.
- *Fourth Priority*: Individual or family with highest HART acuity score AND a disabling condition.
- *Fifth Priority:* Family with highest HART acuity score.

CLIENT INTAKE PROCESS THROUGH COORDINATED ENTRY

PROCESS: Regional Committees determine whether their coordinated entry system will be *centralized* (designated agency or agencies within their community to handle intake and referrals) or *decentralized* (all agencies will employ the common assessment and referral system for intake). All programs will actively participate in their Regional Committee's coordinated entry system. Programs will minimize their entry requirements to ensure that the most vulnerable individuals and families experiencing homelessness are served. CoC and ESG Program housing programs will not accept referrals for housing outside of their community's coordinated entry system. Communities will use the Prevention and Diversion Screening Tool prior to entry into shelter and emergency housing programs. Once entered into shelter or emergency housing, programs will administer the HART to determine the most appropriate housing intervention based on the individual's or family's specific needs and acuity.

STEPS:

1. The only reasons programs may disqualify an eligible individual or family from program entry are:
    a. Ineligibility
    b. All programs' beds are full.
    c. If the housing has in residence at least one family member with a child under the age of 18, the program may exclude registered sex offenders and person with a criminal record that includes violent crime from the program so long as the child resides in the same housing facility (24 CFR 578.93).
2. Programs cannot disqualify an individual or family from program entry for lack of income or employment status.
3. Programs cannot disqualify an individual or family because of prior evictions, poor rental history, criminal history, or credit history.
4. Programs cannot disqualify an individual due to the type or extent of disability-related services or supports that are needed or due to active or a history of substance use.
5. Programs explain available services and encourage each adult household member to participate in program services, but do not make service usage a requirement or the denial of services a reason for disqualification or eviction.
6. All client information should be entered in HMIS@NCCEH in accordance with data quality, timeliness, and additional requirements found in the Agency and User Participation Agreements. At a minimum, programs must record the date the client enters

and exits the program, HUD required data elements, and an update of client's information as changes occur.

TOOLS

Having the standardized tools to operate a coordinated entry is necessary to successfully implement the system. The following list shows the necessary tools and the specific ones used by all Regional Committees in the NC Balance of State Continuum of Care.

Tool of Concept	Specific solution used by the NC BoS CoC
A common prevention tool at entry prior to entry in the homeless service system	Prevention and Diversion Screening Tool
An equity-based assessment tool at entry to determine the most appropriate housing intervention	HART
A common process for prioritization for housing	NC BoS CoC CE Written Standards approved prioritization
A common referral mechanism across programs	Regional Committees determine the common mechanism used within their communities; including but not limited to the HMIS CE Event Data Element.
A common community-level process for housing placement	Regional Committees determine the community-level process which may include local prioritization meetings and shared prioritization lists
A common tool for case management and housing stabilization	Case Management Tool
A monthly implementation call with NCCEH and regional CE staff	Monthly SSO-CE Check-in

ASSESSMENT

Commented [a5]: Updated language regarding timeframe for administering HART.

PROCESS: All programs will actively participate in their Regional Committee's coordinated entry system by sharing responsibilities for implementing the system and closing side doors that circumvent the coordinated entry process. All Regional Committees will use the Prevention and Diversion Screening Tool as the initial triage assessment for coordinated entry. Whenever possible, Regional Committees should divert any individual or family from the homeless service system by providing problem-solving, mediation, and diversion financial assistance to presenting households. When diversion is not possible, programs administering the Prevention and Diversion Screening Tool should refer clients to appropriate emergency services to meet their needs. Once in the shelter or emergency housing system (for 12 – 15 days), communities will administer the HART. Programs should administer the HART immediately for unsheltered households. Programs should submit their HART assessment through HMIS or the agreed upon regional method for non-HMIS and/or DV agencies to ensure

households are added to the by-name list,, prioritized, and slated for the appropriate housing intervention.

STEPS:

1. All staff and/or volunteers administering the Prevention and Diversion Screening Tool, the HART, and the Case Management Tool should participate in training prior to direct work with individuals and families presenting for services.
    a. The Prevention and Diversion Screening Tool can be found at: https://prezi.com/3swi9bhzxszd/prevention-and-diversion-screen-version-2/
    b. The HART can be found at:
2. The coordinated entry system must not screen out anyone due to perceived barriers related to housing or services, including, but not limited to, too little or no income, active or a history of substance use, domestic violence history, resistance to receiving services, the type or extent of disability-related services or supports that are needed, history of evictions or poor credit, lease violations or history of not being a leaseholder, or criminal record–with exceptions for state or local restrictions that prevent projects from serving people with certain convictions.
3. All Regional Committees will use the Prevention and Diversion Screening Tool as the initial triage assessment, diverting households as possible using problem-solving, mediation, and/or financial assistance. If a household cannot be assessed with the Prevention and Diversion Screening Tool immediately, they should not be prevented from entering shelter or receiving other emergency services.
4. Once individuals and families enter the homeless service system, programs should administer the HART to households in emergency shelter or emergency housing within 12 – 14 days and immediately for those living unsheltered. Once complete, the HART provides regions with the ability to determine, across dimensions, the acuity of an individual or family.
5. The HART expresses acuity of an individual or family through a numeric score, with a higher number representing more complex, co-occurring disorders likely to impact overall housing stability. In administering the HART, communities cannot require the disclosure of specific disabilities or diagnoses. The HART score shows the *presence* of these issues and indicates the potential best intervention for housing and services. The assessment tool bases the score on the following:
    a. Housing and Homeless History
    b. Risks
    c. Health and Wellness
    d. Family Unit
6. Regions will use the by-name list to prioritize households based on acuity (as determined through the HART). Within acuity, when participants have the same score, Regional Committees should follow the written prioritization schedule above: (a) residing in a place not meant for habitation, (b) length of time homeless, (c) disability, and (d) families. Prioritization lists may not prioritize households based on a diagnosis or particular disability or another other protected status.
7. Scores on the HART populate the by-name list, allowing Regional Committee to determine who is referred to ESG and/or CoC-funded housing by acuity score.

Commented [a6]: Training links will be updated and added for HART.

Commented [a7]: Updated to reflect HART categories.

8. Regional Committees may not use other factors that would discriminate based on race, color, religion, national origin, sex, age, familial status, disability, type or amount of disability, disability-related services or supports required or actual or perceived sexual orientation, gender identity, or marital status.

ASSIGN WITH CLIENT CHOICE

PROCESS: Programs will provide safe, affordable housing meeting participants' needs in accordance with the coordinated entry process and prioritization schedule, based on acuity and eligibility. Programs will provide rapid and successful entry into permanent housing for each eligible household, by acuity, with as few barriers as possible. The coordinated entry system will focus its attention on the ability of all clients in the community to access the appropriate housing intervention.

STEPS:

1. In providing or arranging for housing, programs consider the specific household needs of the individual or family experiencing homelessness.
2. Programs assist households in finding suitable housing quickly and effectively and do so guided by client input and choice.
3. Programs agree to only accept referrals through the coordinated entry system, closing all side doors to permanent housing placement.

Client choice should remain at the center of any referral and placement, with the client being completely informed of the steps and processes necessary to move from homelessness to permanent housing. Regional Committees decide how the referral process will work in their communities. However, the process should include, whenever possible, a warm hand-off of the client to the referred agency, which could include either a phone call or email with a method for transmitting intake materials including the completed Prevention and Diversion Screening Tool and/or the HART. If a client rejects the program to which they are referred, they should maintain their place on the regional by-name list. Communities should take into consideration resources for transportation to get clients from screening site to referred agency.

FOLLOW-UP AND HOUSING STABILIZATION

PROCESS: To reduce returns to homelessness, programs should provide a continuity of services to all participants following their exit from a program. These services may be provided directly by the program or through referrals to other service providers.

STEPS:

1. Programs prioritize the development of exit plans for each participant to ensure continued permanent housing stability and connection to community resources, as desired.
2. Programs routinely check in with PSH participants to identify those households whose acuity scores are low enough to maintain permanent housing stability in market rate or subsidized housing outside the permanent supportive housing program.
3. Programs develop a plan, in conjunction with the participating household, for effective, timely exit of individuals and families whose acuity scores are low enough to maintain

permanent housing stability in market rate or subsidized housing outside the permanent supportive housing program.

4. Programs should attempt to follow up with participants through verbal or written contact at least once every 6 months after the client exits the program. A program may provide follow-up services to include identification of additional needs and referral to other agency and community services in order to prevent future episodes of homelessness.
5. For HUD CoC RRH and PSH grants, programs may provide services to formerly homeless individuals and families for up to six months after their exit from the program.

Housing programs will use the Case Management Tool, a standardized tool for case management, to track household progress in meeting key needs and determine ongoing acuity of the participant household. Programs begin administering the Case Management Tool at program entry, at housing entry, and every 6 months thereafter until program discharge. Programs should use this tool during the follow-up with participants 6 months after program exit to ensure that the household continues to thrive in permanent housing and can assist with service referral if the acuity score indicates ongoing needs.

Programs should train all staff members who will administer the Case Management Tool or who will supervise case management staff who administer the tool. An online video training can be found at: https://prezi.com/adwfkc2xzig_/case-management-tool-version-2/.

Regional Committees should use data from the Case Management Tool when considering an exit to another higher intensity permanent housing program or housing subsidy based on community resources, keeping in mind that some households may experience ongoing challenges at program exit.

ACCOUNTABILITY

PROCESS: Programs should actively contribute to their local coordinated entry system and prioritization process. Both HUD and VA programs must participate and only accept referrals from the local system. When potential participants contact programs, according to their system, they should assess the household at a point of entry into the system or refer the household to the designated coordinated entry agency in their community. All coordinated entry systems must have a grievance process for participants and agencies using the system to formally bring their concerns to the Regional Committee.

STEPS:

1. Regional Committees must ensure that all providers serving individuals and families experiencing homelessness or at-risk of homelessness have been invited to participate in the local coordinated entry system. For providers unwilling to play a role, Regional Committees must consistently outreach and engage these providers to reconsider their role with coordinated entry.
2. Regional Committees should ensure that all counties under their purview play a role in the coordinated entry system either through a central system for the entire area or individual county systems that coordinate with one another on participant referral and service/permanent housing access.

3. Programs should make every effort to take as many referrals from their local prioritization process as possible within federal and state eligibility criteria. If programs exhibit a consistent history of turning down referrals, the coordinated entry system should reach out to said programs to encourage them to lower barriers to entry. Communities are able to set a limit of the number of referrals that participating programs can deny.
4. Regional Committees must create a grievance process for participants and agencies using the system when they have a concern with decisions made by the coordinated entry system or agencies operating under said system. Local grievance procedures will handle the majority of issues. For issues that the local system cannot resolve, participants and/or agencies can appeal their concern to the NC BoS CoC Coordinated Entry Council for resolution. Documentation about the grievances filed and resolved should be kept by the community.
5. Regional Committees should evaluate the effectiveness of their coordinated entry systems on a regular basis, using their own data. Regional Committees should make changes to their system that can make them more effective. Some changes require CEC approval, which include:
    a. Referral mechanism/process
    b. By-name list mechanism/process
    c. Stop/start using HMIS for coordinated entry
    d. Changes to assessment tools

Regional Committees should request to make these changes through the following form: http://bit.ly/29Ym8ID

Privacy Protections

All participants in coordinated entry must be informed of how information collected during the coordinated entry process would be shared and used and must provide consent before that information is shared.

Participants in coordinated entry must be allowed to refuse to have their information shared or refuse to disclose certain information. Regional Committees cannot deny services to participants if participants refuse to share or disclose information, unless federal statute requires collection, use, storage, and reporting of a participant's personally identifiable information (PII) as a condition of program participation.

The assessment and prioritization process cannot require disclosure of specific disabilities or diagnoses. Specific diagnosis or disability information may only be obtained for purposes of determining program eligibility to make appropriate referrals.

Safety Planning

The coordinated entry system must ensure the safety of people fleeing or attempting to flee domestic violence, dating violence, stalking, sexual assault, and human trafficking.

People administering the Prevention and Diversion Screening Tool must always follow the interpersonal violence protocol, which directs agencies to refer clients directly to victim service providers immediately if they indicate they may be fleeing or attempting to flee domestic violence, dating violence, stalking, sexual assault, or human trafficking.

If victim service providers are participating in the Regional Committee's coordinated entry process, their clients must be tracked confidentially, without divulging any information that could put their safety at risk, including, but not limited to, personally identifying information.

Victim service providers may instead use an alternative coordinated entry system, as long as it meets all of HUD's minimum requirements. If victim service providers would like to use an alternative system, they should contact their regional coordinated entry lead as well as NCCEH staff to help design that system.

Non-Discrimination and Equal Access

Participants may not be denied access to the coordinated entry process on the basis that the participant is or has been a victim of domestic violence, dating violence, sexual assault, stalking, or human trafficking.

The coordinated entry process must be available to all eligible persons regardless of race, color, national origin, religion, sex, age, familial status, disability, actual or perceived sexual orientation, gender identity, or marital status.

All populations and subpopulations in the CoC's geographic area, including people experiencing chronic homelessness, Veterans, families with children, youth, and survivors of interpersonal violence, must have fair and equal access to the coordinated entry process, regardless of the location or method by which they access the system.

Regional Committees should take reasonable steps to ensure effective communication with individuals with disabilities, including providing information in appropriate accessible formats as needed (e.g., Braille, audio, large type, assistive listening devices, and sign language interpreters).

Regional Committees should take reasonable steps to ensure the coordinated entry process can be accessed by persons with Limited English Proficiency (LEP).

Participants must be informed of the ability to file a nondiscrimination complaint. Participants may file a fair housing complaint:

- With HUD by calling 1-800-669-9777 or online using this link https://portal.hud.gov/hudportal/HUD?src=/program_offices/fair_housing_equal_opp/online-complaint.
- With the North Carolina Department of Administration using this link https://files.nc.gov/ncdoa/documents/files/HousingDiscriminationComplaint.pdf

Annual Evaluation

Policy

The NC BoS CoC conducts an annual evaluation of its coordinated entry system. The CoC evaluates the performance of the coordinated entry system, and the experience of clients and providers that participate in the system.

The annual evaluation will be conducted on a timeline determined by the NC BoS CoC Coordinated Entry Council.

The CoC uses a combination of surveys and data to conduct its evaluation. Data from the HMIS and from regional by-name lists are used to evaluate the performance of the system in placing people quickly into housing.

All programs funded through the CoC must actively participate in the annual CE evaluation process including providing evaluation materials to program participants and filling out required agency surveys. All other participating programs not funded through the CoC are encouraged to actively participate in the annual CE evaluation to ensure the evaluation captures the true scope and effectiveness of the CE system and comprehensive data is collected to guide & improve the system.

Procedure

Commented [a8]: Procedure: Updated to state the CEC determines the procedure for the evaluation (removed specific steps for procedure as this process will be updated in 2024).

The Coordinated Entry Council determines the process for the CoC's annual coordinated entry evaluation. At a minimum, the process will include feedback from (a) participating providers to understand their experience with the system, understanding of coordinated entry, and current participation in coordinated entry and (b) participants who have experienced the coordinated entry system through currently experiencing homelessness and/or who have been recently housed.

State of Emergency

During a state of emergency, the North Carolina Balance of State Continuum of Care (NC BoS CoC) will be permitted to quickly change Coordinated Entry (CE) access, prioritization, and referral policies and procedures to respond to emerging needs and funding. Local CE leads may make changes to their regional systems without approval from the Coordinated Entry Council (CEC) but will be required to report changes to the CEC at the next scheduled meeting. The Coordinated Entry Council will approve changes without needing the Steering Committee approval and will be required to publicly post any approved changes. Any changes to CE policies and procedures made during a state of emergency will only be effective until the state of emergency is rescinded unless the CEC proposes permanent changes to the Steering Committee and the Steering Committee approves said changes.