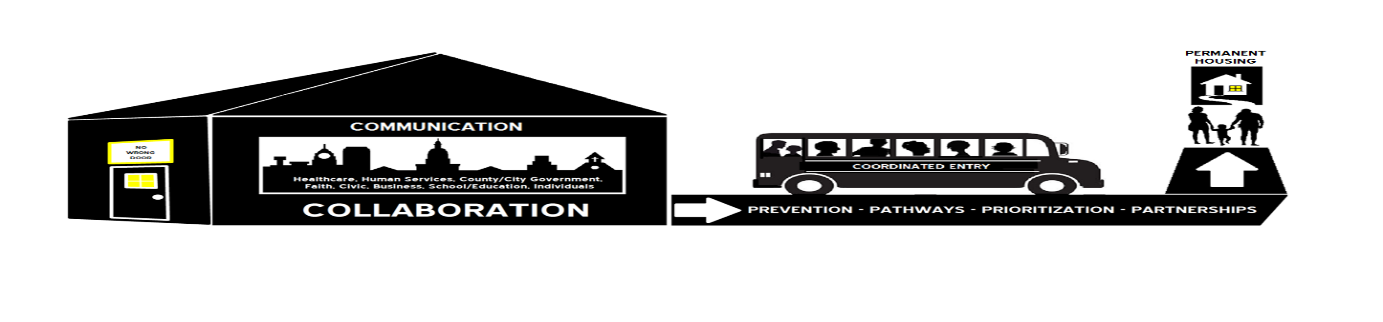
**CAPITAL REGION HOUSING COLLABORATIVE**

**W*e partner to prevent and end homelessness.***

Capital Region Housing Collaborative

Policies and Procedures Manual

Capital Region Housing Collaborative

Policies and Procedures Manual

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**Capital Region Housing Collaborative**

**BYLAWS**

**ARTICLE 1 - NAME OF ORGANIZATION**

# Article 1, Section 1. Name

The name of this organization shall be Capital Region Housing Collaborative (CRHC), hereinafter referred to as the Collaborative.

**ARTICLE 2 - PURPOSE AND RESPONSIBILITY**

# Article 2, Section 1. Mission

We partner to prevent and end homelessness.

To serve as the continuum of care for Ingham County, leading a collaborative, community approach to addressing and ending homelessness.

The corporation is organized exclusively for the purpose of receiving and administering funds for charitable, religious, educational, or scientific purposes as described in Section 501(c)(3) of the Internal Revenue Code of 1986 (or any corresponding provision of the Internal Revenue Code).

**ARTICLE 3 - MEMBERSHIP**

# Article 3, Section 1. General Membership

Members of the Collaborative shall be organizations, agencies, and individuals concerned with housing, shelter, health care, mental health, substance abuse, education, employment, and other services that address the needs of the homeless and those at risk of homelessness. The business of the Collaborative shall be managed by the Board of Directors.

**Article 3, Section 2. Membership Categories**

There shall be two categories of membership: Partner members and Collaborative members. The Collaborative Secretary shall maintain a list of the names, addresses, and status of all members.

**Article 3, Section 3. Collaborative Members**

1. An individual or representative of an organization or agency completing the annual membership application and paying the annual membership dues shall hereafter be known as a collaborative member.
2. Annual dues shall be billed at such time as the Board of Directors determine is reasonable of each year and shall be paid by the end of August of that year to determine and secure voting membership for the following fiscal year, October 1-September 30.
3. If an organization or individual cannot pay the annual membership, that entity can submit a written request for a waiver in writing to the Chair or Chief Executive Officer (CEO) for approval by the Board of Directors.
4. Each individual or agency/organization representative shall have one vote.
5. An agency/organization may have additional representatives participate in committees.
6. Each voting member shall serve on at least one standing committee.
7. Voting members are eligible to serve on the Board of Directors.
8. Collaborative members shall recuse themselves from any vote that considers a project in which they or the organization they represent have a financial or other interest. Collaborative members shall also recuse themselves when a majority vote of the Board of Directors determines a failure to recuse would result in a possible appearance of impropriety.

**ARTICLE 4 - GENERAL NETWORK MEETINGS**

Except as otherwise provided for in these Bylaws, General Network meetings shall be held at a frequency determined by the Board of Directors, at least quarterly, for the purpose of receiving input from the community, providing interagency education and collaboration, and supporting the mission of the Collaborative.

**ARTICLE 5 - ANNUAL MEETING**

**Article 5, Section 1. Purpose**

An Annual meeting of all eligible voting members shall be held to elect members to the Board of Directors and consider proposed revisions to the bylaws.

**Article 5, Section 2. Annual Meetings**

The Annual Meeting shall be held the third Thursday of October, or at such time and place as the Board determines is reasonable and that notice gives members a reasonable time to attend, in accordance with MCL 450.2404.

# Article 5, Section 3. Voting at Annual Meetings

1. Each collaborative member or his/her alternate shall have one vote.
2. Proxy voting is allowed by written notification to the Network Secretary at least 24 hours in advance of the Annual Meeting.
3. For the purposes of the Annual Meeting, a two-thirds majority of eligible members is required, either in person, through electronic media attendance, or by approved proxy.
4. Items requiring Collaborative action shall be determined by a majority vote of the established quorum.

**ARTICLE 6 – BOARD OF DIRECTORS**

**Article 6, Section 1. Authority of Board of Directors**

1. Each member of the Board of Directors shall abide by the position description established in the Board Governance Policies
2. The Board of Directors shall have the authority to establish the long term goals of the Collaborative and to establish the policies for the administration of all programs, business, and property of the Collaborative.
3. No individual Director of the Collaborative may commit the Collaborative to a policy or expenditure without the express authority of a majority of the Board of Directors.
4. The Board of Directors shall be authorized to employ and discharge a chief executive officer and resident agent to implement the Collaborative’s mission, goals, policies, and strategic plans. The Chief Executive Officer is responsible for personnel management including the hiring and discharge of Collaborative staff. In the absence of a Chief Executive Officer, the duties described in this subsection shall be discharged by the Board Chair.

**Article 6, Section 2. Composition of Board of Directors**

The Board of Directors is composed of fifteen members, eleven of whom shall be elected by the general membership. Three seats shall be reserved for one representative each from the Ingham County Commissioners, the field of education, and one consumer representative, who shall be appointed by the Board of Directors. Another seat shall be reserved for the fiduciary with the majority of CRHC funding, as determined by the Board.

**Article 6, Section 3. Board Terms of Office**

The eleven elected members shall serve two-year terms, six elected on even years and five elected on odd years. All elected directors shall serve beginning on the date of the annual meeting of their election and ending on the date of the annual meeting at the end of their term. Board officers shall serve until their replacement is elected at the first board meeting of the new fiscal year. Board-appointed members shall serve a one-year term, which shall be from October 1 through September 30th.

**Article 6, Section 4. Board Nominations**

Nominations for directors shall be received by the Membership Committeeand voted on at the Annual Network meeting in October. Any Collaborative member may submit the name of any voting Collaborative member as a nominee for the Board of Directors to the Membership Committee. The Membership Committee shall present all eligible candidates to the voting members. Candidates for appointed positions shall be identified by the Membership Committee and presented at the November meeting of Board of Directors each year.

# Article 6, Section 5. Board Elections

Each Director shall be chosen by majority vote. If no majority is obtained for an office, a run-off election shall commence immediately between the two persons receiving the largest number of votes.

# Article 6, Section 6. Non-Officer Board Vacancies

1. The resignation of any board member shall be in writing and addressed to the Executive Committee.
2. Any Director may be removed by a majority of directors at a special board meeting called for that purpose. Removal may be with or without cause.
3. The Board of Directors shall determine whether it is necessary to hold an election to fill mid-term vacancies on the Board of Directors.

**Article 6, Section 7. Frequency of Meetings**

The Board of Directors shall meet monthly.

**Article 6, Section 8. Board of Directors, Quorum**

One half of the elected board members must be present at the meeting to constitute a quorum. If less than a quorum is present, a meeting may be conducted, but no action can be taken.

**ARTICLE 7 - OFFICERS**

**Article 7, Section 1. Collaborative Officers**

The minimum officers of the Collaborative shall be the Chair, Vice-Chair, Secretary, and Treasurer.

**Article 7, Section 2. Election of Officers**

1. Officers shall be elected at the first meeting of the Board of Directors. Officers shall be selected from the Board of Directors following the annual meeting by a majority vote of the Board of Directors.
2. Officers shall serve one year terms.

# Article 7, Section 3. Duties and Responsibilities of Chair

The Chair shall fulfill all responsibilities listed in the Board-approved Collaborative Chair position description. The Chair shall chair the Network meeting and Executive Committee. The Chair shall provide supervision of the CEO. The Chair shall act as an authorized signatory on Collaborative contracts.

# Article 7, Section 4. Duties and Responsibilities of Vice-Chair

The Vice-Chair shall fulfill all responsibilities listed in the Board-approved Collaborative Vice-Chair position description. The Vice-Chair shall act as Chair in the temporary absence of the Chair. The Vice Chair shall oversee the annual review of the CEO, or other applicable staff member.

# Article 7, Section 5. Duties and Responsibilities of Secretary

The Secretary shall fulfill all responsibilities listed in the Board-approved Collaboraive Secretary position description. The Secretary shall ensure that a written accurate record of the minutes of all official meetings is maintained. The Secretary shall also ensure that the following records are properly recorded and maintained:

1. Meeting Attendance
2. Membership lists containing names, addresses, and voting status
3. Membership Forms and Documentation

# Agency governing documents, contracts, and other legal documents

# Article 7, Section 6. Duties and Responsibilities of Treasurer

# The Treasurer shall fulfill all responsibilities listed in the Board-approved Collaborative Treasurer position description. The Treasurer shall ensure collaborative dues are paid and deposited, and that an accurate record of any Collaborative finances is maintained. The Treasurer shall also ensure the following:

1. All Collaborative financial accounts are current
2. All financial records of the Collaborative are accurate and up to date
3. The status of Collaborative finances and membership is reported to Collaborative membership

**Article 7, Section 7. Officer Vacancies**

Should the Chair be unable to complete a term, the Vice-Chair shall assume the Chair responsibilities for the remaining term of the Chair. The Board of Directors shall determine whether it is necessary to hold an election to fill mid-term vacancies for other positions on the Executive Committee.

**Article 8 - STANDING AND AD HOC COMMITTEES**

**Article 8, Section 1. Establishment of Committees**

The Board of Directors of the Collaborative may designate ad hoc committees to complete temporary or limited assigned tasks. In addition, the Collaborative shall maintain the following standing committees:

1. **Membership Committee responsibilities:**

* Recruit new members for the collaborative, perform orientation of new members, and review applications for membership.
* Ensure that activities and issues important to those served by the CRHC are presented to and promoted within the community at large in a timely and effective manner.
* Accept nominations in accordance with Article 6, Section 4, and present a slate of eligible candidates.
* Identify candidates for appointed positions in accordance with Article 6, Section 4.

1. **Continuous Quality Improvement Committee responsibilities:**

* Oversee data management.
* Monitor agency reporting and performance.
* Perform grievance management within the Collaborative.
* Manage all other quality improvement activities

3. **Collaborative (Network) Committee responsibilities:**

* Identify gaps in services.
* Identify opportunities and challenges.
* Coordinate discharge planning.
* Provide training and information for Interagency Service Teams.

4. **Finance Committee responsibilities:**

* Oversee of all finances administered by the Collaborative.
* Serve as the Audit Committee for the Collaborative.

The committee shall be chaired by the Collaborative Treasurer. Funding recommendations shall be made by the Finance Committee and reported to the Board of Directors for a vote.

# Article 8, Section 2. Frequency

Except as otherwise provided for in these Bylaws, standing committees shall meet monthly. Ad hoc committees shall meet at the frequency determined by their Chair.

# Article 8, Section 3. Committee Chairs

The Collaborative Chair shall appoint all committee chairs, except for the Chair of the Finance Committee. All committee chairs shall serve one-year terms. The committee chairs’ responsibilities include but are not limited to the following:

* + - 1. Setting the Agenda for the committee meeting

2. Conducting the committee meeting

1. Recruiting committee members as needed from the membership
2. Ensure the compiling and mailing of meeting notices
3. Accurate documentation of meeting minutes and attendance
4. Communicating with the Board of Directors

**ARTICLE 9 – GRIEVANCE REVIEW BOARD**

The Grievance Review Board shall be appointed by the Board of Directors to address grievances and establish a process for concerns to be addressed that involve and impact the Collaborative, clients, and agencies.

**ARTICLE 10 – BYLAWS**

# Article 10, Section 1. Adoption

Adoption of these Bylaws shall require a two-thirds majority vote of eligible voting members.

# Article 10, Section 2. Amendments

Proposed amendments to these Bylaws may be initiated by any member and presented to the Executive Committee for their approval at least 60 days in advance of the annual meeting or of the April Network meeting. Upon approval, the Executive Committee shall present proposed amendments to be voted upon at the annual meeting or the April Network meeting. If bylaw amendments would be voted at the April Network meeting, it is subject to the same meeting requirements of the Annual Meeting, as described in Article 5.

# ARTICLE 11 – OPEN MEETINGS

**Article 11, Section 1. Compliance with Open Meetings Act**

Except as otherwise provided for in these Bylaws, the Collaborative shall abide by the provisions of the State of Michigan’s “Open Meetings Act”.

**Article 11, Section 2. Parliamentary Authority**

All meetings shall be ordinarily conducted in an informal manner, but may be conducted by Robert’s Rules of Order (revised edition) as deemed appropriate by the Chair.

**Article 11, Section 3. Non-discrimination**

The Capital Region Housing Collaborative is committed to equal opportunity for all persons without regard to sex, age, race, color, religion, creed, national origin, marital status, disability or sexual orientation. It is the policy of Collaborative Region Housing Collaborative to comply with all federal, state and local laws and regulations regarding equal opportunity. In keeping with that policy, Capital Region Housing Collaborative

is committed to maintaining an environment that is free of unlawful discrimination and harassment.

Revision History

Revised in July 2019

Revised on 12/1/18

Revised on 4/40/17

Revised on 10/15/15

Revised on 12/31/10

**CRHC**

**Board Governance Manual**

Congratulations!

Welcome to the Board of Directors for Capital Region Housing Collaborative. I am glad you have chosen to serve with us as we guide the direction of CRHC. With this position comes responsibilities and decision-making powers that will shape the operations and future of CRHC and its ability to serve the homeless community in significant ways. Your role on this board will include not only participation as a voting member, but also duties as a committee member. I will talk to you when we meet about the unique talents that you offer to our board and which committees could make the best use of these skills. In addition, every member of the board is expected to contribute to the fiscal responsibilities needed to keep CRHC functioning.

The Board currently meets on the 4th Tuesday of each month at 9:00 am in the Lansing City Rescue Mission conference room. The meetings generally last about two hours. Please make sure the Coordinator has all of your information as all reminders and agendas are sent out electronically prior to each meeting. It is an honor to have you agree to serve on our board and I hope that this will be the beginning of a rewarding experience for you. If you should have any questions, please do not hesitate to contact me.

Sincerely,

Chairperson of the Board

**1. CRHC OVERVIEW**

# 1.1 Mission Statement

We partner to prevent and end homelessness.

To serve as the continuum of care for Ingham County, leading a collaborative, community approach to addressing and ending homelessness.

The corporation is organized exclusively for the purpose of receiving and administering funds for charitable, religious, educational, or scientific purposes as described in Section 501(c)(3) of the Internal Revenue Code of 1986 (or any corresponding provision of the Internal Revenue Code).

# 1.2 Statement of Purpose and Organizational Philosophy

1. The Collaborative integrates and evaluates the delivery of services and prevention activities for the homeless and facilitates efforts to address shelter and housing needs for households with limited resources in Ingham County.

2. The Collaborative planning activities comprehensively address all elements of a strategic approach to outreach, homelessness prevention, emergency shelter/transitional housing, supportive services and permanent supportive housing for the homeless and households with limited resources.

3. Where unmet needs are identified, the Collaborative is responsible for developing new services and promoting collaboration between existing service providers.

4. The Collaborative reviews, evaluates and approves funding proposals for the delivery of services to the homeless and at risk households when funding is available from federal, state or local agencies.

5. The Collaborative is committed to maintaining its own credibility as a collaborative organization and to establishing trust among its members. The Collaborative may offer recommendations regarding funding applications and letters of support to its members who are applying for funding.

**2. BOARD MEMBERS**

**2.1 Board Role in Supporting the CRHC Mission Goals and Philosophy**

The Board of Directors, as the governing body of the Capital Region Housing Collaborative shall develop and monitor policies of the organization that are consistent with its stated philosophy.

**2.2 Board Meetings**

Board meetings are convened once a month. Written agendas must be distributed to the board members prior to each meeting. One half of the elected board members must be present at the meeting to constitute a quorum. If less than a quorum is present, a meeting may be conducted, but no action can be taken. In matters of a time sensitive nature, as determined by the Chair, an emergency meeting may be called.

**2.3 Board Member List**

A list of all the current board members, including their names, addresses, phone numbers, fax numbers, and e-mail addresses is available from the Coordinator.

**2.4 Board Member Description**

**Title**: Member, CRHC Board of Directors

**Reports to**: Chairperson of the Board

**Purpose**: To serve the board as a voting member; to develop policies, procedures, and regulations for the operation of CRHC; to monitor finances of the organization, its programs, and performance.

**Term**: Staggered 2 & 3 year terms

**2.5 Board Member Responsibilities**

The Board of Directors governs the agency according to the specifications detailed in the Board Governance Policies. The Board is interested in the overall direction of the organization, focused on results, not in details of operation. The Board’s involvement in programs and operations should be limited to setting overall policy, assisting in oversight and monitoring results, unless there are extenuating circumstances. The Board establishes a long-range plan for the organization and monitors its implementation.

**1. Setting policy:**

Your primary board function is to fashion policies that ensure CRHC is run effectively, legally, and ethically.

**2. Supporting the Executive Director:**

Without your director’s day-to-day management skills, the policies and plans adopted by the board would be of little impact. He or she truly is the person who makes your ideas and visions real. As you work together to achieve CRHC’s goals, however, you must also remember that your job and the director’s job are quite different. You make the plan, but the director decides how the plan is implemented and the goals accomplished.

**3. Managing committees and implementing policies:**

The board, in its initial stage, will operate without a Director to implement the policies set by the board. Therefore, while in transition, the board directly manages committee work and implements the policies it sets to further the mission and goals of CRHC.

**4. Guiding long-range planning and development:**

The board gives direction to CRHC through long-range goals ranging at least three to five years into the future. During the course of your service, you will be asked to assess the present and future needs of the community and to determine how CRHC fits into that picture.

**5. Hiring an Executive Director:**

When the transition to a 501(c3) is complete and CRHC becomes financially able, the board is responsible for hiring an Executive Director. The board will then be responsible for reviewing the work product and salary of the Executive Director on an annual basis.

**6. Raising money and monitoring finances:**

As a “trustee” for this organization’s money, you are responsible for seeing that it is spent effectively in delivering programs and services. You’re also responsible for looking into the financial future. When you plot CRHC’s goals, you must review your ability to pay for your plans. That means fundraising when appropriate.

**7. Working cooperatively with other board members:**

If you cannot work with your peers, the board will accomplish nothing. This is true in every aspect of board service -- meeting efficiency, conflict management, recruitment, training, and evaluation.

**2.6 Guidelines for Minimizing Risk of Liability**

1. Attend board and committee meetings in accordance with the attendance policy.

2. Be familiar with the minutes of board meetings and the minutes of your committee assignments.

3. Make sure a written permanent record is maintained of all board minutes and official actions.

4. Exercise general supervision over CRHC’s affairs.

5. Be certain your organization’s records are audited in compliance with Federal guidelines.

6. Be familiar with CRHC’s goals, objectives, and operations.

7. Insists that all committee meetings are reported at board meetings either in oral or written form.

8. Know CRHC’s budget, budget process and financial situation.

9. Know who is authorized to sign checks and in what amount.

10. Avoid self-serving or self-enriching policies.

11. Inquire if there is something you do not understand or if something comes to your attention which causes you to question a policy or practice.

12. Ensure CRHC is fulfilling all 990 IRS requirements.

13. Avoid the substance or appearance of conflicts of interest.

14. Be certain CRHC is fulfilling all aspects of its non-for-profit and tax exempt status.

15. Insist on a written and followed board membership and nominating committee procedure.

16. Monitor the community and professional image of CRHC.

17. Be certain that policies are clearly identified and the Board acts on them as a whole rather than action by a small group of individuals.

18. Know CRHC’s organization & structure.

19. Require that CRHC has proper legal counsel when necessary.

20. Monitor the activity of your executive committee to ensure that it does not overstep its authority.

21. Insist on meaningful board meetings with full disclosure of operating results.

**2.7 Policies and Procedures**

**1. Ethics Policy:**

As a member of this board, I will:

• Represent the interests of all people served by CRHC and not favor special interests inside or outside of this non-profit.

• Not use my services on this board for my own personal advantage or for the advantage of my friends or associates.

• Keep confidential information confidential.

• Respect and support the majority decisions of the board.

• Approach all board issues with an open mind, prepared to make the best decisions for everyone involved.

• Do nothing to violate the trust of those who elected or appointed me to the board, or of those I serve.

• Focus my efforts on the mission of CRHC and not on my personal goals.

• Never exercise authority as a board member except when acting in a meeting with the full board or as I am delegated by the board.

• Consider myself a “trustee” of CRHC and do my best to ensure that it is well maintained, financially secure, growing and always operating in the best interests of those we serve.

**2. Conflict of Interest and Voting:**

No member of this Board shall participate in the voting process regarding the provision of services by that member, or any organization which that member directly represents, or vote on any matter which would provide direct financial benefit to that member.

CRHC as a nonprofit, tax-exempt organization, depends on charitable contributions from the public. Maintenance of its tax-exempt status is important both for its continued financial stability and for the receipt of contributions and public support. Therefore, the IRS as well as state corporate and tax officials, view the operations of CRHC as a public trust which is subject to scrutiny by and accountability to such governmental authorities as well as to members of the public. Consequently, there exists between CRHC and its board, a fiduciary duty which carries with it a broad and unbending duty of loyalty and fidelity. The board has the responsibility of administering the affairs of CRHC honestly and prudently, and of exercising their best care, skill, and judgment for the sole benefit of CRHC. Board member shall exercise the utmost good faith in all transactions. The interests of CRHC must have the first priority in all decisions and actions. This statement is directed not only to directors and officers, but to all employees who can influence the actions of CRHC. The Board shall disclose their involvement with other organizations, with vendors, or any association which might produce a conflict as it occurs. A board member shall not use her/his board status to request special access or privilege as a consumer of the organization’s services. Disclosures of conflicts of any kind should be made to the board chair, who shall bring these matters, if material, to the board. The board shall determine whether a conflict exists and is material, and in the presence of an existing material conflict, whether the contemplated transaction may be authorized as just, fair, and reasonable to CRHC. The decision of the board on these matters will rest in their sole discretion, and their concern must be the welfare of CRHC and the advancement of its purpose.

**3. Proxy Representation and Voting:**

A member may designate a representative to attend in his/her absence. The representative may participate in discussions but may not make or second motions or vote. A member providing written voting instructions to the Chairman may have his/her representative cast a vote in accordance with the instructions on the specific item(s).

**4. Confidentiality:**

Board members and employees of CRHC may not disclose, divulge, or make accessible confidential information belonging to, or obtained through their affiliation with CRHC to any person, including relatives, friends, and business and professional associates, other than to persons who have a legitimate need for such information and to whom CRHC has authorized disclosure. Board members and employees shall use confidential information solely for the purpose of performing services as a board member or employee for CRHC. This policy is not intended to prevent disclosure where disclosure is required by law. Board members, employees, volunteers and contractors must exercise good judgment and care at all times to avoid unauthorized or improper disclosures of confidential information. Conversations in public places, such as restaurants, elevators, and public transportation, should be limited to matters that do not pertain to information of a sensitive or confidential nature. In addition, board members and employees should be sensitive to the risk of inadvertent disclosure and should for example, refrain from leaving confidential information on desks or otherwise in plain view and refrain from the use of speaker phones to discuss confidential information if the conversation could be heard by unauthorized persons. At the end of a board member's term in office or upon the termination of an employee's, volunteer's or contractor's relationship with GCRHC, employment, he or she shall return, at the request of CRHC, all documents, papers, and other materials, regardless of medium, which may contain or be derived from confidential information, in his or her possession.

**5. Non-Discrimination and Anti-Harassment Policy:**

CRHC is committed to equal opportunity for all persons without regard to sex, age, race, color, religion, creed, national origin, marital status, disability or sexual orientation. It is the policy of CRHC to comply with all federal, state and local laws and regulations regarding equal opportunity. In keeping with that policy, CRHC is committed to maintaining a work environment that is free of unlawful discrimination and harassment. Accordingly, CRHC will not tolerate unlawful discrimination against or harassment of any of our employees or others present at our facilities by anyone, including any supervisor, co-worker, vendor, client, or other associate of CRHC.

**6. Grievance Procedure:**

All complaints against the Board shall be directed to an independent corporate compliance firm, referred by the Board.

**7. Attendance Policy**

Board members shall attend all board meetings unless excused for reason. Each Board member shall be allowed 3 excused absences. Excused absences defined as prior written notice given to Chairperson of the Board.

**8. Communications:**

All media inquiries and press releases shall be approved by the Chairperson of the Board. The Board shall speak as one body. No member shall speak as a representative of the Board unless he or she has been designated by the Board to speak on its behalf.

**9. Letters of Support:**

Requests for Letters of Support shall be submitted to the Chairperson of the Board and approved by the Board. Any request for a letter that asks for an endorsement more specific than what is included in our template Letter of Good Standing, shall be submitted to the coordinator 14 days in advance of the next regularly scheduled board meeting to be voted on and approved by the Board.

**10. Goals & Objectives:**

The Board may set annual goals and objectives and may review all policies and procedures. All revisions shall be approved by the Board.

**11. Self-Assessment:**

The Board shall conduct an annual self-assessment with regard to goals and objectives set/achieved for the year prior, the 10 Year Plan, the Strategic Plan.

**12. Performance Review of Coordinator/Staff:**

The Board shall conduct an annual review, evaluating the performance of the coordinator and staff.

**13. Annual Financial Report:**

The Board shall produce an annual financial report and audit, conducted by a reputable CPA firm when necessary.

**2.8 Annual Report**

The Board shall provide a synopsis of what CRHC achieved during the last year. It could be an annual narrative or consist only of graphs and charts to show the progress of CRHC over the last fiscal or calendar year.

**2.9 Budget**

The Board should report quarterly on the budget, and supply updated versions with the most recent revenues and expenditures at board meetings. The quarterly financial statement should be prepared by the board treasurer and should include a number of basic elements:

1. indication of the period covered by the report

2. the “beginning balance” (which should correspond with the ending balance of the previous month’s report)

3. listing of income received during the quarter

4. listing of expenditures indicating amount

5. totals for income and expenditures

6. indication of “ending balance” (sum of “beginning balance” and income minus expenditures)

7. compare revenue and expense to budgeted amounts

**3. BOARD OFFICERS & COMMITTEES**

**3.1 Officers of the Board**

**Chair of the Board of Directors**

The Chair shall fulfill all responsibilities listed in the Board-approved Collaborative Chair position description. The Chair shall chair the Collaborative meeting and Executive Committee. The Chair shall provide supervision of the CEO. The Chair shall act as an authorized signatory on Collaborative contracts.

**Vice Chair of the Board of Directors**

The Vice-Chair shall fulfill all responsibilities listed in the Board-approved Collaborative Vice-Chair position description. The Vice-Chair shall act as Chair in the temporary absence of the Chair. The Vice Chair shall oversee the annual review of the CEO.

**Secretary**

The Secretary shall fulfill all responsibilities listed in the Board-approved Collaborative Secretary position description. The Secretary shall ensure that a written accurate record of the minutes of all official meetings is maintained. The Secretary shall also ensure that the following records are properly recorded and maintained:

1. Meeting Attendance

2. Membership lists containing names, addresses, and voting status

3. Membership Forms and Documentation

4. Agency governing documents, contracts, and other legal documents

**Treasurer**

The Treasurer shall fulfill all responsibilities listed in the Board-approved Collaborative Treasurer position description. The Treasurer shall ensure network dues are paid and deposited, and that an accurate record of any Collaborative finances is maintained. The Treasurer shall also ensure the following:

1. All Collaborative financial accounts are current

2. All financial records of the Collaborative are accurate and up to date

3. The status of Collaborative finances and membership is reported to Collaborative membership

**3.2 Officer Nominations and Voting**

The Board shall elect officers to the Executive Board at the first meeting after election to the Board of Directors at the Annual Meeting, in accordance with CRHC By-laws. Each Officer position shall be nominated and voted on individually, in the following order: Chair, Vice Chair, Secretary, and Treasurer. Nominations may be made by any board member, must be accepted, and a short discussion period may be conducted before a vote may occur. Votes must be stated verbally, or written, and recorded. The nominee with the most votes wins the position on the Executive board.

**3.3 GLHRN Coordinator Responsibilities**

The Coordinator shall perform in the best interest of the organization, in all relations with the Board, staff, constituencies, and members of the public. The Coordinator shall interpret and implement policies authorized by the Board. The Coordinator is accountable to the Board for the successful administration of Board policy.

**3.4 Board Committee Structure**

All committee chairs and committee members, with the exception of the Executive Committee shall be appointed annually by the Board Chair beginning at the first meeting of the Board of Directors following the first of October. Committees shall operate based on the following guidelines:

1. Committees have executive or decision making authority only when specifically delegated by the full Board.
2. Committees or committee members are not to manage the agency, staff or any program.
3. Committees are to prepare and recommend policies and/or procedures for Board deliberation and approval.
4. Committees requiring appropriate information directly related to the responsibilities of their committee shall request the information from the Coordinator in a timely fashion.
5. Committees shall be proposed and assigned in accordance with formal Board Governance Policy.
6. Committees (with the exception of the Executive Committee) may consist of Board Members, staff, outside experts and volunteers interested in participating in Board committee work.
7. Ad Hoc committees may be established to conduct specific activities.
8. Each elected board member shall chair one committee and serve on others.

**3.5 Executive Committee**

The Executive Committee is chaired by the Board Chair. The Executive Committee shall consist of the elected officers of the Board of Directors. The Executive Committee has the authority to make decisions as necessary to guide the organization between board meetings. The Executive Committee can act on behalf of the Board on any item requiring action prior to the next scheduled meeting of the Board. The Executive Committee shall meet at all times necessary to meet the needs of the Board.

Responsibilities include:

* To make recommendations to the Coordinator on Board training needs.
* All applicable duties as defined in Board Governance Policies and By-laws.
* To ensure the annual review of the Coordinator.
* To annually review that insurance coverage is appropriate and policies are current.
* To oversee Network activities to ensure compliance with the Mission Statement.
* To ensure Board Monitoring Calendar activities are completed on time.
* To review and update organizational policy, procedures, By-laws, and Governance Policies as necessary, and to ensure the Board Governance policies are implemented.

**3.6 Standing Committees**

Standing committees shall include Finance Committee, Human Services Committee, Quality Improvement Committee, and Membership Committee. Each standing committee shall operate by and within the guidelines set in the CRHC By-laws, submitting recommendations for approval of the Board.

**3.7 Ad Hoc Committees**

The Board of Directors may establish such other committees and assign duties that are necessary. At the time of the appointment, the Board shall establish a review date in order to determine the status of and continued need for the group, and to establish a sunset date when appropriate.

**Capital Region Housing Collaborative**

**Board Member Pledge Form**

***My Role***

I acknowledge that my primary role as a board member is to contribute to the defining of CRHC’s mission and governing the fulfillment of that mission, and to carry out the functions of the office of Board Member and/or Officer as stated in the bylaws.

My role as a board member will focus on the development of broad policies that govern the implementation of institutional plans and purposes.

\*This role is separate and distinct from the role of the Director, who determines means of implementation.\*

***My Commitment***

I will exercise the duties and responsibilities of this office with integrity and collegiality.

***I Pledge***

1. To abide by and uphold each policy and procedure in the Board Governance Manual.

2. To establish as a high priority, and always in accordance with the Attendance Policy, my attendance at all meetings of the board, committees and task forces on which I serve.

3. To come prepared to discuss the issues and business to be addressed at scheduled meetings having read the agenda and all background material relevant to the topics at hand.

4. To work with and respect the opinions of my peers who serve this board, and to leave my personal prejudices out of all board discussions.

5. To always act for the good of the organization.

6. To participate in the annual strategic planning, board self-evaluation programs, and board development events that enhance my skills as a board member.

7. To agree to chair one committee, attend all meetings in accordance with the Attendance Policy, and participate in the accomplishment of its objectives. If I chair the board, a committee, or ad-hoc committee, I will:

a) call meetings as necessary until objectives are met;

b) ensure that the agenda and support materials are mailed to all members in advance of

the meetings;

c) conduct the meetings in an orderly, fair, open and efficient manner;

d) make committee progress reports/minutes to the board at its scheduled meetings.

If, for any reason, I find myself unable to carry out the above duties as best as I can, I agree to resign my position as a board member/officer.

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Board member signature Date*

Capital Region Housing Collaborative

Member Conflict of Interest Policy

No member of the Capital Region Housing Collaborative shall derive any personal profit or gain, directly or indirectly, by reason of his or her participation in the Capital Region Housing Collaborative.

As a CRHC Member

1. I will not participate, directly or indirectly, in any arrangement, agreement, investment, or other activity with any vendor, supplier, or other party; doing business with the Capital Region Housing Collaborative which has resulted or could result in personal benefit to me.
2. I will not receive directly or indirectly, any salary payments or loans or gifts of any kind or any free service or discounts or other fees from or on behalf of any person or organization engaged in any transaction with the Capital Region Housing Collaborative.

In addition to my service for Capital Region Housing Collaborative, I am a member or an employee of the following affiliated organizations:

1.  
2.

3.

4.

5.

I accept the duties assumed as a member of Capital Area Housing Collaborative and understand that I am required to declare any potential conflict of interest in matters that come before the Membership.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_

Capital Region Housing Collaborative

General Policies

**1. Coordination with Clinton and Eaton Counties**

Per the tri-county MOU, CRHC and its agencies will coordinate with Clinton and Eaton providers to help clients originally from Clinton or Eaton enter into services in their county of origin, if they so choose.

**2. Establishing a CE Committee**

The Coordinated Entry ad-hoc committee will oversee Coordinated Entry policies and procedures.

**3. Time for Homeless Verification**

Shelters must wait 14 days to issue homeless verification.

**4. PSH Client Referrals**

All PSH referrals must come from the CEA, which will prioritize the most vulnerable with disabilities.

**4. Reallocation Process**

The CRHC (MI-508 Lansing/East Lansing/Ingham County CoC) considers reallocation throughout the year primarily during meetings of the CRHC Board. This process includes a review of HUD priorities, gaps analysis of homeless populations and types of housing and services available in the community, reviews of HMIS data including the PIT and HIC counts and data trends over time, threshold review of the current CoC and ESG funded programs and their efficacy, and prioritizing needs of subpopulations.

Any decision to reallocate is made with the involvement of the CoC Board, who is elected by the CoC membership at large to conduct strategic planning for the area. All CoC funded agencies are encouraged to attend these meetings. Reallocation occurs during the NOFA process once the targets for reallocation have been announced by HUD. The Board reviews the current inventory of CoC programs and votes on whether a reallocation is needed. This information is posted to the website along with the Opportunity for Funding announcement, delineating the new program criteria, the target population to be served, and a proposed overall budget. An application informational meeting is offered to new applicants. New project proposals are reviewed and ranked along with all other projects. All applicants are notified at least 15 days in advance of the NOFA submission deadline to allow for solo applicant procedures.

CRHC LGBTQ Policy

Board Approved 6/26/18

All member agencies receiving federal funding commit to adhering strictly to all and any equal access policies set out by MSHDA and HUD for those agencies to be eligible to receive federal funding. These eligible agencies also commit to following the tenets set forth in this policy.

All member agencies commit to quality, compassionate care for all clients served by that agency, regardless of race, creed, color, ethnicity, national origin, religion, sex, sexual orientation, and gender identity. That compassionate care will be evidenced by staff of the member agencies referring to the client verbally by the preferred name given at the time of program admittance. The agency will also strive, when utilizing a personal pronoun, to strictly adhere to proper use as concerns the name and gender identify qualified by the client at time of admittance. Should the client’s gender identity change during extended stay at a member agency, that client will have the opportunity to complete a new assessment.

Member agencies will commit to providing a safe environment to all clients served by that agency. Where facility or client needs dictate, member agencies will provide service exceptions and/or special accommodations to ensure that safe environment. ***CRHC*** will also commit, as an agency, to working with member agencies to find stable accommodation for those clients determined to be of an increased vulnerability.

Member agencies will create a way for clients to formally submit grievances for issues in which they feel that a staff member or volunteer has committed a prejudiced action or willfully kept said client from needed services out of prejudice. The member agency will take steps to thoroughly review the situation and make notes of the grievance and the resulting review committee’s determination in the accused staff member’s employee file or any documentation connected with an accused volunteer. The review committee will be made up of immediate supervisors and, when appropriate, board members, or recipient rights representative. Should the review find the staff member or volunteer at fault, the member agency will commit to action based upon the severity of the claim. Staff determined to have acted willfully out of prejudice may undergo disciplinary action according to the agency policy. Those staff determined to have acted negligently but not willfully will be asked to attend training for sensitivity made available at that time to other staff. Volunteers who may have committed the action willfully will be asked to resign their volunteer position. Those volunteers who are determined to have acted out of ignorance will either be asked to resign their volunteer position or to fulfill their service in a position that does not directly impact or interact with clients; they may also be offered training for sensitivity depending upon the availability/cost of the training and/or the volunteers’ necessity to the organization.

Members agencies will keep documentation of client grievances readily available for review by MSHDA, HUD, or ***CRHC***, should a client or group of clients file a grievance with either or all of those agencies. Agencies determined no longer to be eligible due to prejudicial actions will face disciplinary measures and loss of funding from MSHDA and HUD, as well as requested expulsion from ***CRHC***.

CRHC VAWA Policy and Forms

In accordance with the Violence Against Women Act (VAWA), the Housing and Urban Development (HUD) required all continuum of care organizations to have a Transfer Policy.  The policy protects the housing rights of survivors of domestic and dating violence, sexual assault, and stalking requiring owners to develop emergency transferplans.

The Capital Region Housing Collaborative's (CRHC) Board of Directors approved best practice forms and a VAWA transfer policy for use by Ingham County housing providers. Listed below are member agencies that will provide resources to support tenants with legal and survivor services.

All HUD housing providers are required to have a transfer policy.  It is the intention of the CRHC to provide forms and a policy to Ingham County housing providers that meets the HUD and grant auditing requirements.

**Capital Region Housing Collaborative  
Consumer Grievance Policy**

It is the policy of the Ingham County Continuum of Care to establish an efficient and fair procedure for the resolution of consumer complaints and problems.   
  
**1.  Specific Objectives**

**1.1** The objectives of this policy are to:

**a.** provide a means of fair, expedient and equitable treatment of all consumers

**b.** minimize potential causes of consumer dissatisfaction   
**c.** provide a mechanism for the acceptable solution of problems regarding consumers and the Continuum’s members

**2.  Definitions**

**2.1** Grievance: A complaint which is registered by a consumer as a result of an unresolved problem, misunderstanding or disagreement

**2.2** Grievance Review Committee: The committee consisting of the Executive Members of the Board and the Chair of the CQI Committee

**2.3** Member agency: An entity which is officially a member of CRHC in good standing

**2.4** Collaborative agency: An entity which is connected to CRHC unofficially  
  
Note: Please note the purpose of a *Consumer Grievances Policy* is to give consumers ample time and opportunity to voice their grievances. Consumers must not be made to feel threatened or guilty for making such grievances known. It is the responsibility and obligation of the Continuum of Care to ensure that complaints registered with the Grievance Review Committee are investigated and appropriate actions are taken where necessary.

**3  Responsibilities**

**3.1** The Grievance Review Committee will:

**a.** review, amend, and adopt changes to the *Consumer Grievances Policy*   
**b.** conduct investigations, where appropriate, regarding the consumer complaint or grievance

**c.** take corrective actions, where appropriate, to resolve the consumer complaint or grievance

**d.** ensure the proper implementation and administration of the *Consumer Grievances Policy*   
**e.** ensure that member agencies and consumers are aware of the *Consumer Grievances Policy* and its contents

**3.2** Other Capital Region Housing Collaborative Committees and Member agencies will:

**a.** recommend changes to the *Consumer Grievances Policy* when appropriate to the Grievance Review Committee  
**b.** ensure, in co-operation with the Grievance Review Committee, that the *Consumer Grievances Policy* is properly implemented   
**c.** ensure that their consumers are aware of the *Consumer Grievances Policy* and its contents

**4.  Grievance Procedure**

**4.1** The causes for grievance may include but are not limited to the following:

**a.** lack of an established network policy or procedure   
**b.** a member agency or network policy or procedure which is perceived to be unfair or causes the consumer a hardship or concern   
**c.** a deviation from an accepted network policy or procedure   
**d.** disagreement or misunderstanding with a member or network agency

**e.** a discretionary action of the network in the application and/or interpretation of the policies, procedures, rules or regulations of the network

**4.2** Eligibility for Grievance

**a.** Any consumer of services or housing offered by an agency or individual member of the network may grieve a particular matter.

**4.3** The Formal Grievance Procedure

**a.** Prior to the initiation of the formal grievance procedure the consumer(s) and network member(s) are encouraged to discuss problems and consider possible solutions. If the discussion between the consumer(s) and Collaborative member(s) does not lead to a satisfactory and timely resolution of the problem, the consumer and/or the member(s) are encouraged to proceed with the formal grievance procedure as soon as possible.

**4.3.1** Step 1: Submission of the Grievance to the Collaborative

**a.** The consumer(s) shall complete the Consumer Grievance Review Request form and deliver it the Collaborative Coordinator, who shall deliver it to the Grievance Review Committee and any involved agency within seventy-two (72) hours.

**b.** Upon receipt of the Grievance Review form, the parties being grieved will review the form and submit to the Grievance Review Committee a written response to the allegations within five (5) business days of receipt. This will then be forwarded to the consumer.

**b.** The Grievance Review Committee shall hold a meeting within thirty (30) days of receiving the Consumer Grievance Review Request Form. The consumer making the grievance and any members named in the grievance shall be required to attend. Any other involved party will be invited to attend.

**4.3.2** Step 2: Review of Grievance at Grievance Review Committee Meeting

**a.** The Grievance Review Committee shall review the Grievance and hear any discussion related to the grievance offered by consumers and/or members.   
  
**b.** The Grievance Review Committee will make (a) recommendation(s) to the consumer filing the grievance and/or the member agency involved in the grievance and any other involved party. Any action taken by the network will first be approved by the Board of Directors for the Collaborative. All involved parties will receive notice of the decision and action within 5 business days.

**4.4** Records of Grievance Procedures and Decisions

**a.** A copy of a grievance submitted at any level and any official action taken shall be retained by the Collaborative Coordinator.

**4.5** Revision to Policies

**a.** Any agreed upon changes or revisions to the formal policies utilized by the network which arise as a result of the consumer grievance process will be developed by the CQI Committee, or designate, and forwarded to the Board for review, amendment, and approval.

ESG Process for Monitoring Outcomes of ESG Recipients

HMIS data is used to evaluate performance on a quarterly basis for the following outcomes:

Households served by type, prevention and homeless assistance

Percent of clients with “known” exit destinations (Engagement)

Percent of clients discharged to permanent housing

Percent of clients discharged from shelter to permanent housing within 30 days

Percent of clients recidivating in the emergency shelter system

Percent of adults with Earned Income, SSI/SSDI or TANF at exit

Percent of adults with any cash or non-cash income/benefits at exit

Percent of adults employed at exit

Percent of total CoC clients who were served by the HARA

The CoC evaluates the performance of the ESG funded programs using data from HMIS (or a comparable database for DV and legal services providers). On a quarterly basis the CoC’s Continuous Quality Improvement Committee reviews the performance of ESG funded program outcomes to ensure that programs are meeting their performance expectations and to identify opportunities for improvements. The baseline for comparison of the performance measures was set using historic data from the ESG programs and other similar programs types in the CoC. High performing programs are asked to share their practices with other providers and programs performing below targets are expected to be able to explain the reasons behind the low achievement and how they plan to improve going forward.

Following the CQI committee’s approval of the accuracy and completeness of the ESG quarterly report the information is sent to the CoC Board for their review and approval.

ESG program monitoring is conducted annually by the Grantee agency, the City of Lansing, using HUD guidelines (exhibits) that cover compliance with HUD regulations, HMIS use, desk audits, client outcomes, exits, and terminations, APRs and barriers. Monitoring results are shared with the agency, the CRHC Board and the CoC Ranking/Applications review committees during their capacity review. A monitoring letter is sent to the agency with any findings, recommendations or corrective actions. Program expenditures are reviewed via monthly desk audits.

The CRHC Board works closely with the City of Lansing staff of the Planning and Neighborhood Development (PND) Office that is responsible for the Consolidated Plan. PND is also a voting member of the Board. Information is provided to PND through the CoC's CQI committee, Finance Committee, Strategic Planning Committee (chaired by a PND staff person) and the HMIS Lead Agency (City of Lansing, HRCS Department) quarterly reporting process, monitoring and other information gathered as part of the CoC application process. HRCS staff and key CoC providers provide most of this information directly to PND. CoC members and HRCS staff attend and provide comments at the PND Public Hearings.

**Financial Grant Monitoring Policy and Procedure**

Policy:

The Capital Region Housing Collaborative (CRHC) has authorized the Financial Committee to oversee the responsibility of monitoring the financial position of CRHC approved grants along with the collaborative applicant/recipient. The Finance Committee will bring recommendations to the Board. The Board along with the collaborative applicant/recipient will make decisions regarding action to be taken.

Procedure:

1. The CRHC Finance Committee will review the financial position of each Continuum of Care (CoC) approved grant, including the City Emergency Solutions Grant (ESG), MSHDA ESG, and HUD CoC grants quarterly.
2. An **11**% variance of a grant’s spending will trigger a **Corrected Action Plan (CAP)** at the Finance Committee related to the Subrecipient’s grant financial performance. The Finance Committee will review the Spending Analysis Report and may make recommendations.
3. The Finance Committee will report to the Board the need for a Subrecipient to submit a Corrective Action Plan (CAP) to ensure that services with related expenditures are performed on a timely basis to avoid a potential negative impact on the community. The collaborative applicant/recipient will work with the Subrecipient regarding the CAP.
   1. A CAP will trigger a monthly Finance Committee review of the grant performance.
   2. If the funded Subrecipient does not show significant improvements in spending in a reasonable time, as designated by the Finance Committee and the collaborative applicant/recipient, then the Finance Committee may recommend to the CRHC Board the need for a subcontractor (CRHC and collaborative applicant/recipient approved agency) to work with the Subrecipient to ensure services and related expenditures are performed in the community in the grant time frame.
   3. The need for a CAP and if applicable, the need for a subcontractor will result in 5% reduction of the total allowable application points for the related competitive application and failure to show significant improvement in financial performance through use of the CAP can result in 5% loss total points in the next related competitive grant application process.
4. There may be times when a Funding agencies and/or the collaborative applicant/recipient may request a CAP or other action with regards to negative financial performance.

**Capital Region Housing Collaborative**

**Coordinated Entry (CE) Policies and Procedures and**

**Standards for Administering Assistance**

**Ingham County Continuum of Care**

**A Community Coordinated Entry Procedural Manual (Version 5)**

**Board Approved January 30, 2018**

**1.0 INTRODUCTION**

Coordinated Entry is designed to coordinate and prioritize access to housing and homeless programs for households experiencing homelessness and ensures clients are referred to a prioritization list regardless of race, color, national origin, religion, sex, age, familial status, disability, actual or perceived sexual orientation, gender identity, or marital status. There is no guarantee that the household will meet final eligibility requirements, be referred to a housing resource, or receive a referral to a particular housing option, nor does it ensure availability of resources for all eligible households. Coordinated Entry is not designed to provide supportive services; but is designed to maximize access to housing services. Additional supportive service needs may be identified during the Coordinated Entry process but Coordinated Entry does not offer or guarantee such services.

Coordinated Entry (CE) is the community’s design to ensure the availability of safe and affordable housing resources to those experiencing homelessness and those at imminent risk of homelessness.  It is mandated by HUD and is essential to providing quality services that coordinate with government and agencies/providers to know who we are assisting and how we are assisting them.  The Capital Region Housing Collaborative (CRHC) is the US Department of Housing and Urban Development (HUD) designated Continuum of Care for Ingham County, Michigan. It has existed since the 1980s for the purpose of uniting community partners to fight homelessness more effectively.

This manual is a living document that may be amended as Coordinated Entry is refined, as other service providers or programs join Coordinated Entry, or as necessary to maintain compliance with federal guidance and regulations governing Coordinated Entry and housing services.

CRHC has approved the following Policies and Procedures to provide specific guidance on how to successfully navigate and implement Coordinated Entry.

1. **OVERVIEW:**

Coordinated Entry (CE) is a program mandated by HUD to effectively assess and prioritize individuals and families experiencing homelessness according to specific client needs. CE is based on an approach that considers disability status, severe service needs, and the length of time an individual or family has experienced homelessness when prioritizing clients for housing interventions.

CE’s purpose is to ensure that all people experiencing homelessness have fair and equal access to housing using standardized tools and practices. Clients enter the CE System through a designated access point of their own choosing or are engaged by a multi-agency outreach team resourced to address homelessness for any individual encountered.

CE is designed to:

* Allow anyone who needs assistance with a housing crisis to know where to go to get that assistance and to be assessed in a standard and consistent way;
* Ensure households who are experiencing homelessness gain access to available housing interventions as efficiently and effectively as possible;
* Prioritize households for limited housing resources based on length of time homeless and the severity of need;
* Provide clarity, transparency, consistency, and accountability throughout the assessment and referral process for households experiencing homelessness, community partners, and homeless and housing service providers; and
* Facilitate exits from homelessness to stable housing as quickly as possible.

CE objectives:

* A **standard assessment process** is provided to all clients seeking assistance, and standard criteria used for determining the appropriate next level of assistance;
* **Uniform guidelines** are established among homeless housing programs participating in CE (transitional housing, rapid rehousing, and permanent supportive housing) regarding eligibility for services, screening criteria, prioritized populations, expected outcomes, and targets for length of stay;
* Consistent **referral policies and procedures** from CE to housing programs and other resources are used;
* The CE policies are a sub-set of the CRHC **Policies and Procedures Manual** which details the overall CRHC operations.

The following policies govern the CoC: Provisions of the HUD Continuum of Care (CoC) Program Interim Rule (24 CFR 578.7(a)(8); ESG CE standards per 24 CFR, Part 576.400(c)(3), as amended; HUD Coordinated Entry Notice CPD-17-01 Notice Establishing Additional Requirements for a Continuum of Care Centralized or Coordinated Assessment System (2017) established a Centralized or Coordinated Assessment System and HUD CPD-16-11 Notice on Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing and Recordkeeping Requirements for Documenting Chronic Homeless Status.

**3.0 CE PARTICIPATION REQUIREMENTS**

HUD recently established guidance that instructs all CoC projects to participate in their local CoC’s CE system. Any project that receives HUD funding (CoC Programs/projects and Emergency Solutions Grants) must comply with CE participation requirements as established by the CoC. Recipients and sub-recipients of these funds must comply with the nondiscrimination and equal opportunity provisions of the Federal Civil Rights regulations including the Fair Housing Act, Section 504 of the Rehabilitation Act, Title VI of the Civil Rights Act, Title II and Title III of the Americans with Disabilities Act.

* 1. **Cooperating Agencies**

Cooperating agencies include homeless and housing service providers that have entered a Qualified Service Organization Business Association Agreement (QSOBAA) that standardizes data sharing and a CRHC Memorandum of Agreement, which is being revised based on existing CE procedures. Cooperating agencies must be actively engaged in CE and/or entering or accessing data from the Homeless Management Information System (HMIS).

Partially cooperating agencies may participate in key weekly meetings, such as the Inter-Disciplinary Team meetings, and make referrals to the prioritized list but will not be designated Access Points.

The QSOBAA maintains that client-level information can only be shared between agencies that have signed the agreed upon QSOBAA, and have received informed consent from any given client agreeing to share their personal information with other identified agencies. The agency receiving the client’s written consent can share the client’s information in a coordinated entry meeting or electronically through a database system with collaborating agencies. The list of fully cooperating agencies is managed by the HMIS Lead and the CRHC and will be listed on the CRHC website.

Fully cooperating agencies may participate in the multi-agency outreach meetings to review referrals made to the client prioritization list and/or participate in the Inter-Disciplinary Team (IDT) meetings to discuss which programs have vacancies to support client housing. Prioritization list referrals are made through the designated CE agency. Fully cooperating agencies utilize the prioritization list referrals to fill all permanent housing vacancies. Fully cooperating agencies will collaborate to assist with CoC planning and coordinating community crisis responses.

**3.0 COORDINATED ENTRY COMPONENTS**

**3.1 Uniform Process and Assessment Tools**

CRHC uses a standardized CE process for both intake and assessment. Our standardized intake form is consistent with the data entry sequence required in the Homeless Management Information System (HMIS). In addition to the intake form and data entry, all cooperating agencies use the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT)[[1]](#footnote-1) developed by OrgCode Consulting. This is an assessment tool that aims to identify a household’s level of service need and acuity, although participants may refuse to answer questions without retribution or limiting their access to assistance. Population specific versions of VI-SPDAT are used, which include additional appropriate questions by sub-populations that support eligibility for housing resources. The scoring from the VI-SPDAT tool determines the level of acuity for each household. To facilitate appropriate access, referral to housing resources is prioritized based on length of time homeless and the score from the VI-SPDAT. Additional ranking criteria for prioritization list eligibility are customized to each service category: permanent supportive housing services, rapid re-housing, or prevention services.

|  |  |  |
| --- | --- | --- |
| Single Adult Assessment  & VI-SPDAT | Family Assessment  & VI-FSPDAT | Transition Age Youth (TAY) Assessment  & TAY-VI-SPDAT |
| * Use for single adults | * Use for a pregnant or parenting   individual/family including young adults (18-24) | * Use for a single, young adult   between 18-24 years old   * Score can transfer to single adult resources |

**3.2 Housing First and Low Barrier**

CRHC follows and promotes Housing First principles. As such, accessing temporary and permanent housing has been addressed by the community process in the following ways:

* State funded shelters have low barrier admission policies and do not exclude people from admission due to mental health or substance use disorders, domestic violence, or criminal background except where legal, grant or agency requirements must be followed.
* HUD PSH/PH providers accept referrals, based on the prioritized list. The prioritized list incorporates people directly from shelters, street outreach, drop-in centers, and any part of the crisis response system.
* Services emphasize engagement over therapeutic goals. Services plans are person centered, without preset goals. Participation in services is not a condition of tenancy.
* There are few to no programmatic prerequisites to temporary, transitional or permanent housing entry, except as required by funders.
* Access to CoC resources are according to selection from the CE prioritization list of eligible applicants; rather than on other methods, such as “first come, first serve”.
* Housing is not dependent on minimum payments and each tenant’s share of rent is set at 30% of income, unless HUD CoC programs operate under other criteria approved through HUD applications.
* Potential tenants are able to choose options for treatment services but are not required to accept treatment or case management services as a condition of tenancy, except as required by a funding source.
* Treatment, case management, and tenancy support-type services will be offered regularly with client centered progressive engagement methods for each tenant.
* Use of alcohol or drugs, in and of themselves, are not considered a reason for eviction.

**3.3 Housing Components**

**3.3.1 Emergency Shelter**

Emergency shelters are critical access points for the CE system. Emergency shelters participate in diversion practices as a strategy that prevents homelessness at the front door by helping persons identify immediate alternate housing arrangements and, if necessary, connecting them with services and financial assistance to help them return to permanent housing. Diversion strategies are designed to reduce the number of individuals/families becoming homeless, reduce the demand for shelter beds, and minimize program wait lists. The U.S. Interagency Council on Homelessness and the National Alliance to End Homelessness encourages communities to include shelter diversion as an important part of Coordinated Entry efforts, particularly for families. Shelter diversion strategies include: financial assistance to maintain current housing; conflict resolution and mediation to return to housing; or assistance to locate and secure new housing through financial assistance and advocacy.

Emergency shelters have agreed to CRHC uniform admission and discharge policies, which serve to enhance the CE system. Admission policies include adoption of Housing First standards for all persons served, standardized intake, referrals for employment, health care, substance abuse and related community services. Emergency shelters are required to adhere to all fair housing and anti-discrimination policies and do not deny admission to or involuntarily separate family members from on another regardless of race, color, national origin, religion, sex, age, familial status, disability, actual or perceived sexual orientation, gender identity, or marital status. Discharge policies are based on the needs of the person served and are not restricted to a specific length of stay. However, most average stays vary between 30 to 90 days. Persons served may be offered extensions based on their individual housing plan.

Additionally, CRHC has a long established “Cold Weather Policy” that ensures shelter beds are available in weather emergencies.

* + 1. **Rapid Rehousing**
    2. For rapid rehousing (RRH) projects, the CoC has established similar standards for ESG and CoC funded projects, determining how much a client receiving financial assistance will contribute, as listed below. RRH projects are funded through HUD COC and Emergency Solutions grants. RRH funds are applied to households on the CE prioritization list for individuals/families in HUD Categories 1 and/or 4 with VI SPDAT scores between 4 and 8. ESG RRH funds are used for households with annual income below thirty percent of Ingham County’s median family income per ESG regulations

Rapid Rehousing funds are used as housing relocation and stabilization services and for short to medium-term rental assistance necessary to help eligible individuals or families move and sustain permanent housing as quickly as possible. Eligible costs include security deposits, first month's rent, utility deposits/arrearages, housing stability case management, landlord-tenant mediation, tenant legal services, and credit repair.

The amount of rent and utilities costs each participant must pay is determined by the amount owed minus the amount of assistance they are able to receive from other agencies, such as DHHS and other agencies. For ESG RRH the balance owed represents their co-pay of 30% of adjusted gross income.

These amounts and length of financial assistance are based on ongoing client needs assessments.

See Section 6.2 for further details.

**3.3.2 Prevention**

Access points assess a household’s eligibility and appropriateness for homelessness prevention programs and services. Prevention programs and services may offer financial assistance, case management, legal services, and linkages to mainstream resources. If prevention is determined the best form of housing intervention for a client, a VI-SPDAT will not be administered. Prevention funds are often provided through the Eviction Diversion Programs sponsored by the CoC, held at the Courts, and attended by CoC agencies to prevent eviction into homelessness.

CRHC has established an eviction diversion program that has been operational in 55A District Court (Mason, Michigan) for several years. In 2017 a larger eviction diversion pilot was established in Lansing, MI at 54A District Court.

**3.3.3 Housing Choice Vouchers (HCV)**

The designated CE Housing agency is responsible for placing people on the waitlist for HCV. People that show evidence experiencing homelessness for a minimum of 14-days are placed on the HCV waitlist. All persons added to the HCV list are HUD Category 1 and/or 4. Persons are recertified every 90-days to be maintained on the wait list.

**3.3.4 Permanent Supportive Housing (PSH)**

CRHC has both leasing and rental assistance PSH projects. All units prioritize chronically homeless persons or families. However, all units are currently designated solely for persons experiencing chronic and long-term homelessness with service needs in accordance with CRHC policies and HUD CPD 16-11 Notice of Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing.

For CoC leasing projects, client contributions in the form of an occupancy charge are the highest of either:

* 30% of the monthly adjusted income;
* 10% of the monthly gross income; or
* The portion of the welfare assistance, if any, that is designated for the payment of rent.

The applicability of leasing funds will vary across cooperating agencies as dictated by funding sources and/or grant requirements.

All CoC Program-funded PSH programs in CRHC accept referrals only through the CEA.[[2]](#footnote-2) The CEA or Access Points conduct an initial needs assessment using the VI-SPDAT tool (per 24 CFR 578.3) to ascertain the most appropriate referrals for the individual or family. This determines the priority participants for Ingham County PSH openings as they arise, using a single prioritized list for all CoC Program-funded PSH within the CoC that is informed by the CoC’s street outreach. The single, prioritized list for PSH is updated bi-weekly by the CEA, or more frequently as new data is available, working closely with the HMIS Administrator and the InterDisciplinary Team (IDT) Coordinator. Regulations for the PH program are found at 24 CFR, Part 578.37 and should be reviewed by all CEA coordinated entry staff.

Permanent Supportive Housing in the COC regulations prioritizes housing to individuals and families with disabilities in which one adult (head of household) has a disability. Supportive services are made available to program participants in a voluntary, non-discriminatory manner. The Orders of Priority for new and vacant units are not based upon diagnosis or disability type but rather on the following:

**Target Population:** For CoC Program-funded PSH that is dedicated or prioritized for persons experiencing chronic homelessness, the highest priority is given to a chronically homeless individual or family with the longest length of time homeless with the highest severity of needs (see HUD Orders of Priority and Record-keeping procedures later in this policy.)

**Uses CPD Notice CPD-16-11** for open PSH slots that prioritize chronically homeless who have been homeless the longest with the most severe service needs.[[3]](#footnote-3) These CEA standards were updated to reflect the new Orders of Priority in CPD Notice CPD 16-11, Section III, issued July 2016.[[4]](#footnote-4)

No designated length of stay is established for PSH participants.

PSH funds may be used for acquisition, rehabilitation, new construction, leasing, rental assistance, operating costs or supportive services according to the current HUD Project Grant Agreement approved by HUD and submitted by the CRHC CoC in the most recent NOFA.

PSH programs use current FMR, rent reasonableness, or per unit costs as approved by HUD in the most recent grant agreement governing the PSH Project.

3.4 **Community Outreach Team**

Clients enter the system through a designated access point of their own choosing or are engaged by a multi-agency outreach team (PATH, Youth Street Outreach, CABHI program, etc.) designed to effectively work with any individual or family experiencing homelessness. PATH connects people to the CEA using a “warm hand-off” to ensure a solid connection for unsheltered persons. Many CRHC agency outreach activities take place throughout the year to make contact with street homeless or those residing in places not meant for or ordinarily used as regular sleeping accommodations. This includes shelter and agency staff who encounter people in the regular course of business, day shelter staff, special outreach to known encampments sometimes resulting from alerts by law enforcement or code enforcement, weather disasters that threaten the health of those living outside, locally funded efforts to provide assistance and necessities, and the annual Point in Time (PIT) outreach that goes to more than 100 sites in the community where people may seek temporary shelter. It is the policy of the CEA to work closely with all outreach efforts and prioritize chronic homeless individuals and families for housing resources as determined by history of homelessness and VI-SPDAT score.

* 1. **Prioritization List**

The Coordinated Entry (CE) process is linked to street outreach efforts so that unsheltered persons are prioritized for assistance in the same manner as any other person assessed through the Coordinated Entry process.

The CE process is committed to a Housing First approach. The coordinated entry process does not screen people out for assistance because of perceived barriers to housing or services, including, but not limited to, lack of employment or income, drug or alcohol use, or having a criminal record. In addition, housing and homelessness programs lower their screening barriers in partnership with the coordinated entry process. The CE process includes all subpopulations, including people experiencing chronic homelessness, Veterans, families, youth, and survivors of domestic violence; although people may access the CE process through any designated Access Points. Unsheltered persons will receive immediate referral to shelter.

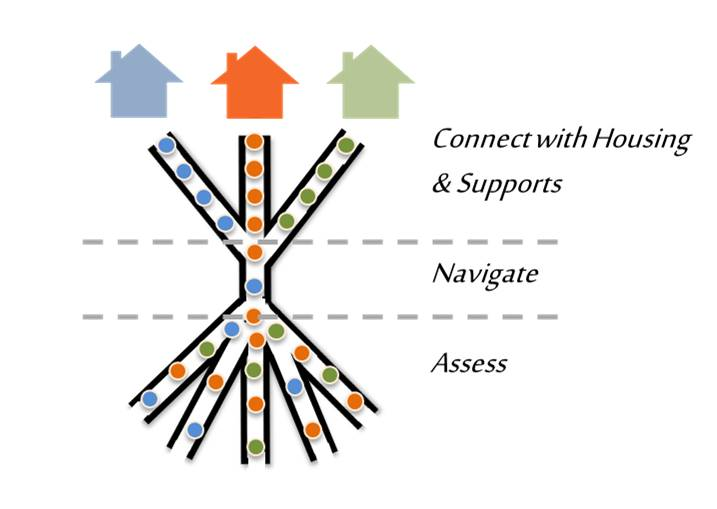
**4.0 CE PROCESS FLOW**

**4.1 Designated Operating Agency**

The designated CE Agency is selected by the CRHC and at minimum receives MSHDA ESG RRH and Prevention funds. The CE Agency is primarily responsible for:

* Administering designated RRH/Prevention funds and associated policies
* Managing the HCV Waitlist and related policies and procedures
* Developing housing relationships and sharing housing resources that meet a variety of housing needs
* Developing CE policies and procedures in conjunction with the GLHRN
* Managing the prioritization list in collaboration with other cooperating agencies
* Assisting the CRHC with training related to CE policies and processes.
* Assisting the CRHC with ongoing program development and training
  1. **CE Flow Chart**

1. The CE process begins with assessment by a fully cooperating agency
2. The assessing agency inputs data into the Homeless Management Information System and places the household on the appropriate prioritization list.
3. The household is informed of available resources and directed to the CE Agency
4. The CE Agency connects the household to available housing supports



**5.0 ACCESS AND REFERRAL POINTS**

**5.1 Access Points**

An Access Point is an organization that is fully integrated into the CE system. The organization has the capacity and is equipped to administer the VI-SPDAT and make adequate referrals or diversions based on the assessment outcome and resources currently available. Cross-training on assessments is planned for all access points to align with CE’s “no wrong door” policy. These fully cooperating agencies may participate in street outreach and can complete assessments and enter data into MSHMIS. Access points are subject to revision as the CE process is implemented within the CRHC. Housing Resource Specialists or other appropriate staff will perform the following activities: intake, assessment, creation of a personalized Housing Plan that includes a path to permanent housing stability, arrangement, coordination, monitoring, referral and delivery of services to assist participants to obtain housing stability.

|  |  |
| --- | --- |
| **Access Point** | **Location** |
| Holy Cross | 430 N. Larch St.  Lansing, MI 48912 |
| Loaves and Fishes Ministries | 831 N. Sycamore St.  Lansing, MI 48906 |
| Haven House | 121 Whitehills Dr.  East Lansing, MI 48823 |
| Advent House | 743 N. Martin Luther King  Lansing, MI 48915 |
| Gateway Youth Services  Child and Family Charities | 4287 Five Oaks Dr.  Lansing, MI 48911 |
| Mid-Michigan Recovery Services | 913 West Holmes, Ste 200,  Lansing, MI 48910 |
| End Violent Encounters (EVE) | Not listed for safety reasons |

**5.2 Referral Points**

A Referral Point is an organization that works with the CE system and is a related social or community service, but does not do intakes into the system. These organizations should be knowledgeable about the Access Points for the different populations and be able to assist in getting people to the appropriate Access Point. Referral points include the organizations listed below and are subject to revision as the CE process is implemented within the CRHC.

* City Rescue Mission
* Ingham County Department of Health and Human Services
* Community Mental Health Authority of Clinton, Eaton, & Ingham Counties (CMH-CEI)
* Legal Services of South Central Michigan – Lansing Office (LSSCM)
* Lansing Police Department (LPD)
* City of Lansing Human Relations and Community Services Department (HRCS)
* City of Lansing Code Compliance
* Michigan State Police (MSP)
* Ingham County Sheriff’s Department
* Capital Area Community Services (CACS)
* Central Michigan 2-1-1
* Cristo Rey Community Center
* Ingham County Health Department (ICHD), WIC
* Local School Districts
* Head Start, Early Head Start
* Justice in Mental Health Organization (JIMHO)
* Lansing Area AIDS Network (LAAN)
* One Church One Family
* Tri-County Office on Aging (TCOA)
* Michigan State Housing Development Authority (MSHDA)
* Northwest Initiative
* Local hospitals, Health Clinics
* Peckham, Inc.
* Culturally Specific Organizations such as Refugee Development Center, Cristo Rey Community Center
* MI Prisoner Re-Entry Program

**5.3 Community**

Members in the community who should be educated about CE but are not directly involved with the CE system including assessments, MSHMIS, access points, or referral points. Community members educated about CE may include child or after school providers, the National Alliance on Mental Illness, government organizations, faith based organizations and/or family members, friends and supporters of individuals or families experiencing homelessness.

**6.0 STANDARDIZED ASSESSMENT**

VI-SPDAT (Individual, Family, or Youth version depending on client service category)

HUD MSHMIS Universal Data Elements

Diversion Assessment (under development)

Prevention Assessment (under development)

Street Outreach access points will not conduct the Diversion or Prevention assessments because street outreach staff will be working with households who are already experiencing homelessness, not those who may become homeless. These access points will utilize the VI-SPDAT (Individual, Family, or Youth version), and the HUD MSHMIS Universal Data Elements.

**Triage** (VI-SPDAT) – CEA staff and Access Point staff

1. All applicant households will be triaged (screened) either by phone or in person to determine their prioritization of resources. The screening will use the VI-SPDAT tool to prioritize clients into PSH resources, Rapid Re-Housing Resources, or General Assistance. CEA staff and emergency shelters coordinate their efforts in the VI-SPDAT process.

2. Protocol has been developed between the CEA and 211, taking calls during non-traditional work hours. Households who present with immediate safety issues are re-directed appropriately (Domestic Violence shelters, 24 hour DV hotline or 911).

**6.1 ESG Prevention**

Intended to serve those certified as Homeless, Categories 2-4; certified At Risk of Becoming Homeless, Categories 1-3. (see 24 CFR, Part 576.103) First options/strategy to employ for persons at imminent risk for losing their housing would be prevention with a goal to limit persons from entering the homeless system including use of Support Services.

Prevention efforts are designed to keep families or individuals in a place that they already rent or own therefore preventing homelessness and entering the CE System. Prevention funding may be used to meet rent or other bills when a person is short on finances. GLHRN is in the process of designing and implementing a prevention assessment and tracking system. Until prevention mechanisms are fully developed through the CE process, all referrals for prevention services will flow through the designated CE Agency.

If the Triage process concludes there is not an immediate housing need (but other needs are present), the households will be referred to the appropriate resource to address the need (food assistance through DHHS, mental health through CMH, etc.)

Prevention funds are used to provide housing relocation and stabilization services and short-and/or medium-term rental assistance (see 24 CFR, Part 576.105) is provided as necessary to prevent the individual or family from becoming homeless if:

* Annual income of the individual or family is below 30 percent of median family income,
* Assistance is necessary to help program participants regain stability in their current permanent housing or move into other permanent housing and achieve stability in that housing,

Eligible costs include security deposits, rent arrearages, 1st month's rent, utility deposits/arrearages, housing search and placement, housing stability case management, landlord-tenant mediation, tenant legal services, and credit repair.

Prevention Financial Assistance criteria:

Rental Arrearages up to 3 months maximum

Rental Assistance up to 6 months (This may be adjusted on a case-by-case basis according to client needs assessment.)

* NOTE: Total per household/per grant year is capped at 6 months of rental assistance for the combination of rental arrearages and leasing assistance – NOT 6 months for each category.
* Qualifications (income below 30% AMI); Current Fair Market Rent (FMR) guidelines must be used.
* Target group: Available to homeless definition categories 2, 3, 4 (Homeless Certification required) and at risk of homelessness categories 1, 2, 3 (At Risk of Homelessness Certification required).
* Verified income: recertification is required after 3 months’ assistance (if participant continues to need assistance for months 4-6, income must be re-verified.)
* Prioritization for those participants most in need by targeting those closest to going to a shelter, car, or the street with the following Risk Factors:
* Extremely Low Income
* Criminal Histories
* Behavioral Health Issues
* Poor Employment Histories

Security Deposits are allowed using prevention funds only if it prevents a household from becoming homeless. CEA first attempts to get funds from the Michigan Department of Health and Human Services , State Emergency Relief (SER) or other community programs.

Utility Deposits are generally, capped at $200 per household.

Utility Arrearages are generally capped at $1,500 per household/per year.

NOTE: Total per household/per year is $1,500 for the combination of prevention and re-housing. Not $1,500 for each category.

Legal Assistance (Mediation) referrals to Legal Services may be done as determined by a client centered needs assessment.

**6.2 Rapid ReHousing**

**ESG funded Rapid Rehousing Financial Assistance criteria:**

* Rental Assistance up to 6 months (This may be adjusted on a case-by-case basis according to client needs assessment.)
* Qualifications (if income is below 30% AMI)
* Target Population - Certified Homeless - Category 1 - Only. (Homeless Certification required)
* Verified income
* Recertification and reassessment is required after 3 months’ assistance (if participant continues to need assistance for months 4-6, income must be re-verified.)
* Priority populations:
  + Homeless with a Disability – as defined by HUD
  + Chronically Homeless – use orders of priority – CPD-16-11
  + History of vulnerability to victimization, number of previous homeless episodes, unsheltered homelessness, criminal history, bad credit or rental history,
  + General Homeless
* Security Deposit does not exceed one month’s rent. CEA attempts to get funds from Department of Health and Human Services first. This is an allowed expense under Rapid Re-housing, if needed, to assist in getting household into a unit.
* Utility Arrearages are available only if it enables utilities to be turned on at a new address. Generally, are capped at $1,500 per household/per year. Note: Total per household/per year is $1,500 for the combination of prevention and re-housing, not $1,500 for each category.
* Utility deposits are generally capped at $200 per occurrence.

Legal Assistance (Mediation) referrals are made to Legal Services as determined by a client centered needs assessment.

**CoC funded Rapid Rehousing (RRH**) is for homeless individuals or families, with our without disabilities, to move as quickly as possible into Permanent Housing (PH). Supportive services must be provided at least monthly per CoC and ESG regulations.

* **Target Population:** Current CRHC CoC RRH grant agreement is for Ending Family Homelessness Through Rapid Rehousing for families(FY17-18).
* **Allows short term (up to 3 months and/or medium term (for 3 to 24 months) tenant based rental assistance.** Must limit rental assistance to no more than 24 months per household. ESG local program guidelines are for 6 months maximum which can be modified on a case-by-case basis. EFHTRR follows this guideline, but future CoC RRH programs may establish other guidelines that better serve those populations.
* **Must follow written policies established by the CoC** for determining and prioritizing which eligible families and individuals will receive RRH assistance through administration of the VI-SPDAT assessment tool, as well as the amount or percentage of rent each program participant must pay. (578.37(a)(1)(ii) *Rapid Rehousing.)* The CoC EFHTRR program prioritizes households with a VI-SPDAT score of 4-8, with children who have a history of or vulnerability to victimization, multiple previous homeless episodes, are unsheltered, criminal history, bad credit or rental history, and head of household has mental or physical disability. EFHTRR program policies do not require participants to pay rent, but do expect them to start a savings account and pay for utilities.
* **Annual Re-evaluation** of program participants’ service needs is required.
* At Closing, client needs must be reassessed and referrals provided, and/or program may be extended per assessment.
* **Monthly meetings** with a case manager are required.

**6.3 Diversion**

Access points assess a household’s ability to retain housing or rely on natural support systems to avoid entrance into the homeless system. If prevention is determined the best form of housing intervention for a client, a VI-SPDAT will not be administered.

Diversion efforts occur when a family or individual are already out of their previous housing situation but are not experiencing homelessness. For example, the client could be staying with friends or living in a hotel.

**6.4 Referral Process**

The referral process is designed to ensure that the best housing intervention is offered to a household based on vulnerability, severity of service needs, and other locally-relevant data. This information informs policy priorities and the appropriate flow of households into and out of the system.

If the Triage process concludes there is an immediate housing need, households are prioritized based on severity of need and if applicable, Chronically Homeless families or individuals are added to the CoC-wide PSH prioritized list, while others may be referred to the Rapid Re-housing program, provided financial assistance or assisted with mainstream applications for needed funds. An executed sharing agreement (QSOBAA) exists to allow sharing of client information in HMIS between agencies.

**6.5 Referral Denial**

Following a referral, a household may be denied if self-reported information that would affect enrollment eligibility cannot be verified. As a best practice, referral denial is not encouraged by HUD and should be considered only when a client does not meet housing eligibility, services are not available, or through a series of circumstances in which the initial housing approach was unsuccessful.

**7.0 Prioritization List Management**

The Capital Region Housing Collaborative (CRHC) has adopted HUD’s Orders of Priority, according to HUD Notices CPD 17-01 and CPD 16-11. Within each HUD priority category, clients are sub-prioritized based on their length of time homeless and severity of need, as determined by a VI-SPDAT score. Clients are housed accordingly as quickly as possible when housing is available.

Per HUD guidance (CPD 16-11), should housing capacity exceed the local chronically homeless population, open space may be used by those persons not meeting the chronically homeless definition but identified as high-acuity. Considerations to the VI-SPDAT include:

* Significant health or behavioral health challenges or functional impairments which require a significant level of support in order to maintain permanent housing;
* High utilization of crisis or emergency services, including emergency rooms, jails, and psychiatric facilities, to meet basic needs;
* The extent to which people, especially youth and children, are unsheltered;
* Vulnerability to illness or death;
* Risk of continued homelessness; and/or
* Vulnerability to victimization, including physical assault or engaging in human trafficking or sex work.

**Supplemental PSH procedures for Exhausting CH households**

Determining PSH administrator has exhausted reasonable efforts to house the most chronically homeless households:

* Call the applicant three times over seven days. If there is no available phone number, move to next step.
* Contact DHHS, Advent House, and the City Rescue Mission (in writing) to request staff assistance at overnight and weekday shelters that they search for this person or household from X date to X date (allowing no more than 3 weeks for search process, which should be done simultaneously with search at Advent House).
* Request a staff notice for the same 21-day period above for Holy Cross, Advent House, and the City Rescue Mission, requesting Applicant to call/drop into the office at LHC or Advent House, as appropriate per HIPPA rules and regulations.

**Steps 1, 2, & 3 could be concurrent and/or overlap.**

In writing means both letter and e-mail, if available. Request should include a response time and respondent. If all Chronically homeless households are not accessible after following the protocol above and the file is documented, then households that have been determined to be high acuity but are not chronically homeless can be offered PSH assistance.

Also CRHC documentation requirements for Recordkeeping Procedures will adhere to documentation requirements for all recipients of dedicated and non-dedicated CoC Program-funded PSH as provided in 24 CFR 578.103(a)(4) when determining whether or not an individual or family is chronically homeless for the purposes for eligibility, and maintain evidence of implementing these priorities, in respect to the Orders of Priority in CPD-16-11 Recordkeeping Recommendations, p., 11-12

**7.1 Prioritization List Referral Acceptance/Declination/Cancellation**

The Coordinated Entry Lead Agency will make referrals to appropriate housing program options through HMIS; the Prioritization List will be kept and managed using assessment data entered directly into HMIS by each access point combined with collaborative information shared by cooperative agencies.

Currently, prevention and diversion assessments are not tracked in HMIS but will be as the program develops and is implemented within the Ingham County CoC. Additional training for prevention and diversion data entry will be determined by CRHC’s Board and fully cooperating agencies.

The Coordinated Entry Lead Agency hosts weekly or bi-weekly meetings, focused on the needs of the highest acuity clients, with the providers to access current client information and identify gaps in an individual’s plan, anticipate future needs, and discuss available housing options. Monthly meetings will be attended by the CE Lead Agency and all cooperating agencies to review the prioritization process and progress with the list. From these meetings, the CE staff makes housing decisions based on eligibility, prioritization, assessment data, and bed/unit availability. Referrals made through the CE Lead Agency to the prioritization list are facilitated by use of HMIS to support faster linkages between client needs and housing resources.

Program eligibility is determined by each housing provider/cooperating agency’s grant funding or guiding policies and is discussed in outreach meetings as applicable to clients on the prioritization list. Eligibility is based primarily on federal, state, or local funding source homeless program criteria. The HUD federal homeless and “at-risk” of homelessness definitions are key to determining eligibility and can be found in the ESG regulations at 24 CFR, Part 576.2. ESG services funded through MSHDA must adhere to MSHDA policies (Office of Rental Assistance and Homeless Solutions – ESG Funds, Policy and Procedures 12-2014) that requires specific documentation of homelessness. Eligibility for services provided by HUD ESG and CoC funded programs can be determined through a review of the homeless definition, ESG regulations at 24 CFR Part 576 and CoC regulations at 24 CFR Part 578, *as amended,* the population targeted for the specific program component, and a review of HUD and CRHC priorities that address those with the most severe needs, (as determined by the VI-SPDAT,) among eligible persons. Chronic homeless individuals and families should be prioritized for ALL available openings for housing. (Please refer to the CRHC for a list of currently funded programs in Ingham County.)

All clients, regardless of service category, are referred to their respective prioritization list for housing under the CRHC CE process. Case managers, service providers and CE Agency staff across cooperating agencies enter client level data from the appropriate assessment packet into HMIS and make a referral to the prioritization list. The CRHC develops and provides a “how-to” user guide including access instructions and referral expectations on its website. CE case managers, communicate client housing status to the CE Lead Agency including housing acceptance, declinations, or cancellations.

The CE Lead Agency is responsible for removing housed clients from the respective prioritization lists. The CE Lead Agency receives client housing confirmation from case managers within cooperating agencies and informs the Interagency Disciplinary Team and cooperating agencies through weekly circulation of the Prioritization List and monthly CE community updates. The CE Lead Agency removes clients from the prioritization list(s) when housing is verified.

**7.2 Housing Acceptance**

If a client is housed via collaborative CE meetings and client information sharing, the client referral in HMIS is documented as “Accepted” and the referral closed in HMIS and the client removed from the list. Choosing the “Accepted” option after it is confirmed that a client is housed is the only selection used to document housing and removing a client from the prioritization list.

**7.3 Housing Declination, Including 7.3.1 Participant Right of Refusal or Failure to Engage**

If a client is offered housing through CE but chooses not to accept services specific to CE housing programs, the client referral in HMIS is documented as “Declined” and the referral is closed in HMIS therefore removing the client from the list.

Clients may choose to stay on the list if a program within CE better suits their housing needs but is not immediately available when the initial housing offer is made. For example, a client may decline an opening in permanent supportive housing because the placement does not allow pets. The client will remain on the list and wait for an opening that allows pets. The CE case manager does not update the client profile as “Declined” in this circumstance and maintains communication with the CE Lead Agency until housing is found for the client.

**7.3 Housing Cancellation**

A referral cancellation can result from more than one housing situation or change in client circumstance. If a client referred to the list receives an updated referral status of cancelled, the cancellation is documented, and the client is removed from the list. Examples of referral cancellation include:

* CE case manager, service provider or cooperating agency confirms the death of a client;
* A client received a housing intervention from an agency or program outside of the CE system (e.g. a client is hospitalized and is subsequently assigned a social worker. The assigned social worker finds housing in an assisted living program outside of CE.).
* A service provider, case manager, etc. communicates these circumstances to the CE Lead Agency as soon as alternative housing is confirmed for any client on the list.
* A client’s ROI expires and no new ROI is obtained within four months of the final date of expiration. Client data remains in HMIS but information is not shared until a new ROI is signed and uploaded into the system.

**8.0 Client Grievance Procedures**

Clients who feel they are not properly placed on the Prioritization List or that the process is in some manner unfair to them should first discuss their concerns with their CE case manager. If the client still perceives an issue exists, the CE case manager directs the client to the appropriate next level of authority in the CE process, including review of the grievance process at the CE site. If the client pursues the local grievance process and is not satisfied or if the client chooses not to file a grievance with the local site, the client is directed to the CRHC Coordinator or designee for further assessment and action. Additional actions may include one of the following options—a simple assessment and resolution or a full grievance hearing with the CRHC Grievance Committee, comprised of members of the CRHC Board of Directors. (See Grievance Policy in Exhibits Section.)

**8.1 Agency Grievance Procedures**

Cooperating agencies have established internal grievance procedures that include the possibility of notification of a client grievance via the CE case manager or CRHC Coordinator. Actions may include a policy review with the client to help him/her understand why he/she did not qualify for a specific housing intervention or re-administering the assessment packet to verify self-reported information was captured accurately. Actions may also include a corrective action plan to address gaps and/or barriers in the agency’s policies and/or procedures, with oversight of the CRHC Board.

**9.0 Data Collection and Client Confidentiality**

**9.1 Management Information System and Data Sharing**

All fully cooperating agencies or agencies using MIHMIS are subject to confidentiality agreements with regard to data sharing and system access or use. Client confidentiality is detailed in the assessment packet and the informed written consent is required on the release of information (ROI). Clients who sign the ROI can choose to revoke their sharing of information at any time by contacting a fully cooperating agency and requesting to opt out of the information sharing agreement. Clients have a right to receive a copy of any information disclosed in the MIHMIS.

If a client contacts an agency and requests to be removed from data sharing, the agency who received the request will first contact the Ingham County HMIS administrator and make him/her aware of the request. The HMIS Administrator will ensure visibility is restricted and confidentiality is updated and will alert the CRHC Continuous Quality Improvement (CQI) Committee Chair of the request.

**10.0 Community Education and Marketing**

The CRHC Board and the designated CE Agency will work with cooperating agencies, CoC membership and partners to identify opportunities for community education and marketing. Access point information will be used to create information that will be posted in service provider agencies, CoC and partner websites, medical facilities, and other supportive service establishments in Ingham County. Ongoing education and announcements through supportive service forums and the memorandums of agreement will be identified and considered as the CE process grows.

CES written policies include and are available to all eligible persons and markets in Ingham County. The CRHC Coordinator and the CE Agency work collaboratively to ensure fair and equal access are available to all eligible persons including different populations and subpopulations within Ingham County.

Additionally, CRHC has established a memorandum of agreement with neighboring Clinton and Eaton counties to assist with the fair and equal access to the CES for shelter and housing. The agreement recognizes that Ingham County serves as a hub community for temporary shelter resources, due to limited shelter in these counties. However, the agreement also ensures that persons seeking permanent housing, based on personal preference, in Eaton or Clinton county, receive case management and housing services from those counties.

The CoC uses the following distribution standards to ensure persons and markets are effectively being reached with accurate CE policies and information:

* Posting CE policies and marketing material to its website,
* Posting CE Agency flyers/brochures at all Access Points
* Sharing CE information with Referral Points,
* Sharing CE policies and marketing material through its established relationship with 211

**11.0 Evaluation**

Measurable outcomes aligning with HUD and CRHC standards and benchmarks will be the baseline for evaluating CE activities as they apply to single individuals, families and youth. The veteran service category has adopted benchmarks for measurement designed by the Veterans Administration. Quarterly evaluations utilizing MIHMIS data points will serve as the baseline for evaluating the CE process. This data is reviewed by the CRHC CQI Committee, which reports trends, changes and recommendations to the CRHC Board.

**12.0 Exhibits**

* Exhibit A – CRHC Acronyms
* Exhibit B - CPD-16-11
* Exhibit C - VI-SPDAT
* Exhibit D - Full SPDAT – Single Adult
* Exhibit E - MSHMIS Screening Assessment
* Exhibit F – CRHC HMIS QSOBAA – Qualified Service Organization Business Associate Agreement
* Exhibit G – CRHC MSHMIS Client Release of Information/Consent Form
* Exhibit H - MOU Sample
* Exhibit I – CRHC Policy Manual – Table of Contents
* Exhibit J – Coordinated Entry Agency Flyer

**2015 Michigan Statewide Homeless Management System (MSHMIS)**

**Operating Policy and Procedure**

The purpose of HMIS is to record and store client-level information about the numbers, characteristics and needs of persons who use homeless housing and supportive services, to produce an unduplicated count of homeless persons for each Continuum of Care; to understand the extent and nature of homelessness locally, regionally and nationally; and to understand patterns of service usage and measure the effectiveness of programs and systems of care. These are the minimum standards of operation, CoCs may elect to include more rigorous standards as agreed upon by their local CoC. **The following operating policies and procedures apply to all designated HMIS Lead Agencies and participating Agencies (Contributing HMIS Organizations – CHOs).**

**PRIVACY STATEMENT**

MSHMIS is committed to make Michigan’s HMIS safe for all types of programs, the clients whose information is recorded, and to maximize the opportunities to improve services through automation.

**Toward that end:**

􀂃 Sharing is a planned activity guided by Sharing Agreements between agencies (QSOBAAs). The agency may elect to keep private some or all of the client record including all identifying data.

􀂃 All organizations will screen for safety issues related to the use of the automation.

MSHMIS has systematized the risk assessment related to clients through the

MSHMIS Release, offered options in terms of the SS#, and provided guidance around

the use of Un-Named Records and how the Privacy Notice is explained..

􀂃 MSHMIS has adopted a Privacy Notice (with minor modifications) that was developed in close collaboration with those providers that manage information that may put a client at risk.

􀂃 The MSHMIS System runs in compliance with HIPAA, and all Federal and State laws and codes. All privacy procedures are designed to insure that the broadest range of providers may participate in the Project.

􀂃 Privacy Training is a requirement for all agencies and users on the MSHMIS system.

We view our Privacy Training as an opportunity for all participating organizations to revisit and improve their overall privacy practice. Many agencies have elected to put all of their staff through the training curricula – not just those with user access to the system.

􀂃 All those issued user access to the system must successfully complete privacy training

and sign a User’s Agreement and Code of Ethics, and agencies must sign a MSHMIS Participation Agreement. Taken together, these documents obligate participants to core privacy procedures. If agencies decide to share information, they must sign an agreement that defines sharing practice and prevents re-release of information (the Sharing QSOBAA).

􀂃 Policies have been developed that protect not only client’s privacy, but also agency’s privacy. Practice Principles around the use and publication of agency or CoC specific data have been developed and included in both the Participation Agreement and the Policies and Procedures.

􀂃 The MSHMIS System allows programs with multiple components/locations that serve the same client to operate on the a single case plan, reducing the amount of staff and client’s time spent in documentation activities and ensuring that care is coordinated and messages to clients are reinforced and consistent.

􀂃 MSHMIS has incorporated Continuous Quality Improvement Training designed to help agency administrators use the information collected in the HMIS to stabilize and improve program processes, measure outcomes, report to their many funders, and be more competitive in funding requests.

**Key Terms and Acronyms:**

|  |  |  |
| --- | --- | --- |
| Term | **Acronym (if used)** | **Brief Definition** |
| Homeless Management Information System | **HMIS** | Data systems that meet HUD requirements and are used throughout the nation to measure homelessness and the effectiveness of related service delivery systems. The HMIS is also the primary reporting tool for HUD homeless service grants as well as other public money’s related to homelessness. |
| Continuum of Care | **CoC** | Planning body charged with guiding the local response to homelessness. |
| Independent Jurisdictions | **IJs** | CoCs that are recognized by HUD usually organized around the higher population counties. Detroit is its own IJ. |
| Balance of State CoCs | **BOS** | MSHDA/MHAAB have organized local planning bodies throughout Michigan that make up the “Balance of State” IJ. These groups are called BOS CoCs as they are organized like Independent Jurisdictions with many of the same rules, however they have no legal status with HUD. |
| Michigan Homeless Assistance Advisory Board | **MHAAB** | The BOS IJ CoC Governance Board. The Statewide HMIS reports to MHAAB – the BOS IJ CoC Planning Group |
| Michigan State Housing Development Authority | **MSHDA** | MSHDA is the grantee for the Statewide HMIS and subcontracts with MCAH for administration of the System. |
| Joint Governance Charter |  | The Agreement between Michigan’s IJ CoCs and MSHMIS that supports a statewide HMIS operating in a single system environment. |
| Contributing HMIS Organizations | **CHO** | An organization that participates on the HMIS. |
| Participation Agreement |  | The Agreement between all participating agencies and MCAH that specifies the rights and responsibilities of MCAH and participating agencies. |
| Administrative Qualified Services Organization Business Associates Agreement | **Admin.**  **QSOBAA** | The Agreement signed by each Agency, local Lead HMIS Agency, MCAH, and MSHDA that governs the privacy standards for all those that can see multiple organization data. |
| Sharing Qualified Services Organization Business Associates Agreement | **Sharing QSOBAA** | The Agreement between agencies that elect to share information using the HMIS. The Agreement prevents the re-release of data and, in combination with the Participation Agreement, defines the rules of sharing. |
| User Agreement & Code of Ethics |  | The document each HMIS User signs agreeing to the HMIS standards of conduct. |
| Release of Information | **ROI** | An electronic ROI must be completed to share any persons data within the HMIS. A signed (paper) ROI giving informed client consent for sharing is also required to share data between agencies. |
| Sharing |  | Sharing refers to the sharing of data between agencies. It does **not** refer to basic entry into the HMIS. Sharing data requires a signed client Release of Information. Basic entry does not require an ROI as there is implied consent for the agency to keep records when a client provides information.. |
| Visibility |  | Refers to the ability to see a client’s data between provider pages on the HMIS. Visibility is configured on the HMIS system in each Provider Page. |
| Visibility Groups |  | Visibility Groups are defined groups of Provider Pages where data is shared. Internal Visibility Groups control internal sharing. External Visibility Groups control sharing with other agencies and are defined with a Sharing QSOBAA. |
| Coverage Rate |  | For MSHMIS - The percent of the Homeless Population that is measured on the HMIS. Coverage estimates are used to project to a total homeless count that includes those served in Domestic Violence Providers or other non-participating Shelters or Outreach Programs. See Coverage Memo for guidance.  HUD also defines Bed Coverage (beds covered on the HMIS) and Service Coverage (person coverage for none residential programs. |
| Program Types |  | **HUD defines 9 basic Program Types** |
|  |  | * ES: Emergency Shelter- Overnight shelters or shelters with a planned length of stay of less than 3 months. * TH: Transitional Housing- Transitional environments with a planned LOS of not more than 2 years and provide supportive services. * PSH: Permanent Supportive Housing- Permanent Housing for the formerly homeless with services attached to persons served under this program. * PH: Permanent Housing- Permanent housing that may be supported by a voucher but does not have services attached to the housing. * RR: Rapid Rehousing- A program that rapidly rehouses those that are identified at Literally Homeless. * HP: Homeless Prevention- A program that helps those are at imminent risk of losing housing, to retain their housing. * SOP: Street Outreach Program- A program that serves homeless persons that are living on the street or other places not meant for habitation. * SSO: Services Only Program- A program that serves only with no residential component. These programs often provide case management and other forms of support and meet with clients in an office, at the household’s home, or in a shelter. * Safe Haven: A program that provides low-demand shelter for hard-to-serve persons with severe disabilities. The clients have often failed in other sheltering environments. |
| Length of Stay | **LOS** | The number of days between the beginning of services and the end of services. It is calculated using entry and exit dates or shelter stay dates. The HMIS offer calculations for discrete stays as well as the total stays across multiple sheltering events. |
| Point in Time Count | **PIT** | An annual count during the last week in January that is required for all CoCs. Every other year, that count also included an “unsheltered”or street count. |
| Housing Inventory Chart | **HIC** | All residential programs (both HMIS and non-participating) must specify the number of beds and units available to homeless persons. The numbers are logged into related Provider Pages where the corresponding person data is recorded (for participating programs). |
| SOAR Across Michigan | **SOAR** | Using the nation “best practice” curriculum, the SOAR project, lead by Department of Community Health, reduces the barriers and supports the application for Social Security Benefits for Michigan’s disabled homeless. |
| Department of Human Services Emergency Services Program | **DHS ESP** | DHS general fund and TANF dollars designated for homeless services primarily sheltering. The dollars are managed through the Salvation Army and require HMIS participation. |
| Homeless Definition |  | **See Homeless Definition Crosswalk.**  **Hearth defines 4 categories of homelessness.** Not all programs can serve all categories and some may utilize a different definition when delivering services. MSHMIS has adopted the HUD definition for counting the homeless.   * Category 1: Literally Homeless * Category 2: Imminent Risk of Homelessness * Category 3: Homeless under other Federal Statute * Category 4: Fleeing/Attempting to Flee DV |
| Projects for Assistance in Transition from Homelessness | **PATH** | PATH is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) administered by the Michigan Department of Community Health. It provides services to mentally ill homeless people, primarily through street outreach, to link them to permanent community housing. This program has different reporting requirements than HUD funded programs and uses HMIS to collect this information. |
| Shelter Plus Care | **S+C** | Lead by the Michigan Department of Community Health, provides Permanent Supportive Housing to disabled persons throughout the State of Michigan and reports to the HMIS. |
| Housing Opportunities for Persons with AIDS | **HOPWA** | Lead by the Michigan Department of Community Health, provides housing assistance and related supportive services for persons with HIV/AIDs and family members who are homeless or at risk of homelessness. This program has different program reporting requirements than the other HUD funded programs in this document. |
| Housing Assessment and Resource Agencies | **HARAs** | Michigan has implemented HARA’s across the state to serve as “single points of entry” for homeless persons. HARAs work with other service providers to insure that access to homeless resources is optimized and based on assessment of need. |

**Policy Disclaimers and Updates**

Operating Procedures defined in this document represent the minimum standards of participation on MSHMIS and general “best practice” operation procedures. Local Lead Agencies in coordination with their CoCs may include additional standards.

Operation Standards in this document are not intended to supersede grant specific requirements and operating procedures as required by funding entities. Path, HOPWA and VA providers have operating rules specific to HHS and VA.

The MSHMIS Operating Policies and Procedures are updated routinely as HUD publishes additional guidance or as part of the annual review. Updates will be reviewed at the Monthly System Administrator Call-In and included the Meeting Minutes distribution email. To allow for evolution of compliance standards without re-issuing core agreements, updated policies supersede related policies in previously published Policies and Procedures or Agreements. Any changes from the previous year will be highlighted. A current copy of the Procedures may also be found on the MSHMIS WEB Site [www.mihomeless.org](http://www.mihomeless.org) .

**Agreements, Certifications, Licenses and Disclaimers:**

1. All CoCs participating on the MSHMIS must sign a **Joint Governance Charter** that designates the use of a the Michigan Statewide HMIS Vendor and identifies the Michigan Coalition Against Homelessness as the Statewide Lead Agency for administration of the statewide database. Each Jurisdiction will also identify a local Lead Agency that coordinates with the Statewide Agency and is responsible for specific tasks. The Charter supports the ability for multiple jurisdictions to participate on a single HMIS information system.
2. All Agencies must have all User Agreements and Training Certifications on file as well as agency related Participation Agreements and documentation?
3. All Agencies must have fully executed and be in compliance with the following Agreements and Policies:
   1. Administrative QSOBAA governing administrative access to the System.
   2. Participation Agreement governing the basic operating principals of the System and rules of membership.
   3. Sharing QSOBAA’s (if applicable) governing the nature of the sharing and the re-release of data.
   4. A board certified Confidentiality Policy governing the over Privacy and Security standards for the Agency.
   5. User Agreement and Code of Ethics governing the individual’s participation in the System.
4. Agencies must have an assigned Agency Administrator. The Agency Administrator maintains files that document:
   1. Workflow and provider page training (and have documentation of training)
   2. All users have signed User Agreements/Code of Ethics documents on file
   3. All Users have refreshed Privacy Training since moving to ServicePoint 5.x (June 2011 or later) and Privacy Training is refreshed thereafter annually. Successful completion of the Certification Questionnaire is required for Privacy Training.
   4. All users have completed workflow training and related updates and have documentation of training. Further, Agencies must have users certified by completing the associated Certification Questionnaire and returning it to MCAH.
   5. Reports Training (agency users and leadership are tasked with supporting data quality as well as monitoring outcome and other performance issues).

**Privacy and Security Plan:**

**All records entered into the HMIS and downloaded from the HMIS are required to be kept in a confidential and secure manner.**

**Oversight:**

1. All Agency Administrators with support of agency Leadership must[[5]](#footnote-5):
   1. Insure that all staff using the System complete annual privacy & security training. Training must be provided by MSHMIS Certified Trainers and based on the MSHMIS Privacy/Security Training Curriculums.
   2. Conducts quarterly review of their Providers Visibility insuring that it properly reflects any signed Sharing QSOBAAs, their adapted Release of Information, and the Script used to explain privacy to all clients.
   3. Insure the removal licenses to the HMIS when a staff person leaves the organization or revision of the user’s access level as job responsibilities change.
   4. Report any security or privacy incidents to the local Lead HMIS System Administrator for the CoC Jurisdiction. The System Administrator investigates the incident including running applicable audit reports. If the System Administrator and Security Officer determine that a breach has occurred and/or the staff involved violated privacy or security guidelines, the System Administrator will report to the chair of the CoC. A Corrective Action Plan will be implemented. Components of the Plan must include at minimum supervision and retraining. It may also include removal of HMIS license, client notification if a breach has occurred, and any appropriate legal action.
2. Criminal background checks must be completed on all Local System Administrators by the Lead Agency that employs the local SA. All agencies should be aware of the risks associated with any person given access to the System and limit access as necessary. System Access levels should be used to support this activity.
3. The HMIS Lead Agency conducts routine audits of participating agencies to insure compliance with the Operating Policies and Procedures. The audit will include a mix of system and on-site reviews. The Lead Agency document the inspection and recommendations.

**Privacy:**

1. All Agencies are required to have the **HUD Public Notice** posted and visible to clients where information is collected. See Appendix A for link to the Notice.
2. All Agencies must have a **Privacy Notice**. They may adopt the MSHMIS sample notice or integrate MSHMIS into their existing Notice. See Appendix A for a link to the sample Notice with required sections highlighted. All Privacy Notices must define the uses and disclosures of data collected on HMIS including:
   1. The purpose for collection of client information.
   2. A brief description of policies & procedures governing privacy including protections for vulnerable populations.
   3. Data collection, use and purpose limitations. The Uses of Data must include de-identified data.
   4. The client right to copy/inspect/correct their record. Agencies may establish reasonable norms for the time and cost related to producing any copy from the record. The agency may say “no” to a request to correct information, but the agency must inform the client of its reasons in writing within 60 days of the request.[[6]](#footnote-6)
   5. The client complaint procedure
   6. Notice to the consumer that the Privacy Notice may be updated overtime and applies to all client information held by the Agency.
3. All Notices must be posted on the Agencies WEB Site.

1. All Agencies are required to have a **Privacy Policy**. Agencies may elect to use the Sample Privacy Policy provided by MSHMIS. See Appendix A for link. All Privacy Policies must include:
   1. Procedures defined in the Agencies Privacy Notice
   2. Protections afforded those with increased privacy risks such as protections for victims of domestic violence, dating violence, sexual assault, and stalking. Protection include at minimum:
      1. Closing of the profile search screen so that only the serving agency may see the record.
      2. The right to refuse sharing if the agency has established an external sharing plan.
      3. The right to be entered under an Un-Named Record Protocol where identifying information is not recorded in the System and the record is located through a randomly generated number (note: this interface does allow for unduplication because the components of the Unique Client Id are generated)
      4. The right to have a record marked as inactive.
      5. The right to remove their record from the System.
   3. Security of hard copy files: Agencies may create a paper record by printing the Assessment screens located within the HMIS. These records must be kept in accordance with the procedures that govern all hard copy information (see below).
   4. Client Information Storage and Disposal: Users may not store information from the System on personal portable storage devises. The Agency will retain the client record for a period of **7** years, after which time the forms will be discarded in a manner that ensures client confidentiality is not compromised.
   5. Remote Access and Usage: The Agency must establish a policy that governs use of the System when access is approved from remote locations. The policy must address:
      1. The use of portable storage devises with client identifying information is strictly controlled.
      2. The environments where use is approved are not open to public access and all paper and electronic records that include client identified information are secured in locked spaces or are password controlled.
      3. All browsers used to connect to the System must be secure. **No user is allowed to access the database from a public or none-secured private network such as an airport, hotel, library, or internet café.**
      4. All computers accessing the System are owned by the agency.
2. Agencies must protect **hard copy data** that includes client identifying information from unauthorized viewing or access?
   1. Client files are locked in a drawer/file cabinet
   2. Offices that contain files are locked when not occupied.
   3. Files are not left visible for unauthorized individuals.
3. Agency provides a **Privacy Script** to all staff charged with explaining privacy to standardize the explanation of agency privacy rules.
   1. The Script must be d eveloped by the Agency Leadership to reflect the agencies sharing agreements and the level of risk associated with the type of data the Agency collects and shares.
   2. The Script should be appropriate to the general education / literacy level / language of the Agencies clients.
   3. A copy of the Script should be available to clients as they complete the intake interview.
4. Agencies that plan to share information through the System must sign a **Sharing QSOBAA** (Qualified Services Organization Business Associates Agreement).
   1. The Agreement proscribes the re-release of information shared under the terms of the Agreement.
   2. The Agreement specifies what is shared with whom.
   3. Agencies may share different thing with different partners and may sign multiple Sharing QSOBAAs to define the layered practice.
   4. The signatories on the Agreement include authorized representatives from all Agencies covered by the Agreement.
   5. All members of the existing Sharing QSOBAA are informed that, by sharing the electronic record they are creating a common record that can impact the data reflected on Reports. Members of the sharing group agree to negotiate data conflicts. The data quality of the agency applying for membership should be considered in the decision.
   6. No Agency may be added to the Agreement without the approval of all other participating agencies.
      1. Documentation of that approval must be available for review and may include such items as meeting minutes, email response or other written documentation.
   7. When a new member is added to the Sharing QSOBAA, the related Visibility Group is end-dated and a new Visibility Group is begun**. A new member may not be added to an existing Visibility Group.**
5. Agencies must have appropriate **Release(s) of Information** that are consistent with the type of data the agency plans to share.
   1. The Agency has adopted the MSHMIS basic Release of Information appropriate to their sharing practice to share basic demographic and transaction information.
   2. If the Agency integrates the MSHMIS Release into their existing Releases, the Release must include the following components:
      1. A brief description of MSHMIS including a summary of the HUD Public Notice.
      2. A specific description of the Client Profile Search Screen and an opportunity for the client to request that the Screen be closed.
      3. A description of the Agencies sharing partners (if any) and a description of what is share, and must reflect items negotiated in the Agencies Sharing QSOBAA.
      4. A defined term of the Agreement[[7]](#footnote-7).
      5. Inter-Agency sharing must be accompanied by the negotiation of a Sharing QSOBAA.
   3. A HIPAA compliant **Authorization to Release Confidential Information** is also required if the planned sharing includes any of the following:
      1. Progress Notes
      2. Information or referral for health, mental health, HIV/AIDs, substance abuse, or domestic violence.
      3. To streamline paper, the basic HMIS Release may be adapted to include the language necessary for a HIPAA compliant release if sharing practice is likely to include the items above in ii.[[8]](#footnote-8)
6. An **automated ROI** is required to enable the sharing of any particular client’s information between any Provider Pages on the System.
   * 1. Agencies should establish internal sharing by creating a Visibility Group(s) that includes all Agency provider pages where sharing is planned and allowed by law.
        1. **Internal sharing** does not require a Client Release of Information unless otherwise specified by law.
        2. If new provider pages are added to the Agency tree, they may be included in the existing Visibility Group. The information available to that Provider Page will include all information covered by the Visibility Group from the beginning date of the Group – sharing will be retrospective.
     2. Agencies may elect to share information with other Agencies – **External Sharing** - by negotiating a Sharing QSOBAA (see 7 above).
        1. A signed and dated Client Release of Information(s) must be stored in the Client Record (paper or scanned onto the System) for all Automated ROIs that release data between different agencies – external sharing.
        2. To prevent retrospective sharing, a new Visibility Group is constructed whenever a new sharing partner is added to the agencies existing sharing plan / QSOBAA.
7. The Agency must have a procedure to assist clients that are hearing impaired or do not speak English as a primary language. For example:
   1. Provisions for Braille or audio
   2. Available in multiple languages
   3. Available in large print
8. **Agencies are required to maintain a culture that supports privacy**.
   1. Staff do not discuss client information in the presence of others without a need to know.
   2. Staff eliminate unique client identifiers before releasing data to the public
   3. The Agency configures workspaces for intake that supports privacy of client interaction and data entry
   4. User accounts and passwords are not shared between users, or visible for others to see
   5. Program staff are educated to not save reports with client identifying data on portable media as evidenced through written training procedures or meeting minutes.
   6. Staff are trained regarding use of email communication.
9. All staff using the System must complete Privacy and Security Training annually. Certificates documenting completion of training must be stored for review upon audit.
10. Victim Service Providers are precluded from entering client level data on the HMIS or providing client identified data to the HMIS. These providers will maintain a comparable database to respond to grant contracts.

**Data Security:**

1. All licensed Users of the System must be assigned **Access Levels** that are consistent with their job responsibilities and their business “need to know”.
2. All computers have **virus protection with automatic updates**.
   1. Agency Administrators or designated staff are responsible for monitoring all computers that connect to the HMIS to insure:
      1. The Anti-Virus Software is using the up-to-date virus database.
      2. That updates are automatic.
      3. OS Updates are also run regularly.
3. All computers are protected by a Firewall.
   1. Agency Administrators or designated staff are responsible for monitoring all computers that connect to the HMIS to insure:
      1. For Single Computers, the Software and Version is current.
      2. For Network Computers, the Firewall Model and Version is current.
      3. That updates are automatic.
4. Physical access to computers that connect to the HMIS is controlled.
   1. All workstations in secured locations (locked offices).
   2. Workstations are logged off when not manned.
   3. All workstations are password protected.
   4. **All HMIS Users are proscribed from using a computer that is available to the public or from access the System from a public location through an internet connect that is not secured.** That is staff are not allowed to use Internet Cafes, Libraries, Airport Wifi or other non-secure internet connections.
5. A plan for remote access if staff will be using the MSHMIS System outside of the office such as doing entry from home. Concerns addressed in this plan should include the privacy surrounding the off-site entry.
   1. The computer and environment of entry must meet all the standards defined above.
   2. Downloads from the computer may not include client identifying information.
   3. Staff must use an agency-owned computer.
   4. System access settings should reflect the job responsibilities of the person using the System. Certain Access levels do not allow for downloads.

Remember that your information security is never better than the trustworthiness of the staff you license to use the System. The data at risk is your own and that of your sharing partners. If an accidental or purposeful breach occurs, you are required to notify MCAH. A full accounting of access to the record can be completed.

Disaster Recovery Plan:

The HMIS can be a critically important tool in the response to catastrophic events. The HMIS data is housed in a secure server bank in Shreveport, LA with nightly off-site backup. The solution means that data is immediately available via Internet connection if the catastrophe is in Michigan and can be restored within 4 hours if the catastrophe is in Louisiana.

1. HMIS Data System (see “Bowman Systems Securing Client Data” for a detailed description of data security and Bowman’s Disaster Response Plan):
   1. MSHMIS is required to maintain the highest level disaster recovery service by contracting with Bowman Systems for Premium Disaster Recovery that includes:
      1. Off site, out-of state, on a different Internet provider and on a separate electrical grid backups of the application server via a secured Virtual Private Network (VPN) connection.
      2. Near-Instantaneous backups of application site (no files older than 5 minutes)
      3. Nightly off site replication of database in case of a primary data center failure.
      4. Priority level response (ensures downtime will not exceed 4 hours).
2. HMIS Lead Agencies:
   1. HMIS Lead Agencies are required to back-up internal management data system’s nightly.
   2. Data back-ups will include a solution for off-site storage for internal data systems.
3. Communication between staff of the Lead Agency, the CoC, and the Agencies in the event of a disaster is a shared responsibility and will be based on location and type of disaster.
   1. Agency Emergency Protocols must include:
      1. Emergency contact information including the names / organizations and numbers of local responders and key internal organization staff., designated representative of the CoCs, local HMIS Lead Agency, and the MSHMIS Project Director.
      2. Persons responsible for notification and the timeline of notification.
   2. In the event of System Failure:
      1. The MSHMIS Project Director or designee will notify all participating CoCs and local System Administrators should a disaster occur at Bowman System’s or in the MSHMIS Administrative Offices. Notification will include a description of the recovery plan related time lines. Local/assigned System Administrators are responsible for notifying Agencies.
      2. After business hours, MSHMIS staff report System Failures to Bowman System using the Emergency Contact protocol. An email is also launched to local System Administrators and Emergency Shelter designated staff no later than one hour following identification of the failure.
   3. MSHMIS Project Director or designated staff will notify the HMIS Vendor if additional database services are required.
4. In the event of a local disaster:
   1. MSHMIS in partnership with the local Lead Agency will provide access to additional hardware and user licenses to allow the CHO(s) to reconnect to the database as soon as possible.
   2. MSHMIS in collaboration with the local Lead Agencies will also provide information to local responders as required by law and within best practice guidelines.
   3. MSHMIS in collaboration with the local Lead Agencies will also provide access to organizations charged with crisis response within the privacy guidelines of the system and as allowed by law.

**System Administration and Data Quality Plan:**

1. **Provider Page Set-Up:**
   1. Provider Page are appropriately named per the MSHMIS naming standards **<agency name>, <location>, <program>, <project/funding>.** Example: “The Salvation Army, Delta, Hotel Voucher Program, ESG, ESP”. Identification of funding stream is critical to completing required reporting to funding organization.
   2. Inactive Provider Pages are properly identified with “XXX Closed”> followed by the year of the last program exit >Provider Page Name.[[9]](#footnote-9)
   3. HUD Data Standards are fully completed on all Provider Pages:
      1. CoC code is correctly set
      2. Program type codes are correctly set
      3. Geocodes are set correctly
      4. Bed and Unit Inventories are set for applicable residential programs.
   4. All Agency Administrators and System Administrators must complete Provider Page Training. Set-up instruction is offered for System 5 by Funding Stream / Program type.
2. **Data Quality Plan:**
   1. Agencies must require documentation at intake of the homeless status of consumers according to the reporting and eligibility guidelines issued by HUD. The “order of priority” for obtaining evidence of homeless status are (1) third party documentation, (2) worker observations, and certification from the person. Lack of third party documentation may not be used to refuse emergency shelter, outreach or domestic violence services. Local CoCs may designate the local HARA’s to establish the homeless designation and maintain related documentation.
   2. 100% of the clients must be entered into the System within 15 days of data collection. If the information is not entered on the same day it is collected, the agency must assure that the date associated with the information is the date on which the data was collected by:
      * 1. Entering the entry/exit data including the UDEs on the Entry/Exit Tab of ServicePoint or
        2. Backdating the information into the System[[10]](#footnote-10)
   3. All staff are required to be trained on the definition of Homelessness.[[11]](#footnote-11)
      1. MSHMIS providers a Homeless Definition Cross-Walk to support agency level training.
      2. Documentation of training must be available for audit.
      3. There is congruity between the following MSHMIS case record responses, based on the applicable homeless definition: (Housing Status and Residence Prior to Project Entry are being properly completed).
   4. Agency has a process to ensure the First and Last Names are spelled properly and the DOB is accurate.
      1. An ID is requested at intake to support proper spelling of the clients name as well as the recording of the DOB.
      2. If no ID is available, staff request the legal spelling of the person’s name. **Staff should not assume they know the spelling of the name.**
      3. Programs that serve the chronic and higher risk populations are encouraged to use the Scan Card process within ServicePoint to improve un-duplication and to improve the efficiency of recording services.
      4. Data for clients with significant privacy needs may be entered under the “Un-Named Record” feature of the System. However, while identifiers are not stored using this feature, great care should be taken in creating the Un-Named Algorithm by carefully entering the first and last name and the DOB. Names and ServicePoint Id #s Cross-Walks (that are required to find the record again) must be maintained off-line in a secure location.
   5. Income and non-cash benefits are being updated at least annually and at exit.
      1. For PH Projects, incomes over two years old must be updated by closing the existing income and entering a new income record even if the income has not changed. This assures that the Income has been reconfirmed.
      2. For all other Project Types, incomes should be closed at exit unless the client is transferring within your agency or you are referring the client to a sharing partner.[[12]](#footnote-12)
   6. Agencies have an organized exit process. Discharge Destination has been changed to a required element in the 2015 update.
      1. Projects must have a defined process for collecting destination information on as many clients as possible.
      2. Clients and staff must be educated on the importance of planning and communicating regarding discharge. This is evidenced through staff meeting minutes or other training logs and records.
      3. There is a procedure for communicating exit information to the person responsible for data entry if not entering real time.
      4. Discharge Destinations are properly mapped to the HUD Destination Categories.
         1. MSHMIS provides a Destination Definition Document to support proper completion of exits (see Appendix A for link. All new staff must have training on this document.[[13]](#footnote-13)
   7. Agency Administrator/Staff regularly run data quality reports.
      1. Report frequency should reflect the volume of data entered into the System. Frequency for funded programs will be governed by Grant Agreements, HUD reporting cycles, and local CoC Standards. However, higher volume programs such as shelters and services only programs must review and correct data at least monthly. Lower volume programs such as Transitional and Permanent Housing must run following all intakes and exits and quarterly to monitor the recording of services and other required data elements including annual updates of income and employment. [[14]](#footnote-14)
      2. The program entry and exit dates should be recorded upon program entry or exit of all participants. Entry dates should record the first day of service or program entry with a new program entry date for each period/episode of service. Exit dates should record the last day of residence before the participant leaves the shelter/housing program or the last day a service was provided.
      3. Data quality screening and correction activities must include the following:
         1. Missing or inaccurate information in (red) Universal Data Element Fields.
            1. The Relationship to Head of Household assessment questions is completed.
            2. The Client Location question is completed.
            3. Time on Streets in Shelter or Safe Haven is completed including the revised 2015 Homeless History Chronic question series is properly completed.
         2. All program specific required field are completed. Of special interest:
            1. The status of Domestic Violence flight is completed (new question)
            2. HUD Verifications are completed on all Income, Non Cash Benefits, Insurance and Disability sub-assessments are completed.
            3. The Residential-in-date is completed for all PH – RRH programs.
         3. Un-exited clients using the Length of Stay and Un-exited Client Data Quality Reports.
         4. Provider Page Completion Reports with an Annual update of the HUD DATA Standard Elements.
            1. The Federal Partner Funding Source is completed with “NA” if no source or the name of the Federal Partner and the Grant Number.
            2. New CoC sub-assessment is completed and aged-out pages are identified via page naming and CoC code convention.
            3. The primary provider contact information reflects where the services are being delivered.
   8. CoCs and Agencies are required to review Outcome Performance Reports defined by HUD and other funding organizations. Measures are adjusted by Program Type. The CoC Lead Agency, in collaboration with the CoC Reports Committee or other designated CQI Committee, establishes local benchmark targets for performance improvement on shared measures. See Appendix A for links and “Setting Targets” training podcast.[[15]](#footnote-15)
   9. MSHMIS publishes regional benchmarks on all defined measures annually (see Appendix A).
   10. Agencies are expected to participate in the CoCs Continuous Quality Improvement Plan. See CQI materials designed to support Data Quality through Continuous Quality Improvement (see Appendix A).
3. **Workflow Requirements:**
   1. Assessments set in the Provider Page Configuration are appropriate for the funding stream.
   2. Users performing data entry have latest copies of the workflow guidance documents.
   3. If using paper, the intake data collection forms correctly align with the workflow.
   4. 100% of client information are entered into the system within 15 days of collection from the client.
   5. Agencies are actively monitoring program participation and exiting clients. Clients are exited within 30 days of last contact unless program guidelines specify otherwise.
   6. All required program information is being collected. [[16]](#footnote-16)
      1. All HMIS participants are required to enter at minimum the Universal Data Elements and if completing entry and exits, the Michigan Basic Exit Form.
      2. Programs that serve over time are required to complete additional program elements as defined by the funding stream. If the Agency is not reporting to a funding stream, they are encouraged to use the Michigan Basic Entry and Exit forms.
   7. Data sharing is properly configured for sharing information internally between programs, including use of visibility groups.
   8. External data sharing aligns with any Sharing QSOBAA’s including use of visibility groups
   9. Visibility groups are managed appropriately (see Privacy 9).
4. **Electronic Data Exchanges:**
   1. Agencies electing to either import or export data from the MSHMIS must assure:
      1. The quality of data being loaded onto the System meets all the data quality standards listed in this policy including timeliness, completeness, and accuracy. In all cases, the importing organization must be able to successfully generate all required reports including but not limited to the APR and the Michigan Basic Counting Report.
      2. Agencies exporting data from MSHMIS must certify the privacy and security rights promised participants on the HMIS are met on the destination System. If the destination System operates under less restrictive rules, the client must be fully informed and approve the transfer during the intake process. The agency must have the ability to restrict transfers to those clients that approve the exchange.
   2. MSHDA/ MCAH or your local CoC may elect to participate in de-identified research data sets to support research and planning.
      1. De-identification will involve the masking or removal of all identifying or potential identifying information such as the name, Unique Client ID, SS#, DOB, address, agency name, and agency location.
      2. Geographic analysis will be restricted to prevent any data pools that are small enough to inadvertently identify a client by other characteristics or combination of characteristics.
      3. Programs used to match and/or remove identifying information will not allow a re-identification process to occur. If retention of identifying information is maintained by a “trusted party” to allow for updates of an otherwise de-identified data set, the organization/person charged with retaining that data set will certify that they meet medical/behavior health security standards and that all identifiers are kept strictly confidential and separate from the de-identified data set.
      4. CoCs will be provided a description of each Study being implemented. Agencies may opt out of the Study through a written notice to MCHA or the Study Owner.
   3. MSHDA/ MCAH or your local CoC may elect to participate in identified research data sets to support research and planning.
      1. All identified research must be governed through an Institutional Research Board including requirements for client informed consent.
      2. CoCs will be provided a description of each Study being implemented. Agencies may opt out of the Study through a written notice to MCHA or the Study Owner.
5. **Staff Training and Required Meetings. See the Michigan Training Certification Site Guide[[17]](#footnote-17) in Links attached.**
   1. All Users are recertified in Privacy Training Annually.
   2. All Users participate in Workflow Training and Training Updates for their assigned Workflows.
   3. All Users are trained in Data Standard data element definitions.
   4. **All Agency Administrators participate in:**
      1. Provider Page Set-Up Training
      2. Workflow Training sponsored by the funding agency or MSHMIS
      3. Reports Training
         1. Data Quality
         2. Progress Reporting
         3. Outcome Reporting
      4. Other training specified by the CoC.
      5. **CoC Agency Administrator Meetings and Trainings**
      6. **Agency specific User Meetings or preside over an HMIS specific topic during routine staff meetings.**
      7. **A local Reports Committee that governs the publication of information as requested.**
   5. **All System Administrators participate in:**
      1. All System Administrators are required to read and understand the HUD Data Standards that underpin the rules of the HMIS.
      2. System Administrator Orientation
      3. Provider Page Set-Up Training
      4. Workflow Training sponsored by the funding agency or MSHMIS
      5. Reports Training
         1. Data Quality
         2. Progress Reporting
         3. Outcome Reporting
      6. CQI Training
      7. HUD Initiative Training (AHAR, PIT, APR, etc.)
      8. On Site and System Audits of Agency compliance of Date Privacy, Security and Oversight standards as well as item1 through 4 under System Administration and Data Quality.
      9. **The Monthly System Administrator Call-In (3rd Wednesday of every Month at 1pm).**
      10. **The CoC Reports Committee or CoC Meeting where data use and release is discussed.**
      11. **Michigan’s Campaign to End Homelessness Work Groups and Regional Meetings as assigned.**

**Appendix A: Links to Documents referred to in this Policy**

<http://mihomeless.org/index.php/user-resources/hmis-training-certification/downloads/2014-01-07-21-22-49/viewcategory/235-5-hud-definitional-files>

* HUD Data Standards 2015
* HUD Data Dictionary 2015
* 2015 HUD Data Standard Changes
* HMIS Requirements Proposed Rules Federal Registered (Hearth)
* MSHMIS Homeless Definition Crosswalk
* HUD Homeless Definition Matrix
* Discharge Destination Guidance

<http://mihomeless.org/index.php/user-resources/hmis-training-certification/downloads/contracts-agreements-policies>

* Participation Agreement
* Administration QSOBAA
* Sharing QSBAA
* HMIS Operating Policies and Procedures
* Joint Governance Charter

<https://vimeo.com/mcah/review/112953319/799d7bfa50>

* Privacy and Security Recorded Training (Training/Quiz found in certification site)

<http://mihomeless.org/index.php/2012-11-28-14-24-30/programs/hmis/hmis-training/viewcategory/194-privacy-training-documents>

* HUD Public Notice
* User Agreement and Code of Ethics
* Privacy Script Suggestions
* Privacy Workflow

<http://mihomeless.org/index.php/2012-11-28-14-24-30/programs/hmis/hmis-training/viewcategory/432-privacy-notices-scripts-and-rois>

* Privacy Notice Sample (Grayed Sections Required) Updated
* MSHMIS Release of Information
* HIPAA compliant Authorization to Release Confidential Information
* Translated Notice for Spanish and Arabic

<http://mihomeless.org/index.php/user-resources/hmis-training-certification/downloads/continuous-quality-improvement-cqi/viewcategory/64-continuous-quality-improvement-cqi>

* CQI Curriculums
* Outcomes Matrix (Michigan State)
* Various Outcomes Training Documents and Pod Casts
* CQI Products from Implementations

<http://mihomeless.org/index.php/2012-11-28-14-24-30/programs/hmis/hmis-training/viewcategory/144-self-sufficiency-matrix>

* Self Sufficiency Matrix Training Materials

<http://mihomeless.org/index.php/workflow-and-addenda-downloads/viewcategory/261-3-workflows-and-grant-specific-documents>

* All technical workflow and training documents and podcasts

<http://mihomeless.org/index.php/user-resources/hmis-training-certification/downloads/system-admin-meetings>

* Minutes from Required System Administrator Meetings (current year/recent)

Last Edit: December 2018 to reflect name change

Exhibit A

Capital Region Housing Collaborative

**CRHC Acronym List**

**FREQUENTLY HEARD ACRONYMS**

**AMI Area Median Income**

**CDBG Community Development Block Grant (from HUD)**

**DHHS Department of Health and Human Services**

**ESG Emergency Solutions Grant (City of Lansing, MSHDA)**

**FEMA Federal Emergency Management Agency**

**HARP Housing Assistance Recovery Program (MSHDA) housing vouchers**

**HEARTH Act Homeless Emergency Assistance and Rapid Transition to Housing Act**

**HOME HOME Investment Partnerships Program**

**HMIS Homeless Management Information System**

**HPRP Homeless Prevention and Rapid re-housing Program**

**HQS Housing Quality Standards**

**HUD U.S. Department of Housing and Urban Development**

**IDT Inter-Disciplinary Team**

**IST Interagency Service Team**

**MSHDA Michigan State Housing Development Authority**

**NOFA Notice of Funding Availability**

**PHA Public Housing Authority**

**PSH Permanent Supportive Housing Programs**

**RFP Request for Proposal**

**RRH Rapid Re-Housing**

**SAMHSA Substance Abuse and Mental Health Services Administration**

**SER State Emergency Relief (from DHHS)**

**SHP Supportive Housing Program**

**SOAR SSI/SSDI Outreach, Access, and Recovery training for service providers**

**SSI Supplemental Security Income Program**

**TANF Temporary Assistance for Needy Families**

**TBRA Tenant-Based Rental Assistance**

**TH Transitional Housing**

**USDA U.S. Department of Agriculture**

**VA U. S. Department of Veteran's Affairs**

**VISTA Volunteers in Service to America**

**WIC Women, Infants and Children**

**AGENCY/GROUP ACRONYMS**

**AH Advent House Ministries**

**BSS Ballentine Stepping Stones**

**CACS Capital Area Community Services**

**CADL Capital Area District Library**

**CAUW Capital Area United Way**

**CFC Child and Family Charities**

**CMH Community Mental Health**

**CoC Continuum of Care**

**CoL City of Lansing**

**CRHC Capital Region Housing Collaborative**

**CRM City Rescue Mission**

**DHHS Department of Health and Human Services**

**EVE End Violent Encounters**

**GLHRN/Network Greater Lansing Homeless Resolution Network *(now CRHC)***

**HARA Housing Assessment and Resource Agency**

**HRCS Human Relations and Community Services (at the City of Lansing)**

**JIMHO Justice in Mental Health Organization**

**L & F Loaves and Fishes Ministries**

**LAAN Lansing Area AIDS Network**

**LHC Lansing Housing Commission**

**LSD Lansing School District**

**LSSCM Legal Services of South Central Michigan**

**MPRI Michigan Prisoner Re-entry Initiative**

**MMRS Mid-Michigan Recovery Services (*formerly NCA/LRA)***

**NCA/LRA National Council on Alcoholism/Lansing Regional Area *(now MMRS)***

**PND Planning and Neighborhood Development (at the city of Lansing)**

**SA The Salvation Army**

**VOA Volunteers of America**

**STVCC St. Vincent Catholic Charities**

**TCOA Tri-County Office on Aging**

**FEDERAL GOVERNMENT ACRONYMS (That may be of interest)**

**ACF Administration for Children and Families**

**ACYF Administration on Children Youth and Families**

**ADA Americans With Disabilities Act of 1990**

**CMHS Center for Mental Health Services**

**CSAP Center for Substance Abuse Prevention**

**CSAT Center for Substance Abuse Treatment**

**FBCI Faith-Based and Community Initiatives**

**FOIA Freedom of Information Act**

**GAO General Accounting Office**

**GIS Geographic Information Systems**

**GNIS Geographic Names Information System**

**HAB HIV/AIDS Bureau**

**HHS U.S. Department of Health and Human Services**

**HRSA Health Resources and Services Administration**

**HSB Head Start Bureau**

**INS Immigration and Naturalization Service**

**MCHB Maternal and Child Health Bureau**

**MedPAC Medicare Payment Advisory Commission**

**NCCC National Civilian Community Corps (AmeriCorps)**

**NIH National Institutes of Health**

**NIMH National Institute of Mental Health**

**OMHAR Office of Multifamily Housing Assistance Restructuring**

**OPHS Office of Public Health and Science**

**PHA Public Housing Agency**

**PHPS Public Health Prevention Service**

**PHS Public Health Service**

**SSA Social Security Administration**

**For More Information:**

**Abbreviations and Acronyms of the U.S. Government**

[**http://www.ulib.iupui.edu/subjectareas/gov/docs\_abbrev.html**](http://www.ulib.iupui.edu/subjectareas/gov/docs_abbrev.html)

**Federal Government Resources Executive Branch**

[**http://www.lib.umich.edu/govdocs/fedexec.html#acronyms**](http://www.lib.umich.edu/govdocs/fedexec.html#acronyms)

Exhibit B

U.S. Department of Housing and Urban Development Office of Community Planning and Development

1

**Special Attention of:** All Secretary's Representatives

# Issued:

All Regional Directors for CPD

# Expires:

All CPD Division Directors Continuums of Care (CoC)

Recipients of the Continuum of Care (CoC) Program

# Notice: CPD-16-11 Issued: July 25, 2016

**Expires:** This Notice is effective until it is amended, superseded, or rescinded

**Cross Reference:** 24 CFR Parts 578 and 42 U.S.C. 11381, *et seq.*

# Subject: Notice on Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing

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# Purpose

This Notice supersedes Notice CPD-14-012 and provides guidance to Continuums of Care (CoC) and recipients of Continuum of Care (CoC) Program (24 CFR part 578) funding for permanent supportive housing (PSH) regarding the order in which eligible households should be served in **all** CoC Program-funded PSH. This Notice reflects the new definition of chronically homeless as defined in CoC Program interim rule as amended by the Final Rule on Defining “Chronically Homeless” (herein referred to as the Definition of Chronically Homeless final rule) and updates the orders of priority that were established under the prior Notice. CoCs that previously adopted the orders of priority established in Notice CPD-14-012, which this Notice supersedes, and who received points for having done so in the FY2015 CoC Program Competition are encouraged to update their written standards to reflect the updates to the orders of priority as established in this Notice. CoCs that have not previously adopted the orders of priority established in Notice CPD- 14-012 are also encouraged to incorporate the orders of priority included in this Notice into their written standards

# Background

In June 2010, the Obama Administration released *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness* (*Opening Doors*), in which HUD and its federal partners set goals to end Veteran and chronic homelessness by 2015, and end family and youth homelessness by 2020. Although progress has been made there is still a long way to go. In 2015, the United States Interagency Council on Homelessness extended the goal timeline for achieving the goal of ending chronic homelessness nationally from 2015 to 2017. In 2015, there were still 83,170 individuals and 13,105 persons in families with children that were identified as chronically homeless in the United States. To end chronic homelessness, it is critical that CoCs ensure that limited resources awarded through the CoC Program Competition are being used in the most effective manner and that households that are most in need of assistance are being prioritized.

Since 2005, HUD has encouraged CoCs to create new PSH dedicated for use by persons experiencing chronic homelessness (herein referred to as dedicated PSH). As a result, the number of dedicated PSH beds funded through the CoC Program for persons experiencing chronic homelessness has increased from 24,760 in 2007 to 59,329 in 2015. This increase has contributed to a 30.6 percent decrease in the number of chronically homeless persons reported in the Point-in-Time Count between 2007 and 2015. Despite the overall increase in the number of dedicated PSH beds, this only represents 31.6 percent of all CoC Program- funded PSH beds.

To ensure that all PSH beds funded through the CoC Program are used as strategically and effectively as possible, PSH needs to be targeted to serve persons with the highest needs and greatest barriers towards obtaining and maintaining housing on their own–persons experiencing chronic homelessness. HUD’s experience has shown that many communities and recipients of CoC Program-funded PSH continue to serve persons on a “first-come, first- serve” basis or based on tenant selection processes that screen-in those who are most likely to succeed while screening out those with the highest level of need. These approaches to tenant selection have not been effective in reducing chronic homelessness, despite the increase in the number of PSH beds nationally.

# Goals of this Notice

The overarching goal of this Notice is to ensure that those individuals and families who have spent the longest time in places not meant for human habitation, in emergency shelters, or in safe havens and who have the most severe service needs within a community are prioritized for PSH. By ensuring that persons with the longest histories of homelessness and most severe service needs are prioritized for PSH, progress towards the Obama Administration’s goal of ending chronic homelessness will increase. In order to guide CoCs in ensuring that all CoC Program- funded PSH beds are used most effectively, this Notice revises the orders of priority related to how persons should be selected for PSH as previously established in Notice CPD-14-012 to reflect the changes to the definition of chronically homeless as defined in the Definition of Chronically Homeless final rule. CoCs are strongly encouraged to adopt and incorporate them into the CoC’s written standards and coordinated entry process.

HUD seeks to achieve two goals through this Notice:

* 1. Establish a recommended order of priority for dedicated and prioritized PSH which CoCs are encouraged to adopt in order to ensure that those persons with the longest histories residing in places not meant for human habitation, in emergency shelters, and in safe havens and with the most severe service needs are given first priority.
  2. Establish a recommended order of priority for PSH that is not dedicated or prioritized for chronic homelessness in order to ensure that those persons who do not yet meet the definition of chronic homelessness but have the longest histories of homelessness and the most severe service needs, and are therefore the most at risk of becoming chronically homeless, are prioritized.

# Applicability

The guidance in this Notice is provided to all CoCs and all recipients and subrecipients of CoC Program funds–the latter two groups referred to collectively as recipients of CoC Program- funded PSH. CoCs are strongly encouraged to incorporate the order of priority described in this Notice into their written standards, which CoCs are required to develop per 24 CFR 578.7(a)(9), for their CoC Program-funded PSH. Recipients of CoC Program funds are required to follow the written standards for prioritizing assistance established by the CoC (see 24 CFR 578.23(c)(10)); therefore, if the CoC adopts these recommended orders of priority for their PSH, all recipients of CoC Program-funded PSH will be required to follow them as required by their grant agreement. CoCs that adopted the orders of priority established in Notice CPD-14-012, which this Notice supersedes, and who received points for having done so in the most recent CoC Program Competition are strongly encouraged to update their written standards to reflect the updates to the orders of priority as established in this Notice. Lastly, where a CoC has chosen to not adopt HUD’s recommended orders of priority into their written standards, recipients of CoC Program- funded PSH are encouraged to follow these standards for selecting participants into their programs as long as it is not inconsistent with the CoC’s written standards.

# Key Terms

* 1. **Housing First.** A model of housing assistance that prioritizes rapid placement and stabilization in permanent housing that does not have service participation requirements or preconditions for entry (such as sobriety or a minimum income threshold). HUD encourages all recipients of CoC Program-funded PSH to follow a Housing First approach to the maximum extent practicable.
  2. **Chronically Homeless.** The definition of “chronically homeless”, as stated in Definition of Chronically Homeless final rule is:
     1. A “homeless individual with a disability,” as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:
        1. lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
        2. Has been homeless and living as described in paragraph (a)(i) 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 paragraph (a)(i). Stays in institutional care facilities for fewer than 90 days will not constitute as 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 an institutional care facility;
     2. An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (a) of this definition, before entering the facility;
     3. A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (a) or (b) of this definition (as described in Section I.D.2.(a) of this Notice), including a family whose composition has fluctuated while the head of household has been homeless.
  3. **Severity of Service Needs.** This Notice refers to persons who have been identified as having the most severe service needs.
     1. For the purposes of this Notice, this means an individual for whom at least one of the following is true:
        1. History of high utilization of crisis services, which include but are not limited to, emergency rooms, jails, and psychiatric facilities; and/or
        2. Significant health or behavioral health challenges, substance use disorders, or functional impairments which require a significant level of support in order to maintain permanent housing.
        3. For youth and victims of domestic violence, high risk of continued trauma or high risk of harm or exposure to very dangerous living situations.
        4. When applicable CoCs and recipients of CoC Program-funded PSH may use an alternate criteria used by Medicaid departments to identify high- need, high cost beneficiaries.
     2. Severe service needs as defined in paragraphs i.-iv. above should be identified and verified through data-driven methods such as an administrative data match or through the use of a standardized assessment tool and process and should be documented in a program participant’s case file. The determination must not be based on a specific diagnosis or disability type, but only on the severity of needs of the individual. The determination cannot be made based on any factors that would result in a violation of any nondiscrimination and equal opportunity requirements, see 24 C.F.R. § 5.105(a).

# Dedication and Prioritization of Permanent Supportive Housing Strategies to Increase Number of PSH Beds Available for Chronically Homeless Persons

* 1. **Increase the number of CoC Program-funded PSH beds that are dedicated to persons experiencing chronic homelessness.**

Dedicated PSH beds are those which are required through the project’s grant agreement to only be used to house persons experiencing chronic homelessness unless there are no persons within the CoC that meet that criteria. If there are no persons within the CoC’s geographic area that meet the definition of chronically homeless at a point in which a dedicated PSH bed is vacant, the recipient may then follow the order of priority for non- dedicated PSH established in this Notice, if it has been adopted into the CoC’s written standards. The bed will continue to be a dedicated bed, however, so when that bed becomes vacant again it must be used to house a chronically homeless person unless there are still no persons who meet that criterion within the CoC’s geographic area at that time. These PSH beds are also reported as “CH Beds” on a CoC’s Housing Inventory Count (HIC).

# Prioritize non-dedicated PSH beds for use by persons experiencing chronic homelessness.

Prioritization means implementing an admissions preference for chronically homeless persons for CoC Program-funded PSH beds. During the CoC Program competition project applicants for CoC Program-funded PSH indicate the number of non-dedicated beds that will be prioritized for use by persons experiencing chronic homelessness during the operating year of that grant, when awarded. These projects are then required to prioritize chronically homeless persons in their non-dedicated CoC Program-funded PSH beds for the applicable operating year as the project application is incorporated into the

grant agreement. All recipients of non-dedicated CoC Program-funded PSH are encouraged to change the designation of their PSH to dedicated, however, at a minimum are encouraged to prioritize the chronically homeless as beds become vacant to the maximum extent practicable, until there are no persons within the CoC’s geographic area who meet that criteria. Projects located in CoCs where a sub-CoC approach to housing and service delivery has been implemented, which may also be reflected in a sub-CoC coordinated entry process, need only to prioritize assistance within their specified area.

For example, if a Balance of State CoC has chosen to divide the CoC into six distinct regions for purposes of planning and housing and service delivery, each region would only be expected to prioritize assistance within its specified geographic area.1

The number of non-dedicated beds designated as being prioritized for the chronically homeless may be increased at any time during the operating year and may occur without an amendment to the grant agreement.

# Order of Priority in CoC Program-funded Permanent Supportive Housing

The definition of chronically homeless included in the final rule on “Defining Chronically Homeless”, which was published on December 4, 2015 and went into effect on January 15, 2016, requires an individual or head of household to have a disability and to have been living in a place not meant for human habitation, in an emergency shelter, or in a safe haven for at least 12 months either continuously or cumulatively over a period of at least 4 occasions in the last 3 years. HUD encourages all CoCs adopt into their written standards the following orders of priority for all CoC Program-funded PSH. CoCs that adopted the orders of priority established in Notice CPD-14-012, which this Notice supersedes, and who received points for having done so in the most recent CoC Program Competition are strongly encouraged to update their written standards to reflect the updates to the orders of priority as established in this Notice. Where a CoC has chosen to not incorporate HUD’s recommended orders of priority into their written standards, recipients of CoC Program- funded PSH are encouraged to follow these standards for selecting participants into their programs as long as it is not inconsistent with the CoC’s written standards.

As a reminder, recipients of CoC Program-funded PSH are required to prioritize otherwise eligible households in a nondiscriminatory manner. Program implementation, including any prioritization policies, must be implemented consistent with the nondiscrimination provisions of the Federal civil rights laws, including, but not limited to the Fair Housing Act, Section 504 of the Rehabilitation Act, Title VI of the Civil Rights Act, and Title II or III of the Americans with Disabilities Act, as applicable. For example, while it is acceptable to prioritize based on level of need for the type of assistance being offered, prioritizing based on specific disabilities would not be consistent with fair housing requirements or program regulations.

1 For the State of Louisiana grant originally awarded pursuant to ‘‘Department of Housing and Urban Development— Permanent Supportive Housing’’ in chapter 6 of title III of the Supplemental Appropriations Act, 2008 (Public Law 110–252; 122 Stat. 2351), projects located within the geographic area of a CoC that is not the CoC through which the State is awarded the grant may prioritize assistance within that geographic area instead of within the geographic area of the CoC through which the State is awarded the grant.

# Prioritizing Chronically Homeless Persons in CoC Program-funded Permanent Supportive Housing Beds Dedicated or Prioritized for Occupancy by Persons Experiencing Chronic Homelessness

* 1. CoCs are strongly encouraged to revise their written standards to include an order of priority, determined by the CoC, for CoC Program-funded PSH that is dedicated or prioritized for persons experiencing chronic homelessness that is based on the length of time in which an individual or family has resided in a place not meant for human habitation, a safe haven, or an emergency shelter and the severity of the individual’s or family’s service needs. Recipients of CoC Program-funded PSH that is dedicated or prioritized for persons experiencing chronic homelessness would be required to follow that order of priority when selecting participants for housing, in a manner consistent with their current grant agreement.
  2. Where there are no chronically homeless individuals and families within the CoC’s geographic area, CoCs and recipients of CoC Program-funded PSH are encouraged to follow the order of priority in Section III.B. of this Notice. For projects located in CoC’s where a sub-CoC approach to housing and service delivery has been implemented, which may also be reflected in a sub-CoC coordinated entry process, need only to prioritize assistance within their specified sub-CoC area. 2
  3. Recipients of CoC Program-funded PSH should follow the order of priority above while also considering the goals and any identified target populations served by the project. For example, a CoC Program-funded PSH project that is permitted to target homeless persons with a serious mental illness should follow the order of priority under Section

III.A.1. of this Notice to the extent in which persons with serious mental illness meet the criteria. In this example, if there were no persons with a serious mental illness that also met the criteria of chronically homeless within the CoC’s geographic area, the recipient should follow the order of priority under Section III.B for persons with a serious mental illness.

* 1. Recipients must exercise due diligence when conducting outreach and assessment to ensure that chronically homeless individuals and families are prioritized for assistance based on their total length of time homeless and/or the severity of their needs. HUD recognizes that some persons–particularly those living on the streets or in places not meant for human habitation–might require significant engagement and contacts prior to their entering housing and recipients of CoC Program-funded PSH are not required to allow units to remain vacant indefinitely while waiting for an identified chronically homeless person to accept an offer of PSH. CoC Program-funded PSH providers are encouraged to follow a Housing First approach to the maximum extent practicable. Therefore, a person experiencing chronic homelessness should not be forced to refuse an offer of PSH if they do not want to participate in the project’s services, nor should a PSH

2 For the State of Louisiana grant originally awarded pursuant to ‘‘Department of Housing and Urban Development— Permanent Supportive Housing’’ in chapter 6 of title III of the Supplemental Appropriations Act, 2008 (Public Law 110–252; 122 Stat. 2351), projects located within the geographic area of a CoC that is not the CoC through which the State is awarded the grant may prioritize assistance within that geographic area instead of within the geographic area of the CoC through which the State is awarded the grant.

project have eligibility criteria or preconditions to entry that systematically exclude those with severe service needs. Street outreach providers should continue to make attempts to engage those persons that have been resistant to accepting an offer of PSH and where the CoC has adopted these orders of priority into their written standards, these chronically homeless persons must continue to be prioritized for PSH until they are housed.

# Prioritizing Chronically Homeless Persons in CoC Program-funded Permanent Supportive Housing Beds Not Dedicated or Not Prioritized for Occupancy by Persons Experiencing Chronic Homelessness

* 1. CoCs are strongly encouraged to revise their written standards to include the following order of priority for non-dedicated and non-prioritized PSH beds. If adopted into the CoCs written standards, recipients of CoC Program-funded PSH that is not dedicated or prioritized for the chronically homeless would be required to follow this order of priority when selecting participants for housing, in a manner consistent with their current grant agreement.

# First Priority–Homeless Individuals and Families with a Disability with Long Periods of Episodic Homelessness and Severe Service Needs

An individual or family that is eligible for CoC Program-funded PSH who has experienced fewer than four occasions where they have been living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter but where the cumulative time homeless is at least 12 months **and** has been identified as having severe service needs.

# Second Priority–Homeless Individuals and Families with a Disability with Severe Service Needs.

An individual or family that is eligible for CoC Program-funded PSH who is residing in a place not meant for human habitation, a safe haven, or in an emergency shelter and has been identified as having severe service needs. The length of time in which households have been homeless should also be considered when prioritizing households that meet this order of priority, but there is not a minimum length of time required.

# Third Priority—Homeless Individuals and Families with a Disability Coming from Places Not Meant for Human Habitation, Safe Haven, or Emergency Shelter Without Severe Service Needs.

An individual or family that is eligible for CoC Program-funded PSH who is residing in a place not meant for human habitation, a safe haven, or an emergency shelter where the individual or family has not been identified as having severe service needs. The length of time in which households have been homeless should be considered when prioritizing households that meet this order of priority, but there is not a minimum length of time required.

# Fourth Priority–Homeless Individuals and Families with a Disability Coming from Transitional Housing.

An individual or family that is eligible for CoC Program-funded PSH who is currently residing in a transitional housing project, where prior to residing in the transitional housing had lived in a place not meant for human habitation, in an emergency shelter, or safe haven. This priority also includes individuals and families residing in transitional housing who were fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking and prior to residing in that transitional housing project even if they did not live in a place not meant for human habitation, an emergency shelter, or a safe haven prior to entry in the transitional housing.

* 1. Recipients of CoC Program-funded PSH should follow the order of priority above, as adopted by the CoC, while also considering the goals and any identified target populations served by the project. For example, non-dedicated or non-prioritized CoC Program-funded PSH that is permitted to target youth experiencing homelessness should follow the order of priority under Section III.B.1. of this Notice, as adopted by the CoC, to the extent in which youth meet the stated criteria.
  2. Recipients must exercise due diligence when conducting outreach and assessment to ensure that persons are prioritized for assistance based on their length of time homeless and the severity of their needs following the order of priority described in this Notice, and as adopted by the CoC. HUD recognizes that some persons–particularly those living on the streets or in places not meant for human habitation–might require significant engagement and contacts prior to their entering housing and recipients are not required to keep units vacant indefinitely while waiting for an identified eligible individual or family to accept an offer of PSH (see [FAQ 1895](https://www.hudexchange.info/faqs/1895/are-recipients-of-dedicated-or-prioritized-psh-funded-under-the-coc-program/)). Recipients of CoC Program-funded PSH are encouraged to follow a Housing First approach to the maximum extent practicable. Street outreach providers should continue to make attempts to engage those persons that have been resistant to accepting an offer of PSH and where the CoC has adopted these orders of priority into their written standards, these individuals and families must continue to be prioritized until they are housed.

# Using Coordinated Entry and a Standardized Assessment Process to Determine Eligibility and Establish a Prioritized Waiting List

* 1. **Coordinated Entry Requirement**

Provisions at 24 CFR 578.7(a)(8) requires that each CoC, in consultation with recipients of Emergency Solutions Grants (ESG) program funds within the CoC's geographic area, establish and operate either a centralized or coordinated assessment system (referred to in this Notice as coordinated entry or coordinated entry process) that provides an initial, comprehensive assessment of the needs of individuals and families for housing and services. CoCs that adopt the order of priority in Section III of this Notice into the CoC’s written standards are strongly encouraged to use a coordinated entry process to ensure that there is a single prioritized list for all CoC Program-funded PSH within the CoC. The [Coordinated Entry Policy Brief,](https://www.hudexchange.info/resource/4427/coordinated-entry-policy-brief/) provides recommended criteria for a quality coordinated entry process and standardized assessment tool and process. Under no circumstances shall the order of priority be based upon diagnosis or disability type, but instead on the length of time an individual or family has been experiencing homelessness and the severity of needs of an individual or family.

# Written Standards for Creation of a Single Prioritized List for PSH

CoCs are also encouraged to include in their policies and procedures governing their coordinated entry system a requirement that all CoC Program-funded PSH accept referrals only through a single prioritized list that is created through the CoCs coordinated entry process, which should also be informed by the CoCs street outreach. Adopting this into the CoC’s policies and procedures for coordinated entry would further ensure that CoC Program-funded PSH is being used most effectively, which is one of the goals in this Notice. The single prioritized list should be updated frequently to reflect the most up-to-date and real-time data as possible.

# Standardized Assessment Tool Requirement

CoCs must utilize a standardized assessment tool, in accordance with 24 CFR 578.3, or process. The [Coordinated Entry Policy Brief,](https://www.hudexchange.info/resource/4427/coordinated-entry-policy-brief/) provides recommended criteria for a quality coordinated entry process and standardized assessment tool.

# Nondiscrimination Requirements

CoCs and recipients of CoC Program-funded PSH must continue to comply with the nondiscrimination provisions of Federal civil rights laws, including, but not limited to, the Fair Housing Act, Section 504 of the Rehabilitation Act, Title VI of the Civil Rights Act, and Titles II or III of the Americans with Disabilities Act, as applicable. See 24

C.F.R. § 5.105(a).

# Recordkeeping Recommendations for CoCs that have Adopted the Orders of Priority in this Notice

24 CFR 578.103(a)(4) outlines documentation requirements for all recipients of dedicated and non-dedicated CoC Program-funded PSH associated with determining whether or not an individual or family is chronically homeless for the purposes of eligibility. In addition to those requirements, HUD expects that where CoCs have adopted the orders of priority in Section III. of this Notice into their written standards. The CoC, as well as recipients of CoC Program-funded PSH, will maintain evidence of implementing these priorities. Evidence of following these orders of priority may be demonstrated by:

1. **Evidence of Severe Service Needs.** Evidence of severe service needs is that by which the recipient is able to determine the severity of needs as defined in Section I.D.3. of this Notice using data-driven methods such as an administrative data match or through the use of a standardized assessment. The documentation should include any information pertinent to how the determination was made, such as notes associated with case- conferencing decisions.
2. **Evidence that the Recipient is Following the CoC’s Written Standards for Prioritizing Assistance.** Recipients must follow the CoC’s written standards for prioritizing assistance, as adopted by the CoC. In accordance with the CoC’s adoption of

written standards for prioritizing assistance, recipients must in turn document that the CoC’s revised written standards have been incorporated into the recipient’s intake procedures and that the recipient is following its intake procedures when accepting new program participants into the project.

# Evidence that there are no Households Meeting Higher Order of Priority within CoC’s Geographic Area.

* 1. When dedicated and prioritized PSH is used to serve non-chronically homeless households, the recipient of CoC Program-funded PSH should document how it was determined that there were no chronically homeless households identified for assistance within the CoC’s geographic area – or for those CoCs that implement a sub-CoC 3planning and housing and service delivery approach, the smaller defined geographic area within the CoC’s geographic area – at the point in which a vacancy became available. This documentation should include evidence of the outreach efforts that had been undertaken to locate eligible chronically homeless households within the defined geographic area and, where chronically homeless households have been identified but have not yet accepted assistance, the documentation should specify the number of persons that are chronically homeless that meet this condition and the attempts that have been made to engage the individual or family. Where a CoC is using a single prioritized list, the recipient of PSH may refer to that list as evidence.
  2. When non-dedicated and non-prioritized PSH is used to serve an eligible individual or family that meets a lower order of priority, the recipient of CoC Program-funded PSH should document how the determination was made that there were no eligible individuals or families within the CoC’s geographic area - or for those CoCs that implement a sub-CoC planning and housing and service delivery approach, the smaller defined geographic area within the CoC’s geographic area - that met a higher priority. Where a CoC is using a single prioritized list, the recipient of PSH may refer to that list as evidence that there were no households identified within the CoC’s geographic area that meet a higher order of priority.

# Questions Regarding this Notice

Questions regarding this notice should be submitted to HUD Exchange Ask A Question (AAQ) Portal at: <https://www.hudexchange.info/get-assistance/my-question/>.

3 For the State of Louisiana grant originally awarded pursuant to ‘‘Department of Housing and Urban Development— Permanent Supportive Housing’’ in chapter 6 of title III of the Supplemental Appropriations Act, 2008 (Public Law 110–252; 122 Stat. 2351), projects located within the geographic area of a CoC that is not the CoC through which the State is awarded the grant may prioritize assistance within that geographic area instead of within the geographic area of the CoC through which the State is awarded the grant.

Exhibit C

# Vulnerability Index -

**Service Prioritization Decision Assistance Tool (VI-SPDAT)**

## Prescreen Triage Tool for Single Adults

#### AMERICAN VERSION 2.01

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### Welcome to the SPDAT Line of Products

The Service Prioritization Decision Assistance Tool (SPDAT) has been around in various incarnations for over a decade, before being released to the public in 2010. Since its initial release, the use of the SPDAT has been expanding exponentially and is now used in over one thousand communities across the United States, Canada, and Australia.

More communities using the tool means there is an unprecedented demand for versions of the SPDAT, customized for specific client groups or types of users. With the release of SPDAT V4, there have been more current versions of SPDAT products than ever before.

## VI-SPDAT Series

The Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) was developed as a pre-screening tool for communities that are very busy and do not have the resources to conduct a full SPDAT assessment for every client. It was made in collaboration with Community Solutions, creators of the Vulnerability Index, as a brief survey that can be conducted to quickly determine whether a client has high, moderate, or low acuity. The use of this survey can help prioritize which clients should be given a full SPDAT assessment first. Because it is a self-reported survey, no special training is required to use the VI-SPDAT.

### *Current versions available:*

* VI-SPDAT V 2.0 for Individuals
* VI-SPDAT V 2.0 for Families
* VI-SPDAT V 1.0 for Youth

## SPDAT Series

All versions are available online at

[www.orgcode.com/products/vi-spdat/](http://www.orgcode.com/products/vi-spdat/)

The Service Prioritization Decision Assistance Tool (SPDAT) was developed as an assessment tool for front- line workers at agencies that work with homeless clients to prioritize which of those clients should receive assistance first. The SPDAT tools are also designed to help guide case management and improve housing stability outcomes. They provide an in-depth assessment that relies on the assessor’s ability to interpret responses and corroborate those with evidence. As a result, this tool may only be used by those who have received proper, up-to-date training provided by OrgCode Consulting, Inc. or an OrgCode certified trainer.

### *Current versions available:*

* SPDAT V 4.0 for Individuals
* SPDAT V 2.0 for Families
* SPDAT V 1.0 for Youth

Information about all versions is available online at

[www.orgcode.com/products/spdat/](http://www.orgcode.com/products/spdat/)

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## SPDAT Training Series

To use the SPDAT, training by OrgCode or an OrgCode certified trainer is required. We provide training on a wide variety of topics over a variety of mediums.

The full-day in-person SPDAT Level 1 training provides you the opportunity to bring together as many people as you want to be trained for one low fee. The webinar training allows for a maximum of 15 dif- ferent computers to be logged into the training at one time. We also offer online courses for individuals that you can do at your own speed.

The training gives you the manual, case studies, application to current practice, a review of each compo- nent of the tool, conversation guidance with prospective clients – and more!

### *Current SPDAT training available:*

* Level 0 SPDAT Training: VI-SPDAT for Frontline Workers
* Level 1 SPDAT Training: SPDAT for Frontline Workers
* Level 2 SPDAT Training: SPDAT for Supervisors
* Level 3 SPDAT Training: SPDAT for Trainers

### *Other related training available:*

* Excellence in Housing-Based Case Management
* Coordinated Access & Common Assessment
* Motivational Interviewing
* Objective-Based Interactions

More information about SPDAT training, including pricing, is available online at

<http://www.orgcode.com/product-category/training/spdat/>

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## Administration



**Interviewer’s Name**

**Agency**

**Survey Date**

**Survey Time**

DD/MM/YYYY / /

* Team
* Staff
* Volunteer

**Survey Location**

**Opening Script**

Every assessor in your community regardless of organization completing the VI-SPDAT should use the same introductory script. In that script you should highlight the following information:

* the name of the assessor and their affiliation (organization that employs them, volunteer as part of a Point in Time Count, etc.)
* the purpose of the VI-SPDAT being completed
* that it usually takes less than 7 minutes to complete
* that only “Yes,” “No,” or one-word answers are being sought
* that any question can be skipped or refused
* where the information is going to be stored
* that if the participant does not understand a question or the assessor does not understand the ques- tion that clarification can be provided
* the importance of relaying accurate information to the assessor and not feeling that there is a correct or preferred answer that they need to provide, nor information they need to conceal

## Basic Information

**First Name**

**Nickname**

**Last Name**

**In what language do you feel best able to express yourself?**

**Date of Birth**

**Age**

**Social Security Number Consent to participate**

DD/MM/YYYY / / ¨ Yes ¨ No

IF THE PERSON IS 60 YEARS OF AGE OR OLDER, THEN SCORE 1.

**SCORE:**

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## History of Housing and Homelessness

* 1. Where do you sleep most frequently? (check one) ¨ Shelters



* + - Transitional Housing
    - Safe Haven

#### Outdoos

* + - **Other (specify):**



□ **Refused**

IF THE PERSON ANSWERS ANYTHING OTHER THAN “SHELTER”, “TRANSITIONAL HOUSING”, OR “SAFE HAVEN”, THEN SCORE 1.

**SCORE:**

0

* 1. How long has it been since you lived in permanent stable housing?

Years

Refused

* 1. In the last three years, how many times have you been homeless?

□

* Refused

IF THE PERSON HAS EXPERIENCED 1 OR MORE CONSECUTIVE YEARS OF HOMELESSNESS, AND/OR 4+ EPISODES OF HOMELESSNESS, THEN SCORE 1.

**SCORE:**

0

## Risks

1. In the past six months, how many times have you...
   1. Received health care at an emergency department/room? Refused

□

* 1. Taken an ambulance to the hospital? Refused

□

* 1. Been hospitalized as an inpatient? Refused

□

□

* 1. Used a crisis service, including sexual assault crisis, mental health crisis, family/intimate violence, distress centers and

suicide prevention hotlines?

* 1. Talked to police because you witnessed a crime, were the victim of a crime, or the alleged perpetrator of a crime or because the

□

police told you that you must move along?

* 1. Stayed one or more nights in a holding cell, jail or prison, whether that was a short-term stay like the drunk tank, a longer stay for a

□

more serious offence, or anything in between?

Refused Refused Refused

**SCORE:**

0

Have you been attacked or beaten up since you’ve become homeless?

1. Have you threatened to or tried to harm yourself or anyone else in the last year?
   * **Y** ¨ N ¨ Refused
   * **Y** ¨ N ¨ Refused



IF “YES” TO ANY OF THE ABOVE, THEN SCORE 1 FOR **RISK OF HARM.**

**SCORE:**

0

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1. Do you have any legal stuff going on right now that may result in you being locked up, having to pay fines, or that make it more difficult to rent a place to live?

* **Y** ¨ N ¨ Refused

IF “YES,” THEN SCORE 1 FOR **LEGAL ISSUES.**

**SCORE:**

0

1. Does anybody force or trick you to do things that you do not want to do?
2. Do you ever do things that may be considered to be risky like exchange sex for money, run drugs for someone, have unprotected sex with someone you don’t know, share a needle, or anything like that?
   * **Y** ¨ N ¨ Refused
   * **Y** ¨ N ¨ Refused

IF “YES” TO ANY OF THE ABOVE, THEN SCORE 1 FOR **RISK OF EXPLOITATION.**

**SCORE:**

0

## Socialization & Daily Functioning

1. Is there any person, past landlord, business, bookie, dealer, or government group like the IRS that thinks you owe them money?
2. Do you get any money from the government, a pension, an inheritance, working under the table, a regular job, or anything like that?
   * **Y** ¨ N ¨ Refused
   * Y ¨ **N** ¨ Refused



12.Do you have planned activities, other than just surviving, that make you feel happy and fulfilled?

□ Y

□ **N** ¨ Refused

13.Are you currently able to take care of basic needs like bathing, changing clothes, using a restroom, getting food and clean water and other things like that?

□ Y

□ **N** ¨ Refused

14.Is your current homelessness in any way caused by a relationship that broke down, an unhealthy or abusive relationship, or because family or friends caused you to become evicted?

□ **Y** ¨ N ¨ Refused

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IF “YES” TO QUESTION 10 OR “NO” TO QUESTION 11, THEN SCORE 1 FOR **MONEY MANAGEMENT.**

**SCORE:**

0

IF “NO,” THEN SCORE 1 FOR **MEANINGFUL DAILY ACTIVITY.**

**SCORE:**

0

IF “NO,” THEN SCORE 1 FOR **SELF-CARE.**

**SCORE:**

0

IF “YES,” THEN SCORE 1 FOR **SOCIAL RELATIONSHIPS.**

**SCORE:**

0

## Wellness

1. Have you ever had to leave an apartment, shelter program, or other place you were staying because of your physical health?
2. Do you have any chronic health issues with your liver, kidneys, stomach, lungs or heart?
3. If there was space available in a program that specifically assists people that live with HIV or AIDS, would that be of interest to you?
4. Do you have any physical disabilities that would limit the type of housing you could access, or would make it hard to live independently because you’d need help?
5. When you are sick or not feeling well, do you avoid getting help?

* **Y** ¨ N ¨ Refused
* **Y** ¨ N ¨ Refused
* **Y** ¨ N ¨ Refused
* **Y** ¨ N ¨ Refused
* **Y** ¨ N ¨ Refused

1. *FOR FEMALE RESPONDENTS ONLY:* Are you currently pregnant? ¨ **Y** ¨ N ¨ N/A or

Refused

IF “YES” TO ANY OF THE ABOVE, THEN SCORE 1 FOR **PHYSICAL HEALTH.**

**SCORE:**

0

1. Has your drinking or drug use led you to being kicked out of an apartment or program where you were staying in the past?
2. Will drinking or drug use make it difficult for you to stay housed or afford your housing?

* **Y** ¨ N ¨ Refused
* **Y** ¨ N ¨ Refused

IF “YES” TO ANY OF THE ABOVE, THEN SCORE 1 FOR **SUBSTANCE USE.**

**SCORE:**

0

1. Have you ever had trouble maintaining your housing, or been kicked out of an apartment, shelter program or other place you were staying, because of:
   1. A mental health issue or concern? ¨ **Y** ¨ N ¨ Refused
   2. A past head injury? ¨ **Y** ¨ N ¨ Refused
   3. A learning disability, developmental disability, or other impairment?
2. Do you have any mental health or brain issues that would make it hard for you to live independently because you’d need help?

* **Y** ¨ N ¨ Refused
* **Y** ¨ N ¨ Refused



IF “YES” TO ANY OF THE ABOVE, THEN SCORE 1 FOR **MENTAL HEALTH.**

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IF THE RESPONENT SCORED 1 FOR **PHYSICAL HEALTH** AND 1 FOR **SUBSTANCE USE** AND 1 FOR **MENTAL HEALTH**, SCORE 1 FOR **TRI-MORBIDITY**.

**SCORE:**

1. Are there any medications that a doctor said you should be taking that, for whatever reason, you are not taking?
2. Are there any medications like painkillers that you don’t take the way the doctor prescribed or where you sell the medication?
   * **Y** ¨ N ¨ Refused
   * **Y** ¨ N ¨ Refused



IF “YES” TO ANY OF THE ABOVE, SCORE 1 FOR **MEDICATIONS.**

**SCORE:**

0

1. *YES OR NO:* Has your current period of homelessness been caused by an experience of emotional, physical,

psychological, sexual, or other type of abuse, or by any other trauma you have experienced?

* **Y** ¨ N ¨ Refused

IF “YES”, SCORE 1 FOR **ABUSE AND TRAUMA.**

**SCORE:**

0

## Scoring Summary

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **DOMAIN** | **SUBTOTAL** | |  | **RESULTS** |
| PRE-SURVEY | 0 | /1 | **Score:** | **Recommendation:** |
| A. HISTORY OF HOUSING & HOMELESSNESS | 0 | /2 |
| 0-3: | no housing intervention |
| B. RISKS | 0 | /4 |
| 4-7: | an assessment for Rapid Re-Housing |
| C. SOCIALIZATION & DAILY FUNCTIONS | 0 | /4 |
| D. WELLNESS | 0 | /6 | 8+: | an assessment for Permanent Supportive Housing/Housing First |
|
| **GRAND TOTAL:** | 0 | /17 |

**Follow-Up Questions**

|  |  |
| --- | --- |
| **On a regular day, where is it easiest to find you and what time of day is easiest to do so?** | place:  time: : or Night |
| **Is there a phone number and/or email where someone can safely get in touch with you or leave you a message?** | phone: ( ) -  email: |
| **Ok, now I’d like to take your picture so that it is easier to find you and confirm your identity in the future. May I do so?** | □ Yes ¨ No ¨ Refused |

Communities are encouraged to think of additional questions that may be relevant to the programs being operated or your specific local context. This may include questions related to:

* + military service and nature of discharge
  + ageing out of care
  + mobility issues
* legal status in country
* income and source of it
* current restrictions on where a person can legally reside
* children that may reside with the adult at some point in the future
* safety planning

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# Appendix A: About the VI-SPDAT

The HEARTH Act and federal regulations require communities to have an assessment tool for coordinated entry - and the VI-SPDAT and SPDAT meet these requirements. Many communities have struggled to comply with this requirement, which demands an investment of considerable time, resources and exper- tise. Others are making it up as they go along, using “gut instincts” in lieu of solid evidence. Communities need practical, evidence-informed tools that enhance their ability to to satisfy federal regulations and quickly implement an effective approach to access and assessment. The VI-SPDAT is a first-of-its-kind tool designed to fill this need, helping communities end homelessness in a quick, strategic fashion.

## The VI-SPDAT

The VI-SPDAT was initially created by combining the elements of the Vulnerability Index which was cre- ated and implemented by Community Solutions broadly in the 100,000 Homes Campaign, and the SPDAT Prescreen Instrument that was part of the Service Prioritization Decision Assistance Tool. The combina- tion of these two instruments was performed through extensive research and development, and testing. The development process included the direct voice of hundreds of persons with lived experience.

The VI-SPDAT examines factors of current vulnerability and future housing stability. It follows the structure of the SPDAT assessment tool, and is informed by the same research backbone that supports the SPDAT

- almost 300 peer reviewed published journal articles, government reports, clinical and quasi-clinical assessment tools, and large data sets. The SPDAT has been independently tested, as well as internally reviewed. The data overwhelmingly shows that when the SPDAT is used properly, housing outcomes are better than when no assessment tool is used.

The VI-SPDAT is a triage tool. It highlights areas of higher acuity, thereby helping to inform the type of support and housing intervention that may be most beneficial to improve long term housing outcomes. It also helps inform the order - or priority - in which people should be served. The VI-SPDAT does not make decisions; it informs decisions. The VI-SPDAT provides data that communities, service providers, and people experiencing homelessness can use to help determine the best course of action next.

## Version 2

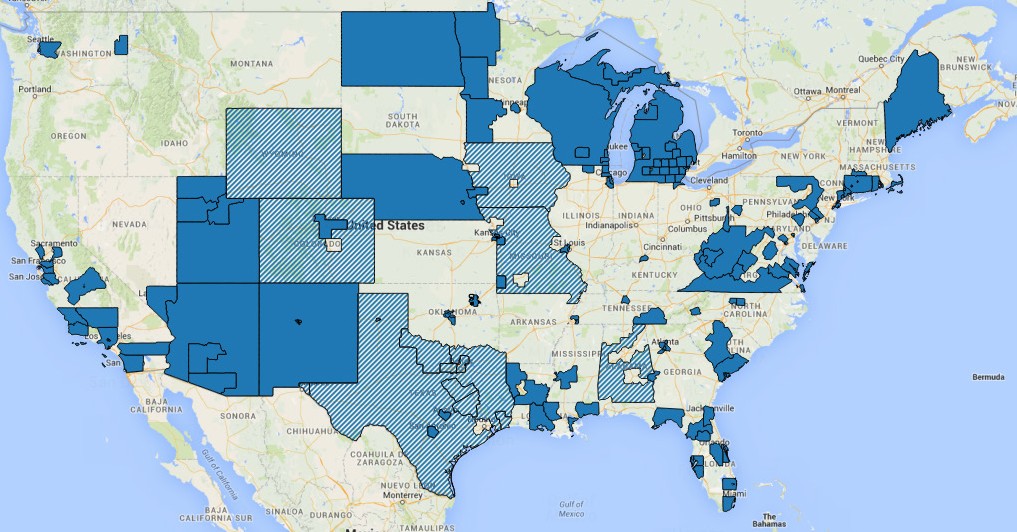
Version 2 builds upon the success of Version 1 of the VI-SPDAT with some refinements. Starting in August 2014, a survey was launched of existing VI-SPDAT users to get their input on what should be amended, improved, or maintained in the tool. Analysis was completed across all of these responses. Further re- search was conducted. Questions were tested and refined over several months, again including the direct voice of persons with lived experience and frontline practitioners. Input was also gathered from senior government officials that create policy and programs to help ensure alignment with guidelines and fund- ing requirements.

You will notice some differences in Version 2 compared to Version 1. Namely:

* + it is shorter, usually taking less than 7 minutes to complete;
  + subjective elements through observation are now gone, which means the exact same instrument can be used over the phone or in-person;
  + medical, substance use, and mental health questions are all refined;
  + you can now explicitly see which component of the full SPDAT each VI-SPDAT question links to; and,
  + the scoring range is slightly different (Don’t worry, we can provide instructions on how these relate to results from Version 1).

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# Appendix B: Where the VI-SPDAT is being used in the United States

Since the VI-SPDAT is provided completely free of charge, and no training is required, any community is able to use the VI-SPDAT without the explicit permission of Community Solutions or OrgCode Consulting, Inc. As a result, the VI-SPDAT is being used in more communities than we know of. It is also being used in Canada and Australia.

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A partial list of continua of care (CoCs) in the US where

we know the VI-SPDAT is

District of Columbia

* District of Columbia

Florida

Louisiana

* + Lafayette/Acadiana
  + Shreveport/Bossier/

North Dakota

* + Statewide

Nebraska

Texas

* + - San Antonio/Bexar County
    - Austin/Travis County

being used includes:

* Sarasota/Bradenton/

Northwest

•

erson Parish

* Statewide
  + Dallas City & County/Irving

Alabama

* + Parts of Alabama Balance of

Manatee, Sarasota Counties

* Tampa/Hillsborough County
* St. Petersburg/Clearwater/

New Orleans/Jeff

* Baton Rouge
* Alexandria/Central Louisiana

New Mexico

* Statewide

Nevada

* + Fort Worth/Arlington/Tarrant County
  + El Paso City and County

State

Largo/Pinellas County

•

CoC

* + - Las Vegas/Clark County
* Waco/McLennan County

Arizona

* + Statewide

Tallahassee/Leon County

* + Orlando/Orange, Osceola,

Massachusetts

* Cape Cod Islands

New York

* + New York

City

* + - Texas Balance of State
    - Amarillo

California

* + - San Jose/Santa Clara City &

Seminole Counties

* Gainesville/Alachua, Putnam
* Springfield/Holyoke/ Chicopee/Westfield/Hampden
* Yonkers/Mount Vernon/New Rochelle/Westchester County
* Wichita Falls/Wise, Palo Pinto, Wichita, Archer Counties

County

Counties

•

1. Duval, Clay

County

Ohio

edo/Lucas County

* + Bryan/College Station/Brazos
    - San Francisco
    - Oakland/Alameda County

Jacksonvill Counties

•

evard

Maryland

* Baltimore City
  + Tol
  + Canton/Massillon/Alliance/

Valley

* Beaumont/Port Arthur/South
  + Sacramento City & County

Palm Bay/Melbourne/Br

* Montgomery County

Stark County

East Texas

* + Richmond/Contra Costa

County

•

County

Maine

ewide

Oklahoma

& County/Broken

Utah

ewide

County

Ocala/Marion

•

* + Stat
    - Tulsa City
    - Stat
  + Watsonville/Santa Cruz City &

Miami/Dade County

•

Beach

Michigan

Arrow

•

City

Virginia

o,

County

* + Fresno/Madera County
  + Napa City & County
  + Los Angeles City & County
  + San Diego
  + Santa Maria/Santa Barbara

West Palm Beach/Palm County

Georgia

* Atlanta County
* Fulton County
* Columbus-Muscogee/Russell

• Statewide

Minnesota

• Minneapolis/Hennepin County

• Northwest Minnesota

• Moorhead/West Central Minnesota

Oklahoma

* Norman/Cleveland County

Pennsylvania

* Philadelphia
* Lower Marion/Norristown/ Abington/Montgomery County
* Richmond/Henric Chesterfield, Hanover Counties
* Roanoke City & County/Salem
* Virginia Beach
* Portsmouth

County

County

•

County

* + Southwest Minnesota
  + Allentown/Northeast
  + Virginia Balance of State
    - Bakersfield/Kern County

Marietta/Cobb

•

Missouri

County

Pennsylvania

•

& County

* Arlington County
  + Pasadena

DeKalb County

Ha

* St. Louis

City

Lancaster City

* + em/Bucks

Washington

County

* + Riverside City & County

waii

•

* + St. Louis

, Newton

Bristol/Bensal

* Seattle/King

& County

* + Glendale
  + San Luis Obispo County

Colorado

Honolulu

Illinois

* Rockford/Winnebago, Boone
* Joplin/Jasper Counties
* Kansas City/Independence/

County

• Pittsburgh/McKeesport/Penn Hills/Allegheny County

* Spokane City

Wisconsin

* Statewide
  + Metropolitan Denver

Homeless Initiative

Counties

* Waukegan/Nor

th Chicago/

Lee’s Summit/Jackson County

* Parts of Missouri Balance of

Rhode Island

* Statewide

West Virginia

* + Statewide
  + Parts of Colorado Balance of

State

Lake County

* Chicago

•

State

Mississippi

ankin, Madison

South Carolina

* + Charleston/Low Country

Wyoming

* + Wyoming

Statewide is in the

implementing

Connecticut

Cook County

Io

* + - Jackson/R
    - Columbia/Midlands

process of

* + - Hartford

wa

* + - ts of Iowa Balance of State

Counties

•

Coast Regional

Tennessee

t

* + - Bridgeport/Stratford/Fairfield

Par

K

Gulf Port/Gulf

* Chattanooga/Southeas
* Connecticut Balance of State

ansas

•

City/Wyandotte

North Carolina

orsyth

Tennessee

•

y County

* Norwalk/Fairfield County

Kansas

* Winston Salem/F

Memphis/Shelb

* Stamford/Greenwich

County

K

County

* e/Buncombe County
* Nashville/Davidson County
  + City of Waterbury

entucky

•

e/Jefferson County

Ashevill

•

o/High Point

Louisvill

Greensbor

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Exhibit D

# Service Prioritization Decision Assistance Tool (SPDAT)

## Assessment Tool for Single Adults

#### VERSION 4.01

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# Welcome to the SPDAT Line of Products

The Service Prioritization Decision Assistance Tool (SPDAT) has been around in various incarnations for over a decade, before being released to the public in 2010. Since its initial release, the use of the SPDAT has been expanding exponentially and is now used in over one thousand communities across the United States, Canada, and Australia.

More communities using the tool means there is an unprecedented demand for versions of the SPDAT, customized for specific client groups or service delivery contexts. With the release of SPDAT V4, there have been more current versions of SPDAT products than ever before.

## VI-SPDAT Series

The **Vulnerability Index – Service Prioritization Decision Assistance Tool** (VI-SPDAT) was developed as a pre-screening tool for communities that are very busy and may not have the resources to conduct a full SPDAT assessment for every client. It was made in collaboration with Community Solutions, creators of the Vulnerability Index, as a brief survey that can be conducted to quickly determine whether a client has high, moderate, or low acuity. The use of this survey can help prioritize which clients should be given a full SPDAT assessment first. Because it is a self-reported survey, no special training is required to use the VI-SPDAT.

### *Current versions available:*

* VI-SPDAT V 2.0 for Individuals
* VI-SPDAT V 2.0 for Families
* VI-SPDAT V 1.0 for Youth

## SPDAT Series

All versions are available online at

[www.orgcode.com/products/vi-spdat/](http://www.orgcode.com/products/vi-spdat/)

The **Service Prioritization Decision Assistance Tool** (SPDAT) was developed as an assessment tool for frontline workers at agencies that work with homeless clients to prioritize which of those clients should receive assistance first. It is an in-depth assessment that relies on the assessor’s ability to interpret responses and corroborate those with evidence. As a result, this tool may only be used by those who have received proper, up-to-date training provided by OrgCode Consulting, Inc. or an OrgCode certified trainer.

### *Current versions available:*

* SPDAT V 4.0 for Individuals
* SPDAT V 2.0 for Families
* SPDAT V 1.0 for Youth

Information about all versions is available online at

[www.orgcode.com/products/spdat](http://www.orgcode.com/products/spdat)/

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## SPDAT Training Series

To use the SPDAT, training by OrgCode or an OrgCode certified trainer is required. We provide training on a wide variety of topics over a variety of mediums.

The full-day in-person SPDAT Level 1 training provides you the opportunity to bring together as many people as you want to be trained for one low fee. The webinar training allows for a maximum of 15 different computers to be logged into the training at one time. We also offer online courses for individuals that you can do at your own speed.

The training gives you the manual, case studies, application to current practice, a review of each component of the tool, conversation guidance with prospective clients – and more!

### *Current SPDAT training available:*

* Level 0 SPDAT Training: VI-SPDAT for Frontline Workers
* Level 1 SPDAT Training: SPDAT for Frontline Workers
* Level 2 SPDAT Training: SPDAT for Supervisors
* Level 3 SPDAT Training: SPDAT for Trainers

### *Other related training available:*

* Excellence in Housing-Based Case Management
* Coordinated Access & Common Assessment
* Motivational Interviewing
* Objective-Based Interactions

More information about SPDAT training, including pricing, is available online at

<http://www.orgcode.com/product-category/training/spdat>/

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# Terms and Conditions Governing the Use of the SPDAT

SPDAT products have been developed by OrgCode Consulting, Inc. with extensive feedback from key community partners including people with lived experience. The tools are provided free of charge to communities to improve the client centered services dedicated to increasing housing stability and wellness. Training is indeed required for the administration and interpretation of these assessment tools. Use of the SPDAT products without authorized training is strictly prohibited.

By using this tool, you accept and agree to be bound by the terms of this expectation.

No sharing, reproduction, use or duplication of the information herein is permitted without the express written consent of OrgCode Consulting, Inc.

## Ownership

The Service Prioritization Decision Assistance Tool (“SPDAT”) and accompanying documentation is owned by OrgCode Consulting, Inc.

## Training

Although the SPDAT Series is provided free of charge to communities, training by OrgCode Consulting, Inc. or a third party trainer, authorized by OrgCode, must be successfully completed. After meeting the training requirements required to administer and interpret the SPDAT Series, practitioners are permitted to implement the SPDAT in their work with clients.

## Restrictions on Use

You may not use or copy the SPDAT prior to successfully completing training on its use, provided by OrgCode Consulting, Inc. or a third-party trainer authorized by OrgCode. You may not share the SPDAT with other individuals not trained on its use. You may not train others on the use of the SPDAT, unless specifically authorized by OrgCode Consulting, Inc.

## Restrictions on Alteration

You may not modify the SPDAT or create any derivative work of the SPDAT or its accompanying documentation, without the express written consent of OrgCode Consulting, Inc. Derivative works include but are not limited to translations.

## Disclaimer

The management and staff of OrgCode Consulting, Inc. (OrgCode) do not control the way in which the Service Prioritization Decision Assistance Tool (SPDAT) will be used, applied or integrated into related client processes by communities, agency management or frontline workers. OrgCode assumes no legal responsibility or liability for the misuse of the SPDAT, decisions that are made or services that are received in conjunction with the assessment tool.

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### *Mental Health & Wellness & Cognitive Functioning*

|  |  |  |  |
| --- | --- | --- | --- |
| **PROMPTS** |  | **CLIENT SCORE:** |  |
| * *Have you ever received any help with your mental wellness?* * *Do you feel you are getting all the help you need for your mental health or stress?* * *Has a doctor ever prescribed you pills for nerves, anxiety, depression or anything like that?* * *Have you ever gone to an emergency room or stayed in a hospital because you weren’t feeling 100% emotionally?* * *Do you have trouble learning or paying attention?* * *Have you ever had testing done to identify learning disabilities?* * *Do you know if, when pregnant with you, your mother did anything that we now know can have negative effects on the baby?* * *Have you ever hurt your brain or head?* * *Do you have any documents or papers about your mental health or brain functioning?* * *Are there other professionals we could speak with that have knowledge of your mental health?* |  | | |
|  | **NOTES** | |
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| --- | --- |
| **SCORING** | |
| **4** | **Any** of the following:   * Serious and persistent mental illness (2+ hospitalizations in a mental health facility or psychiatric ward in the past 2 years) **and** not in a heightened state of recovery currently * Major barriers to performing tasks and functions of daily living or communicating intent because of a brain injury, learning disability or developmental disability |
| **3** | **Any** of the following:   * Heightened concerns about state of mental health, but fewer than 2 hospitalizations, and/or without knowledge of presence of a diagnosable mental health condition * Diminished ability to perform tasks and functions of daily living or communicating intent because of a brain injury, learning disability or developmental disability |
| **2** | While there may be concern for overall mental health or mild impairments to performing tasks and functions of daily living or communicating intent, **all** of the following are true:   * No major concerns about safety or ability to be housed without intensive supports to assist with mental health or cognitive functioning * No major concerns for the health and safety of others because of mental health or cognitive functioning ability * No compelling reason for screening by an expert in mental health or cognitive functioning prior to housing to fully understand capacity |
| **1** | □ In a heightened state of recovery, has a Wellness Recovery Action Plan (WRAP) or similar plan for promoting wellness, understands symptoms and strategies for coping with them, **and** is engaged with mental health supports as necessary. |
| **0** | □ No mental health or cognitive functioning issues disclosed, suspected or observed. |

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### *Physical Health & Wellness*

|  |  |  |  |
| --- | --- | --- | --- |
| **PROMPTS** |  | **CLIENT SCORE:** |  |
| * *How is your health?* * *Are you getting any help with your health? How often?* * *Do you feel you are getting all the care you need for your health?* * *Any illness like diabetes, HIV, Hep C or anything like that going on?* * *Ever had a doctor tell you that you have problems with blood pressure or heart or lungs or anything like that?* * *When was the last time you saw a doctor? What was that for?* * *Do you have a clinic or doctor that you usually go to?* * *Anything going on right now with your health that you think would prevent you from living a full, healthy, happy life?* * *Are there other professionals we could speak with that have knowledge of your health?* * *Do you have any documents or papers about your health or past stays in hospital because of your health?* |  | | |
|  | **NOTES** | |
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| **SCORING** | |
| **4** | **Any** of the following:   * Co-occurring chronic health conditions * Attempting a treatment protocol for a chronic health condition, but the treatment is not improving health * Pallative health condition |
| **3** | Presence of a health issue with **any** of the following:   * Not connected with professional resources to assist with a real or perceived serious health issue, by choice * Single chronic or serious health concern but does not connect with professional resources because of insufficient community resources (e.g. lack of availability or affordability) * Unable to follow the treatment plan as a direct result of homeless status |
| **2** | * Presence of a relatively minor physical health issue, which is managed and/or cared for with appropriate professional resources or through informed self-care * Presence of a physical health issue, for which appropriate treatment protocols are followed, but there is still a moderate impact on their daily living |
| **1** | Single chronic or serious health condition, but **all** of the following are true:   * Able to manage the health issue and live a relatively active and healthy life * Connected to appropriate health supports * Educated and informed on how to manage the health issue, take medication as necessary related to the condition, and consistently follow these requirements. |
| **0** | * No serious or chronic health condition disclosed, observed, or suspected * If any minor health condition, they are managed appropriately |

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### *Medication*

|  |  |  |  |
| --- | --- | --- | --- |
| **PROMPTS** |  | **CLIENT SCORE:** |  |
| * *Have you recently been prescribed any medications by a health care professional?* * *Do you take any medications prescribed to you by a doctor?* * *Have you ever sold some or all of your prescription?* * *Have you ever had a doctor prescribe you medication that you didn’t have filled at a pharmacy or didn’t take?* * *Were any of your medications changed in the last month? If yes: How did that make you feel?* * *Do other people ever steal your medications?* * *Do you ever share your medications with other people?* * *How do you store your medications and make sure you take the right medication at the right time each day?* * *What do you do if you realize you’ve forgotten to take your medications?* * *Do you have any papers or documents about the medications you take?* |  | | |
|  | **NOTES** | |
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| --- | --- |
| **SCORING** | |
| **4** | **Any** of the following:   * In the past 30 days, started taking a prescription which **is** having any negative impact on day to day living, socialization or mood * Shares or sells prescription, but keeps **less** than is sold or shared * Regularly misuses medication (e.g. frequently forgets; often takes the wrong dosage; uses some or all of medication to get high) * Has had a medication prescribed in the last 90 days that remains unfilled, for any reason |
| **3** | **Any** of the following:   * In the past 30 days, started taking a prescription which is **not** having any negative impact on day to day living, socialization or mood * Shares or sells prescription, but keeps **more** than is sold or shared * Requires intensive assistance to manage or take medication (e.g., assistance organizing in a pillbox; working with pharmacist to blister-pack; adapting the living environment to be more conducive to taking medications at the right time for the right purpose, like keeping nighttime medications on the bedside table and morning medications by the coffeemaker) * Medications are stored and distributed by a third-party |
| **2** | **Any** of the following:   * Fails to take medication at the appropriate time or appropriate dosage, 1-2 times per week * Self-manages medications except for requiring reminders or assistance for refills * Successfully self-managing medication for fewer than 30 consecutive days |
| **1** | □ Successfully self-managing medications for more than 30, but less than 180, consecutive days |
| **0** | **Any** of the following:   * No medication prescribed to them * Successfully self-managing medication for 181+ consecutive days |

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### *Substance Use*

|  |  |  |  |
| --- | --- | --- | --- |
| **PROMPTS** |  | **CLIENT SCORE:** |  |
| * *When was the last time you had a drink or used drugs?* * *Is there anything we should keep in mind related to drugs or alcohol?* * *[If they disclose use of drugs and/or alcohol] How frequently would you say you use [specific substance] in a week?* * *Ever have a doctor tell you that your health may be at risk because you drink or use drugs?* * *Have you engaged with anyone professionally related to your substance use that we could speak with?* * *Ever get into fights, fall down and bang your head, or pass out when drinking or using other drugs?* * *Have you ever used alcohol or other drugs in a way that may be considered less than safe?* * *Do you ever end up doing things you later regret after you have gotten really hammered?* * *Do you ever drink mouthwash or cooking wine or hand sanitizer or anything like that?* |  | | |
|  | **NOTES** | |
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##### Note: Consumption thresholds: 2 drinks per day or 14 total drinks in any one week period for men; 2 drinks per day or 9 total drinks in any one week period for women.

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| --- | --- |
| **SCORING** | |
| **4** | * In a life-threatening health situation as a direct result of substance use, **or**, In the past 30 days, **any** of the following are true...   + Substance use is almost daily (21+ times) **and** often to the point of complete inebriation   + Binge drinking, non-beverage alcohol use, or inhalant use 4+ times   + Substance use resulting in passing out 2+ times |
| **3** | * Experiencing serious health impacts as a direct result of substance use, though not (yet) in a life-threatening position as a result, **or**,   In the past 30 days, **any** of the following are true...   * + Drug use reached the point of complete inebriation 12+ times   + Alcohol use usually exceeded the consumption thresholds (at least 5+ times), but usually not to the point of complete inebriation   + Binge drinking, non-beverage alcohol use, or inhalant use occurred 1-3 times |
| **2** | In the past 30 days, **any** of the following are true...   * Drug use reached the point of complete inebriation fewer than 12 times * Alcohol use exceeded the consumption thresholds fewer than 5 times |
| **1** | * In the past 365 days, no alcohol use beyond consumption thresholds, **or**, * If making claims to sobriety, no substance use in the past 30 days |
| **0** | □ In the past 365 days, no substance use |

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### *Experience of Abuse & Trauma*

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| --- | --- | --- | --- |
| **PROMPTS** |  | **CLIENT SCORE:** |  |
| ***\*To avoid re-traumatizing the individual, ask selected approved questions as written. Do not probe for details of the trauma/abuse. This section is entirely self-reported.***   * *“I don’t need you to go into any details, but has there been any point in your life where you experienced emotional, physical, sexual or psychological abuse?”* * *“Are you currently or have you ever received professional assistance to address that abuse?”* * *“Does the experience of abuse or trauma impact your day to day living in any way?”* * *“Does the experience of abuse or trauma impact your ability to hold down a job, maintain housing or engage in meaningful relationships with friends or family?”* * *“Have you ever found yourself feeling or acting in a certain way that you think is caused by a history of abuse or trauma?”* * *“Have you ever become homeless as a direct result of experiencing abuse or trauma?”* |  | | |
|  | **NOTES** | |
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| **SCORING** | |
| **4** | □ A reported experience of abuse or trauma, believed to be a direct cause of their homelessness |
| **3** | □ The experience of abuse or trauma is **not** believed to be a direct cause of homelessness, but abuse or trauma (experienced before, during, or after homelessness) **is** impacting daily functioning and/or ability to get out of homelessness |
| **2** | **Any** of the following:   * A reported experience of abuse or trauma, but is not believed to impact daily functioning and/or ability to get out of homelessness * Engaged in therapeutic attempts at recovery, but does not consider self to be recovered |
| **1** | □ A reported experience of abuse or trauma, and considers self to be recovered |
| **0** | □ No reported experience of abuse or trauma |

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### *Risk of Harm to Self or Others*

|  |  |  |  |
| --- | --- | --- | --- |
| **PROMPTS** |  | **CLIENT SCORE:** |  |
| * *Do you have thoughts about hurting yourself or anyone else? Have you ever acted on these thoughts? When was the last time?* * *What was occurring when you had these feelings or took these actions?* * *Have you ever received professional help – including maybe a stay at hospital – as a result of thinking about or attempting to hurt yourself or others? How long ago was that? Does that happen often?* * *Have you recently left a situation you felt was abusive or unsafe? How long ago was that?* * *Have you been in any fights recently - whether you started it or someone else did? How long ago was that? How often do you get into fights?* |  | | |
|  | **NOTES** | |
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| **SCORING** | |
| **4** | **Any** of the following:   * In the past 90 days, left an abusive situation * In the past 30 days, attempted, threatened, or actually harmed self or others * In the past 30 days, involved in a physical altercation (instigator or participant) |
| **3** | **Any** of the following:   * In the past 180 days, left an abusive situation, but no exposure to abuse in the past 90 days * Most recently attempted, threatened, or actually harmed self or others in the past 180 days, but not in the past 30 days * In the past 365 days, involved in a physical altercation (instigator or participant), but not in the past 30 days |
| **2** | **Any** of the following:   * In the past 365 days, left an abusive situation, but no exposure to abuse in the past 180 days * Most recently attempted, threatened, or actually harmed self or others in the past 365 days, but not in the past 180 days * 366+ days ago, 4+ involvements in physical alterations |
| **1** | □ 366+ days ago, 1-3 involvements in physical alterations |
| **0** | □ Reports no instance of harming self, being harmed, or harming others |

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### *Involvement in Higher Risk and/or Exploitive Situations*

|  |  |  |  |
| --- | --- | --- | --- |
| **PROMPTS** |  | **CLIENT SCORE:** |  |
| * *[Observe, don’t ask] Any abcesses or track marks from injection substance use?* * *Does anybody force or trick you to do something that you don’t want to do?* * *Do you ever do stuff that could be considered dangerous like drinking until you pass out outside, or delivering drugs for someone, having sex without a condom with a casual partner, or anything like that?* * *Do you ever find yourself in situations that may be considered at a high risk for violence?* * *Do you ever sleep outside? How do you dress and prepare for that? Where do you tend to sleep?* |  | | |
|  | **NOTES** | |
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| **SCORING** | |
| **4** | **Any** of the following:   * In the past 180 days, engaged in 10+ higher risk and/or exploitive events * In the past 90 days, left an abusive situation |
| **3** | **Any** of the following:   * In the past 180 days, engaged in 4-9 higher risk and/or exploitive events * In the past 180 days, left an abusive situation, but not in the past 90 days |
| **2** | **Any** of the following:   * In the past 180 days, engaged in 1-3 higher risk and/or exploitive events * 181+ days ago, left an abusive situation |
| **1** | □ Any involvement in higher risk and/or exploitive situations occurred more than 180 days ago but less than 365 days ago |
| **0** | □ In the past 365 days, no involvement in higher risk and/or exploitive events |

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### *Interaction with Emergency Services*

|  |  |  |  |
| --- | --- | --- | --- |
| **PROMPTS** |  | **CLIENT SCORE:** |  |
| * *How often do you go to emergency rooms?* * *How many times have you had the police speak to you over the past 180 days?* * *Have you used an ambulance or needed the fire department at any time in the past 180 days?* * *How many times have you called or visited a crisis team or a crisis counselor in the last 180 days?* * *How many times have you been admitted to hospital in the last 180 days? How long did you stay?* |  | | |
|  | **NOTES** | |
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##### Note: Emergency service use includes: admittance to emergency room/department; hospitalizations; trips to a hospital in an ambulance; crisis service, distress centers, suicide prevention service, sexual assault crisis service, sex worker crisis service, or similar service; interactions with police for the purpose of law enforcement; interactions with fire service in emergency situations.

|  |  |
| --- | --- |
| **SCORING** | |
| **4** | □ In the past 180 days, cumulative total of 10+ interactions with emergency services |
| **3** | □ In the past 180 days, cumulative total of 4-9 interactions with emergency services |
| **2** | □ In the past 180 days, cumulative total of 1-3 interactions with emergency services |
| **1** | □ Any interaction with emergency services occurred more than 180 days ago but less than 365 days ago |
| **0** | □ In the past 365 days, no interaction with emergency services |

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### *Legal*

|  |  |  |  |
| --- | --- | --- | --- |
| **PROMPTS** |  | **CLIENT SCORE:** |  |
| * *Do you have any “legal stuff” going on?* * *Have you had a lawyer assigned to you by a court?* * *Do you have any upcoming court dates? Do you think there’s a chance you will do time?* * *Any involvement with family court or child custody matters?* * *Any outstanding fines?* * *Have you paid any fines in the last 12 months for anything?* * *Have you done any community service in the last 12 months?* * *Is anybody expecting you to do community service for anything right now?* * *Did you have any legal stuff in the last year that got dismissed?* * *Is your housing at risk in any way right now because of legal issues?* |  | | |
|  | **NOTES** | |
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| **SCORING** | |
| **4** | **Any** of the following:   * Current outstanding legal issue(s), likely to result in fines of $500+ * Current outstanding legal issue(s), likely to result in incarceration of 3+ months (cumulatively), inclusive of any time held on remand |
| **3** | **Any** of the following:   * Current outstanding legal issue(s), likely to result in fines less than $500 * Current outstanding legal issue(s), likely to result in incarceration of less than 90 days (cumulatively), inclusive of any time held on remand |
| **2** | **Any** of the following:   * In the past 365 days, relatively minor legal issue has occurred and was resolved through community service or payment of fine(s) * Currently outstanding relatively minor legal issue that is unlikely to result in incarceration (but may result in community service) |
| **1** | □ There are no current legal issues, **and** any legal issues that have historically occurred have been resolved without community service, payment of fine, or incarceration |
| **0** | □ No legal issues within the past 365 days, **and** currently no conditions of release |

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### *Managing Tenancy*

|  |  |  |  |
| --- | --- | --- | --- |
| **PROMPTS** |  | **CLIENT SCORE:** |  |
| * *Are you currently homeless?* * *[If the person is housed] Do you have an eviction notice?* * *[If the person is housed] Do you think that your housing is at risk?* * *How is your relationship with your neighbors?* * *How do you normally get along with landlords?* * *How have you been doing with taking care of your place?* |  | | |
|  | **NOTES** | |
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##### Note: Housing matters include: conflict with landlord and/or neighbors, damages to the unit, payment of rent on time and in full. Payment of rent through a third party is not considered to be a short-coming or deficiency in the ability to pay rent.

|  |  |
| --- | --- |
| **SCORING** | |
| **4** | **Any** of the following:   * Currently homeless * In the next 30 days, will be re-housed or return to homelessness * In the past 365 days, was re-housed 6+ times * In the past 90 days, support worker(s) have been cumulatively involved 10+ times with housing matters |
| **3** | **Any** of the following:   * In the next 60 days, will be re-housed or return to homelessness, but not in next 30 days * In the past 365 days, was re-housed 3-5 times * In the past 90 days, support worker(s) have been cumulatively involved 4-9 times with housing matters |
| **2** | **Any** of the following:   * In the past 365 days, was re-housed 2 times * In the past 180 days, was re-housed 1+ times, but not in the past 60 days * Continuously housed for at least 90 days but not more than 180 days * In the past 90 days, support worker(s) have been cumulatively involved 1-3 times with housing matters |
| **1** | **Any** of the following:   * In the past 365 days, was re-housed 1 time * Continuously housed, with no assistance on housing matters, for at least 180 days but not more than 365 days |
| **0** | □ Continuously housed, with no assistance on housing matters, for at least 365 days |

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### *Personal Administration & Money Management*

|  |  |  |  |
| --- | --- | --- | --- |
| **PROMPTS** |  | **CLIENT SCORE:** |  |
| * *How are you with taking care of money?* * *How are you with paying bills on time and taking care of other financial stuff?* * *Do you have any street debts?* * *Do you have any drug or gambling debts?* * *Is there anybody that thinks you owe them money?* * *Do you budget every single month for every single thing you need? Including cigarettes? Booze? Drugs?* * *Do you try to pay your rent before paying for anything else?* * *Are you behind in any payments like child support or student loans or anything like that?* |  | | |
|  | **NOTES** | |
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| --- | --- |
| **SCORING** | |
| **4** | **Any** of the following:   * Cannot create or follow a budget, regardless of supports provided * Does not comprehend financial obligations * Does not have an income (including formal and informal sources) * Not aware of the full amount spent on substances, if they use substances * Substantial real or perceived debts of $1,000+, past due or requiring monthly payments |
| **3** | **Any** of the following:   * Requires intensive assistance to create and manage a budget (including any legally mandated guardian/trustee that provides assistance or manages access to money) * Only understands their financial obligations with the assistance of a 3rd party * Not budgeting for substance use, if they are a substance user * Real or perceived debts of $999 or less, past due or requiring monthly payments |
| **2** | **Any** of the following:   * In the past 365 days, source of income has changed 2+ times * Budgeting to the best of ability (including formal and informal sources), but still short of money every month for essential needs * Voluntarily receives assistance creating and managing a budget or restricts access to their own money (e.g. guardian/trusteeship) * Has been self-managing financial resources and taking care of associated administrative tasks for less than 90 days |
| **1** | □ Has been self-managing financial resources and taking care of associated administrative tasks for at least 90 days, but for less than 180 days |
| **0** | □ Has been self-managing financial resources and taking care of associated administrative tasks for at least 180 days |

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### *Social Relationships & Networks*

|  |  |  |  |
| --- | --- | --- | --- |
| **PROMPTS** |  | **CLIENT SCORE:** |  |
| * *Tell me about your friends, family or other people in your life.* * *How often do you get together or chat?* * *When you go to doctor’s appointments or meet with other professionals like that, what is that like?* * *Are there any people in your life that you feel are just using you?* * *Are there any of your closer friends that you feel are always asking you for money, smokes, drugs, food or anything like that?* * *Have you ever had people crash at your place that you did not want staying there?* * *Have you ever been threatened with an eviction or lost a place because of something that friends or family did in your apartment?* * *Have you ever been concerned about not following your lease agreement because of your friends or family?* |  | | |
|  | **NOTES** | |
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| --- | --- |
| **SCORING** | |
| **4** | **Any** of the following:   * In the past 90 days, left an exploitive, abusive or dependent relationship * Friends, family or other people are placing security of housing at imminent risk, **or**   impacting life, wellness, or safety   * No friends or family and demonstrates no ability to follow social norms * Currently homeless and would classify most of friends and family as homeless |
| **3** | **Any** of the following:   * In the past 90-180 days, left an exploitive, abusive or dependent relationship * Friends, family or other people are having some negative consequences on wellness or housing stability * No friends or family but demonstrating ability to follow social norms * Meeting new people with an intention of forming friendships * Reconnecting with previous friends or family members, but experiencing difficulty advancing the relationship * Currently homeless, and would classify some of friends and family as being housed, while others are homeless |
| **2** | **Any** of the following:   * More than 180 days ago, left an exploitive, abusive or dependent relationship * Developing relationships with new people but not yet fully trusting them * Currently homeless, and would classify friends and family as being housed |
| **1** | □ Has been housed for less than 180 days, **and** is engaged with friends or family, who are having no negative consequences on the individual’s housing stability |
| **0** | □ Has been housed for at least 180 days, **and** is engaged with friends or family, who are having no negative consequences on the individual’s housing stability |

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### *Self Care & Daily Living Skills*

|  |  |  |  |
| --- | --- | --- | --- |
| **PROMPTS** |  | **CLIENT SCORE:** |  |
| * *Do you have any worries about taking care of yourself?* * *Do you have any concerns about cooking, cleaning, laundry or anything like that?* * *Do you ever need reminders to do things like shower or clean up?* * *Describe your last apartment.* * *Do you know how to shop for nutritious food on a budget?* * *Do you know how to make low cost meals that can result in leftovers to freeze or save for another day?* * *Do you tend to keep all of your clothes clean?* * *Have you ever had a problem with mice or other bugs like cockroaches as a result of a dirty apartment?* * *When you have had a place where you have made a meal, do you tend to clean up dishes and the like before they get crusty?* |  | | |
|  | **NOTES** | |
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| --- | --- |
| **SCORING** | |
| **4** | **Any** of the following:   * No insight into how to care for themselves, their apartment or their surroundings * Currently homeless and relies upon others to meet basic needs (e.g. access to shelter, showers, toilet, laundry, food, and/or clothing) on an almost daily basis * Engaged in hoarding or collecting behavior and is not aware that it is an issue in her/his life |
| **3** | **Any** of the following:   * Has insight into some areas of how to care for themselves, their apartment or their surroundings, but misses other areas because of lack of insight * In the past 180 days, relied upon others to meet basic needs (e.g. access to shelter, showers, toilet, laundry, food, and/or clothing), 14+ days in any 30-day period * Engaged in hoarding or collecting behavior and is aware that it is an issue in her/his life |
| **2** | **Any** of the following:   * Fully aware and has insight in all that is required to take care of themselves, their apartment and their surroundings, but has not yet mastered the skills or time management to fully execute this on a regular basis * In the past 180 days, relied upon others to meet basic needs (e.g. access to shelter, showers, toilet, laundry, food, and/or clothing), fewer than 14 days in every 30-day period |
| **1** | □ In the past 365 days, accessed community resources 4 or fewer times, **and** is fully taking care of all their daily needs |
| **0** | □ For the past 365+ days, fully taking care of all their daily needs independently |

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### *Meaningful Daily Activity*

|  |  |  |  |
| --- | --- | --- | --- |
| **PROMPTS** |  | **CLIENT SCORE:** |  |
| * *How do you spend your day?* * *How do you spend your free time?* * *Does that make you feel happy/fulfilled?* * *How many days a week would you say you have things to do that make you feel happy/fulfilled?* * *How much time in a week would you say you are totally bored?* * *When you wake up in the morning, do you tend to have an idea of what you plan to do that day?* * *How much time in a week would you say you spend doing stuff to fill up the time rather than doing things that you love?* * *Are there any things that get in the way of you doing the sorts of activities you would like to be doing?* |  | | |
|  | **NOTES** | |
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| --- | --- |
| **SCORING** | |
| **4** | □ No planned, legal activities described as providing fulfillment or happiness |
| **3** | □ Discussing, exploring, signing up for and/or preparing for new activities or to re-engage with planned, legal activities that used to provide fulfillment or happiness |
| **2** | □ Attempting new or re-engaging with planned, legal activities that used to provide fulfillment or happiness, but uncertain that activities selected are currently providing fulfillment or happiness, **or** the individual is not fully committed to continuing the activities. |
| **1** | □ Has planned, legal activities described as providing fulfillment or happiness 1-3 days per week |
| **0** | □ Has planned, legal activities described as providing fulfillment or happiness 4+ days per week |

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### *History of Homelessness & Housing*

|  |  |  |  |
| --- | --- | --- | --- |
| **PROMPTS** |  | **CLIENT SCORE:** |  |
| * *How long have you been homeless?* * *How many times have you been homeless in your life other than this most recent time?* * *Have you spent any time sleeping on a friend’s couch or floor? And if so, during those times did you consider that to be your permanent address?* * *Have you ever spent time sleeping in a car or alleyway or garage or barn or bus shelter or anything like that?* * *Have you ever spent time sleeping in an abandoned building?* * *Were you ever in hospital or jail for a period of time when you didn’t have a permanent address to go to when you got out?* |  | | |
|  | **NOTES** | |
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| --- | --- |
| **SCORING** | |
| **4** | □ Over the past 10 years, cumulative total of 5+ years of homelessness |
| **3** | □ Over the past 10 years, cumulative total of 2+ years but fewer than 5 years of homelessness |
| **2** | □ Over the past 4 years, cumulative total of 30+ days but fewer than 2 years of homelessness |
| **1** | □ Over the past 4 years, cumulative total of 7+ days but fewer than 30 days of homelessness |
| **0** | □ Over the past 4 years, cumulative total of 7 or fewer days of homelessness |

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|  |  |  |  |
| --- | --- | --- | --- |
| **Client:** | **Worker:** | **Version:** | **Date:** |

|  |  |  |
| --- | --- | --- |
| **COMPONENT** | **SCORE COMMENTS** | |
| **MENTAL HEALTH & WELLNESS AND COGNITIVE FUNCTIONING** |  |  |
| **PHYSICAL HEALTH & WELLNESS** |  |  |
| **MEDICATION** |  |  |
| **SUBSTANCE USE** |  |  |
| **EXPERIENCE OF ABUSE AND/ OR TRAUMA** |  |  |
| **RISK OF HARM TO SELF OR OTHERS** |  |  |
| **INVOLVEMENT IN HIGHER RISK AND/OR EXPLOITIVE SITUATIONS** |  |  |
| **INTERACTION WITH EMERGENCY SERVICES** |  |  |

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|  |  |  |  |
| --- | --- | --- | --- |
| **Client:** | **Worker:** | **Version:** | **Date:** |

|  |  |  |
| --- | --- | --- |
| **COMPONENT** | **SCORE COMMENTS** | |
| **LEGAL INVOLVEMENT** |  |  |
| **MANAGING TENANCY** |  |  |
| **PERSONAL ADMINISTRATION & MONEY MANAGEMENT** |  |  |
| **SOCIAL RELATIONSHIPS & NETWORKS** |  |  |
| **SELF-CARE & DAILY LIVING SKILLS** |  |  |
| **MEANINGFUL DAILY ACTIVITIES** |  |  |
| **HISTORY OF HOUSING & HOMELESSNESS** |  |  |
| **TOTAL** |  | **Score: Recommendation:**  0-19: No housing intervention 20-34: Rapid Re-Housing  35-60: Permanent Supportive Housing/Housing First |

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# Appendix A: About the SPDAT

OrgCode Consulting, Inc. is pleased to announce the release of Version 4 of the Service Prioritization Decision Assistance Tool (SPDAT). Since its release in 2010, the SPDAT has been used with over 10,000 unique individuals in over 100 communities across North America and in select locations around the world.

Originally designed as a tool to help prioritize housing services for homeless individuals based upon their acuity, the SPDAT has been successfully adapted to other fields of practice, including: discharge planning from hospitals, work with youth, survivors of domestic violence, health research, planning supports for consumer survivors of psychiatric care systems, and in work supporting people with fetal alcohol spectrum disorders. We are encouraged that so many service providers and communities are expanding the use of this tool, and OrgCode will continue to support the innovative use of the SPDAT to meet local needs.

## SPDAT Design

The SPDAT is designed to:

* Help prioritize which clients should receive what type of housing assistance intervention, and assist in determining the intensity of case management services
* Prioritize the sequence of clients receiving those services
* Help prioritize the time and resources of Frontline Workers
* Allow Team Leaders and program supervisors to better match client needs to the strengths of specific Frontline Workers on their team
* Assist Team Leaders and program supervisors to support Frontline Workers and establish service priorities across their team
* Provide assistance with case planning and encourage reflection on the prioritization of different elements within a case plan
* Track the depth of need and service responses to clients over time The SPDAT is NOT designed to:
* Provide a diagnosis
* Assess current risk or be a predictive index for future risk
* Take the place of other valid and reliable instruments used in clinical research and care

The SPDAT is only used with those clients who meet program eligibility criteria. For example, if there is an eligibility criterion that requires prospective clients to be homeless at time of intake to be eligible for Housing First, then the pre-condition must be met before pursuing the application of the SPDAT. For that reason, we have also created the VI-SPDAT as an initial screening tool.

The SPDAT is not intended to replace clinical expertise or clinical assessment tools. The tool complements existing clinical approaches by incorporating a wide array of components that provide both a global and detailed picture of a client’s acuity. Certain components of the SPDAT relate to clinical concerns, and it is expected that intake professionals and clinicians will work together to ensure the accurate assessment of these issues. In fact, many organizations and communities have found the SPDAT to be a useful method for bridging the gap between housing, social services and clinical services.

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## Version 4

The SPDAT has been influenced by the experience of practitioners in its use, persons with lived experience that have had the SPDAT implemented with them, as well as a number of other excellent tools such as (but not limited to) the Outcome Star, Health of the Nation Outcome Scale, Denver Acuity Scale, Camberwell Assessment of Needs, Vulnerability Index, and Transition Aged Youth Triage Tool.

In preparing SPDAT v4, we have adopted a comprehensive and collaborative approach to changing and improving the SPDAT. Communities that have used the tool for three months or more have provided us with their feedback. OrgCode staff have observed the tool in operation to better understand its implementation in the field. An independent committee composed of service practitioners and academics review enhancements to the SPDAT. Furthermore, we continue to test the validity of SPDAT results through the use of control groups. Overall, we consistently see that groups assessed with the SPDAT have better long-term housing and life stability outcomes than those assessed with other tools, or no tools at all.

OrgCode intends to continue working with communities and persons with lived experience to make future versions of the SPDAT even better. We hope all those communities and agencies that choose to use this tool will remain committed to collaborating with us to make those improvements over time.

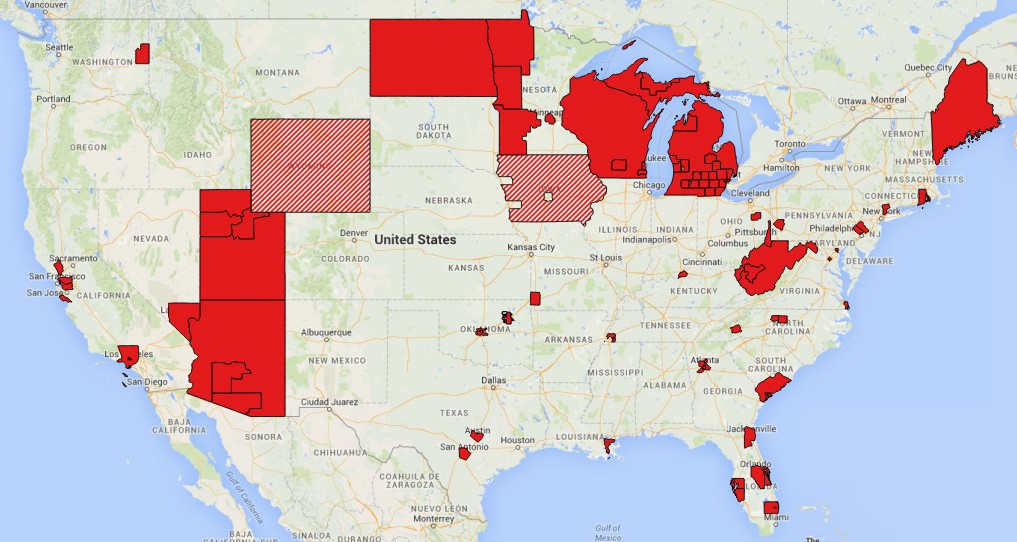
Version 4 builds upon the success of Version 3 of the SPDAT with some refinements. Starting in August 2014, a survey was launched of existing SPDAT users to get their input on what should be amended, improved, or maintained in the tool. Analysis was completed across all of these responses. Further research was conducted. Questions were tested and refined over several months, again including the direct voice of persons with lived experience and frontline practitioners. Input was also gathered from senior government officials that create policy and programs to help ensure alignment with guidelines and funding requirements.

The major differences from Version 3 to Version 4 include:

* The structure of the tools is the same: four domains (five for families) with components aligned to specific domains. The names of the domains and the components remain unchanged.
* The scoring of the tools is the same: 60 points for singles, and 80 points for families.
* The scoring tables used to run from 0 through to 4. They are now reversed with each table starting at 4 and working their way down to 0. This increases the speed of assessment.
* The order of the tools has changed, grouped together by domain.
* Language has been simplified.
* Days are used rather than months to provide greater clarification and alignment to how most databases capture periods of time in service.
* Greater specificity has been provided in some components such as amount of debts.

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# Appendix B: Where the SPDAT is being used (as of May 2015)

## United States of America

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Arizona

* Statewide

California

* Oakland/Alameda County CoC
* Richmond/Contra Costa County CoC
* Watsonville/Santa Cruz City & County CoC
* Napa City & County CoC
* Los Angeles City & County CoC
* Pasadena CoC
* Glendale CoC

District of Columbia

* District of Columbia CoC

Florida

* Sarasota/Bradenton/Manatee, Sarasota Counties CoC
* Tampa/Hillsborough County CoC
* St. Petersburg/Clearwater/Largo/Pinellas County CoC
* Orlando/Orange, Osceola, Seminole Counties CoC
* Jacksonville-Duval, Clay Counties CoC
* Palm Bay/Melbourne/Brevard County CoC
* West Palm Beach/Palm Beach County CoC

Georgia

* Atlanta County CoC
* Fulton County CoC
* Marietta/Cobb County CoC
* DeKalb County CoC

Iowa

* Parts of Iowa Balance of State CoC

Kentucky

* Louisville/Jefferson County CoC

Louisiana

* New Orleans/Jefferson Parish CoC

Maryland

* Baltimore City CoC

Maine

* Statewide

Michigan

* Statewide

Minnesota

* Minneapolis/Hennepin County CoC
* Northwest Minnesota CoC
* Moorhead/West Central Minnesota CoC
* Southwest Minnesota CoC

Missouri

* Joplin/Jasper, Newton Counties CoC

North Carolina

* Winston Salem/Forsyth County CoC
* Asheville/Buncombe County CoC
* Greensboro/High Point CoC

North Dakota

* Statewide

Nevada

* Las Vegas/Clark County CoC

New York

* Yonkers/Mount Vernon/New Rochelle/ Westchester County CoC

Ohio

* Canton/Massillon/Alliance/Stark County CoC
* Toledo/Lucas County CoC

Oklahoma

* Tulsa City & County/Broken Arrow CoC
* Oklahoma City CoC

Pennsylvania

* Lower Marion/Norristown/Abington/ Montgomery County CoC
  + Bristol/Bensalem/Bucks County CoC
  + Pittsburgh/McKeesport/Penn Hills/ Allegheny County CoC

Rhode Island

* + Statewide

South Carolina

* + Charleston/Low Country CoC

Tennessee

* + Memphis/Shelby County CoC

Texas

* + San Antonio/Bexar County CoC
  + Austin/Travis County CoC

Utah

* + Salt Lake City & County CoC
  + Utah Balance of State CoC
  + Provo/Mountainland CoC

Virginia

* + Virginia Beach CoC
  + Arlington County CoC

Washington

* + Spokane City & County CoC

Wisconsin

* + Statewide

West Virginia

* + Statewide

Wyoming

* + Wyoming is in the process of implementing statewide

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## Canada

Alberta

* + - Province-wide

Manitoba

* + - City of Winnipeg

New Brunswick

* + - City of Fredericton
    - City of Saint John

Newfoundland and Labrador

* + - Province-wide

Northwest Territories

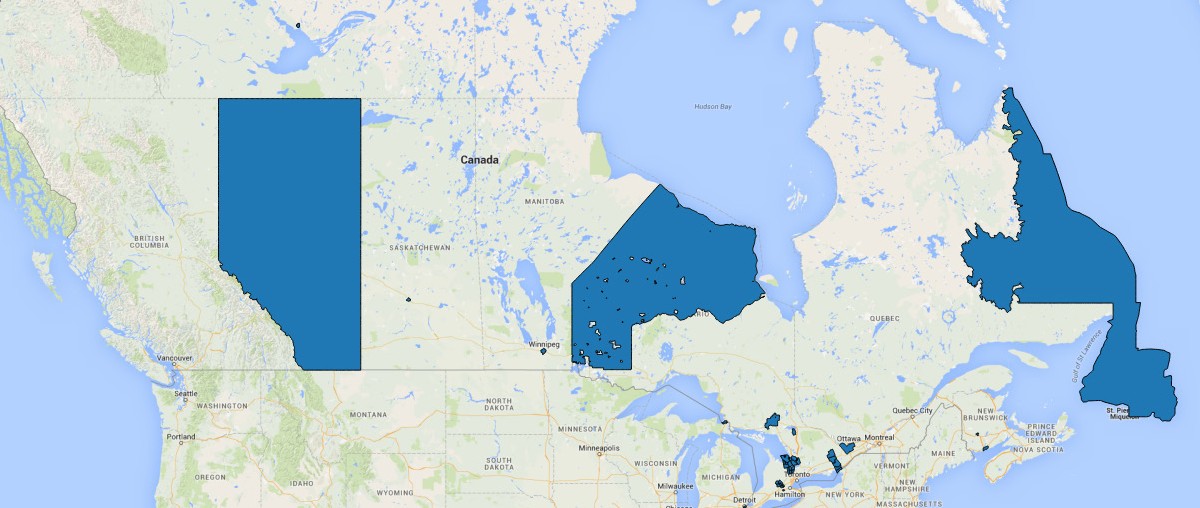
* + - City of Yellowknife

Ontario

* + - City of Barrie/Simcoe County
    - City of Brantford/Brant County
    - City of Greater Sudbury
    - City of Kingston/Frontenac County
    - City of Ottawa
    - City of Windsor
* District of Kenora
* District of Parry Sound
* District of Sault Ste Marie
* Regional Municipality of Waterloo
* Regional Municipality of York

Saskatchewan

* Saskatoon



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## Australia

Queensland

* + Brisbane

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Exhibit E **Capital Region Housing Collaborative Coordinated Entry Screening Assessment**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **HOUSEHOLD INFORMATION**  **Answer this section for all persons in the household (use additional sheets for larger families)** | | | | | | |
| **Full Name** | **Relationship to Head of Household** | **SSN** | **US Military Veteran** | **Date of Birth**  mm/dd/yyyy | **Gender** | **Race**  *(Select all that apply)* |
| **Name Data Quality**   * Full name * Partial, street or code name * Client doesn’t know * Client refused | □ Self (Head of household) | **SSN Data Quality**   * Full SSN Reported * Approximate or partial SSN reported * Client doesn’t know * Client refused | *(Answer for adults 18+ only)*   * Yes * No * Client doesn’t know * Client refused | **/ /**  **DOB Data Quality**   * Full DOB reported * Approximate or partial DOB * Client doesn’t know * Client refused | * Female * Male * Trans Female (MTF or Male to Female) * Trans Male (FTM or Female to Male) * Gender Non Conforming * Client doesn’t know * Client refused | * American Indian or Alaskan Native * Asian * Black or African American * Native Hawaiian or other Pacific Islander * White * Client doesn’t know * Client refused |
| **Name Data Quality**   * Full name * Partial, street or code name * Client doesn’t know * Client refused | * Head of Household’s child * Head of household’s spouse or partner * Head of household’s other relation member (other relation to head of household) * Other: non-relation member | **SSN Data Quality**   * Full SSN Reported * Approximate or partial SSN reported * Client doesn’t know * Client refused | *(Answer for adults 18+ only)*   * Yes * No * Client doesn’t know * Client refused | **/ /**  **DOB Data Quality**   * Full DOB reported * Approximate or partial DOB * Client doesn’t know * Client refused | * Female * Male * Trans Female (MTF or Male to Female) * Trans Male (FTM or Female to Male) * Gender Non Conforming * Client doesn’t know * Client refused | * American Indian or Alaskan Native * Asian * Black or African American * Native Hawaiian or other Pacific Islander * White * Client doesn’t know * Client refused |
| **Name Data Quality**   * Full name * Partial, street or code name * Client doesn’t know * Client refused | * Head of Household’s child * Head of household’s spouse or partner * Head of household’s other relation member (other relation to head of household) * Other: non-relation member | **SSN Data Quality**   * Full SSN Reported * Approximate or partial SSN reported * Client doesn’t know * Client refused | *(Answer for adults 18+ only)*   * Yes * No * Client doesn’t know * Client refused | **/ /**  **DOB Data Quality**   * Full DOB reported * Approximate or partial DOB * Client doesn’t know * Client refused | * Female * Male * Trans Female (MTF or Male to Female) * Trans Male (FTM or Female to Male) * Gender Non Conforming * Client doesn’t know * Client refused | * American Indian or Alaskan Native * Asian * Black or African American * Native Hawaiian or other Pacific Islander * White * Client doesn’t know * Client refused |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **HOUSEHOLD INFORMATION continued…**  **Answer this section for all persons in the household (use additional sheets for larger families)** | | | | | | | |
| **Name** *(Answer for All Persons in HH)* | **Ethnicity** | **Does the client have a disabling condition?** | **If client has a disabling condition, please answer the following sub-assessment questions:** | | | | |
| *Disability Type (Select all that apply)* | *Disability Determination* | *Long Term (Yes/ No)* | *If Yes, will the condition to be long-continued and indefinite duration and substantially impairs ability to live independently?* |
|  | □ Non- Hispanic/ Non-Latino  ☐Hispanic/ Latino  ☐Client doesn’t know  ☐Client refused | * Yes * No * Client doesn’t Know * Client refused | * Physical * Developmental * Chronic Health Condition * HIV/AIDS * Mental Health Problems * Alcohol Abuse * Drug Abuse * Both Alcohol & Drug Abuse | * Yes * No * Client doesn’t know * Client refused | * Yes * No | * Yes * No * Client doesn’t know * Client refused |
|  | □ Non- Hispanic/ Non-Latino  ☐Hispanic/ Latino  ☐Client doesn’t know  ☐Client refused | * Yes * No * Client doesn’t Know * Client refused | * Physical * Developmental * Chronic Health Condition * HIV/AIDS * Mental Health Problems * Alcohol Abuse * Drug Abuse * Both Alcohol & Drug Abuse | * Yes * No * Client doesn’t know * Client refused | * Yes * No | * Yes * No * Client doesn’t know * Client refused |
|  | □ Non- Hispanic/ Non-Latino  ☐Hispanic/ Latino  ☐Client doesn’t know  ☐Client refused | * Yes * No * Client doesn’t Know * Client refused | * Physical * Developmental * Chronic Health Condition * HIV/AIDS * Mental Health Problems * Alcohol Abuse * Drug Abuse * Both Alcohol & Drug Abuse | * Yes * No * Client doesn’t know * Client refused | * Yes * No | * Yes * No * Client doesn’t know * Client refused |





**Homeless History Interview**

**Answer the following questions for ALL Household Members**

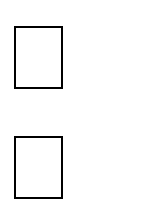
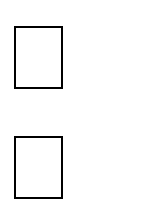
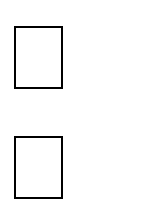
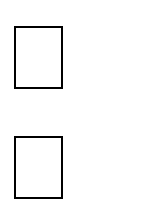
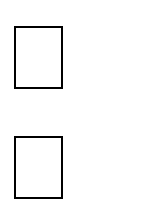
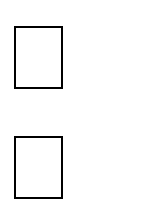
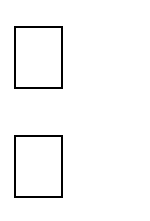
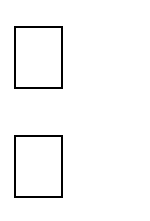
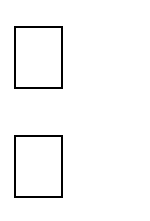
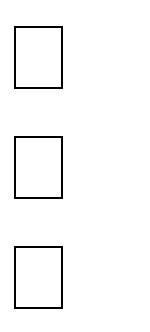
**(Use additional sheets if members of the same household have different homeless histories)**

*Chronic status is determined by a client’s history of homelessness, disability status, and the length of time spent on the street, in an emergency shelter or safe haven. Requires a*

*substantiated disability and, continuously homeless for past 12 months to qualify or 4 separate occasions in the past 3 years as long as the combined occasions total at least 12 months.* Intake workers should not instruct the client on the length of time/# of episodes necessary to qualify as chronically homeless. Questions should be asked in the exact order they are presented below.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Describe the client’s living situation (immediately) prior to project entry?**  **(Select one Living Situation and answer the corresponding questions in the order in which they appear)** | | | | |
|  | **Literally Homeless Situation** | **Institutional Situation** | **Transitional/Permanent Housing Situation** | **Don’t Know/ Refused** |
| **SECTION I** | Place not meant for habitation (e.g. a vehicle, abandoned building, bus/train/subway station, airport, anywhere outside).    Emergency shelter, including hotel or motel paid for with emergency shelter voucher.    Safe Haven (not Haven House)    Interim Housing (e.g. client applied for permanent housing and a unit/voucher has been reserved but client is not able to move in immediately). | Foster care home or foster 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 (other than RRH) for formerly homeless persons (such as CoC Project)    Rental by client, no ongoing housing subsidy Rental by client, with VASH housing subsidy Rental by client, with GPD TIP subsidy  Rental by client, with RRH or equivalent housing 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) | Client doesn’t know Client refused |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SECTION II** | **Length of Stay in Prior Living Situation (i.e. the literally homeless situation identified above)?**  One night or less Two to six nights  One week or more but less than one month  One month or more but less than 90 days  90 days or more but less than one year  One year or longer | **Length of Stay in Prior Living Situation (i.e. the institutional situation identified above)?**  One night or less Two to six nights  One week or more but less than one month  One month or more but less than 90 days  90 days or more but less than one year One year or longer  **Did you stay in the institutional situation less than 90 days?**  Yes **(If YES – Complete SECTION III)**  No **(If NO- End Homeless History Interview)** | **Length of Stay in Prior Living Situation (i.e. the housing situation identified above)**  One night or less Two to six nights  One week or more but less than one month One month or more but less than 90 days 90 days or more but less than one year One year or longer  **Did you stay in the housing situation less than 7 nights?**  Yes **(If YES – Complete SECTION III)**  No **(If NO – End Homeless History Interview)** | Client doesn’t know Client refused |
| **SECTION III** | **N/A**  **Complete SECTION IV Below** | **On the night before entering the institutional situation did you stay on the streets, in emergency shelter or a safe haven?**  Yes **(If YES – Complete SECTION IV)**  No **(If NO- End Homeless History Interview)** | **On the night before entering the housing situation did you stay on the streets, in emergency shelter or a safe haven?**  Yes **(If YES – Complete SECTION IV)**  No **(If NO – End Homeless History Interview)** | Client doesn’t know Client refused |
| *Have the client look back to the date of the last time s(he) “had a place to sleep* ***other than*** *the streets, ES, or SH”.*  *If the client knows the month and year but not the day, the worker may substitute the day of the month with the same day of the month as project entry.*  *What Counts as a Break in Homelessness?*  *As the client looks back, there may be breaks in their stay on the streets, ES, or SH. A break in homelessness is considered to be:*   * ***7 or more consecutive nights in a Housing Situation*** *(see Section III above).* * ***90 or more consecutive days in an Institutional Situation*** *(see Section II above)*   *Follow-up questions:*   1. *“Did you stay anywhere other than on the streets, in emergency shelter, or safe haven for less than 7 nights” (if not an institution). or* 2. *“Were you in jail/hospital/other Institution less 90 days” (if break is an institution).*   ***If 1 or 2 is yes, include all those days in the client’s total number of days homeless and continue back to the next break in homelessness.*** | | | | |
| **SECTION IV** | **Approximate date current literal homelessness started:** (MM/DD/YYYY)  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**  One Time (this is the first time homeless) Three Times Client doesn’t know  Two Times (this time and once before) Four or more Times Client refused  **Total number of months homeless (on the street, in emergency shelter or safe haven) in the past 3 years? (e.g. # of cumulative, but not necessarily consecutive months spent homeless)**  One month (this time is the first month) More than 12 months Client doesn’t know  2 – 12 months Must specify # months Client refused | | | |





## Housing Status

* Category 1 - Homeless
* Category 2 - At imminent risk of losing housing within 14 days
* Category 3 – Homeless only under other federal statues
* Category 4 – Fleeing domestic violence
* At-risk of homelessness
* Stably Housed
* Client doesn’t know
* Client refused

## Zip Code of Last Permanent Address (not shelter’s zip): \_\_\_\_\_\_\_\_\_\_ City of Residence: County of Residence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*Answer the following questions for HEAD OF HOUSEHOLD Only\*\***

**Client Location (CoC Code/Name)** MI-508 - Ingham

Do you have other housing options for the next few days/weeks? □ Yes □ No If yes, how long?

If Doubled-Up: Describe Issues & Resource Needs

If Own Unit: Describe Issues & Resources Needs

## Household Type

|  |  |  |  |
| --- | --- | --- | --- |
| Household without children | Household with adult(s) and minor child(ren) | Household of unaccompanied youth (18-24) | Household of unaccompanied youth (under 18) |

## Number in Household (enter “1” if single adult only): Household Size: # of Adults: # of Children (under 18):

**Total Household monthly income % of Median Income:** □ 0-30% □ 31-50% □ 51-80% □ over 80% (Use Median Income Chart)

**\*\*Answer the following questions for HEAD OF HOUSEHOLD and ADULTS only!**

**DOMESTIC VIOLENCE**

*Domestic Violence Victim/Survivor should be indicated as* ***“Yes”*** *if the person has experienced any domestic violence, dating violence, sexual assault, stalking or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has taken place* ***within the individual’s or family’s primary nighttime residence.***

**Domestic Violence Victim/Survivor?**

* Yes
* No
* Client doesn’t know
* Client refused

***(If yes)* When Experience Occurred**

* Within the past three months
* Three to six months ago (excluding six months exactly)
* Six months to one year ago (excluding one year exactly)
* One year ago or more
* Client doesn’t know
* Client refused

*Currently fleeing should be indicated as* ***“Yes”*** *if the Person is fleeing, or is attempting to flee, the domestic violence situation* ***or*** *is afraid to return to their primary nighttime residence.*

***(If yes)* Are you currently fleeing?**

* Yes
* No
* Client doesn’t know
* Client refused

**Overview of domestic violence:**

***Prevention Only (Complete this section for Head of Household Only - Skip if Literally Homeless)***

What is the monthly rent amount? No of bedrooms: Is back rent/late fees owed? □ Yes □ No If yes: # of Mos. Delinquent: Total Due $

Is another agency/person/program providing any of the rent costs? □ Yes (*How Much*?) $ □ No Have eviction proceedings begun? □ Yes □ No

If yes, list evidence provided:

|  |  |  |
| --- | --- | --- |
| Utility | Monthly Amount | Past Due Balance |
| Gas |  |  |
| Electric |  |  |
| Water |  |  |
|  |  |  |

## OPTIONAL: List any utilities that are not included in the rent (Phone and Internet/TV are not eligible for ESG asst.)

**Emergency Contact Information**

To obtain the client’s emergency contact information, intake staff should ask the client, “*If you wish to be contacted regarding benefits that you may be eligible for or in the case of an emergency, we will need your best Contact Information. Some services are very time limited so please be as accurate as possible and include how we might reach you even as your circumstances are changing."*

## Client’s Cell Phone Number

**Emergency Contact’s Name**

**Contact Type (Relationship to Client)**

**Phone Number**

**Second Phone Number**

**Email Address**

**Contact’s Address: Street City State Contact’s Zip Code**

**Assessment Disposition**

**Required for Coordinated Assessment - Head of Household Only**

* Referred to emergency shelter/safe haven
* Referred to transitional housing
* Referred to rapid re-housing
* Referred to permanent supportive housing
* Referred to homeless outreach
* Referred to street outreach
* Referred to other continuum project type
* Referred to a homelessness diversion program
  + Unable to refer/accept within continuum; ineligible for continuum projects
  + Unable to refer/accept within continuum; continuum services unavailable
  + Referred to other community project (non-continuum)
  + Applicant denied referral/acceptance
  + Applicant terminated assessment prior to completion
  + Other/specify
* If Other Assessment Disposition, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exhibit F

Michigan State Homeless Management Information System (MSHMIS)

**Qualified Service Organization Business Associate Agreement**

**Lansing/Ingham, Michigan Implementation**

# *The following agencies, on behalf of their listed program components, hereby enter into a “Coordinated Services Agreement.”*

**1. Advent House Ministries**

1. One Church One Family PSH
2. PSH for Families
3. Hope Housing PSH
4. Fresh Start RRH

**2. CFC - Gateway Youth Services Div.**

1. HYR Services\*
2. Higher Ground Shelter (BCC)\*
3. Crossroads Transitional Housing (TLP)\*
4. Crossroads Non-Residential\*
5. Housing Young Families (MGH)
6. Rapid Re-Housing for Youth
7. Street Outreach Programs\*

**3. City of Lansing – HRCS Department**

1. Citizen assists for identification and birth records
2. Veterans Services Coordination

**4. City Rescue Mission of Lansing**

* 1. Women and Children Shelter
  2. Men’s Shelter

**5. Community Mental Health Authority of Clinton, Eaton, Ingham Counties**

1. Veterans Navigator
2. Housing Specialist

**6. Haven House**

1. Family Emergency Shelter

**7. Holy Cross Services**

* 1. City of Lansing ESG Prevention
  2. HARA – Screening, RRH & Prevention
  3. Emergency Shelter
  4. HELP Hoteling Program
  5. New Hope Day Shelter
  6. Community Kitchen
  7. IDT - Behavioral Health Coordination
  8. Ingham County – PSH 1
  9. Ingham County – PSH 2
  10. Ingham County – PSH 3 (PSH Bonus)
  11. GPD Veteran Housing components (clinical, hospital to home, low-demand)

**8. Homeless Angels**

1. Burkewood Inn Emergency Hoteling
2. Community Free Store

**9. Housing Services Mid Michigan**

1. Ingham County PATH Outreach
2. Ingham County PATH Services

**10. Lansing Housing Commission**

1. Permanent Supportive Housing 2
2. Shelter Plus Care

**11. Loaves and Fishes Ministries**

1. Overnight Shelter ESG
2. Luke’s House
3. Zaccheaus’ House

**12. Mid-Michigan Recovery Services**

* 1. Glass House\*
  2. Holden House\*
  3. Transitions for Men\*
  4. CABHI – services, RRH & Prevention

**13. Oakland Livingston Human Service Agency**

1. Supportive Services for Veteran Families (SSVF) – Ingham County – RRH & Prevention

**14. One Church One Family**

a. Ending Family Homelessness through Rapid Rehousing

**15. Volunteers of America, Michigan**

1. Supportive Services for Veteran Families (SSVF) – Ingham County – RRH & Prevention

\*Programs marked with an asterisk permit data to be shared to them, but do not share their client data with other providers due to the nature of services they provide

Exhibit G

Capital REgion HOusing COllaborative

MSHMIS CLIENT RELEASE OF INFORMATION & SHARING PLAN

SECTION 1 - Identifying Information

**Introduction**: Many Michigan shelters and assistance programs use the Michigan Statewide Homeless Management Information System (MSHMIS) to keep information about people that they help. We collect personal information from you that we need to help us help you. We have strict rules about sharing your information.

**Why do we collect information about you?**

* Work with other agencies to help you
* Help case managers work together for you

Connect you with other helping agencies. You may be eligible for other benefits.

* Reduce the number of times you have to tell your story
* To allow agencies to be paid for their work with you and to help them apply for additional dollars that can be used to help you.
* To help agencies meet their legal obligations.

We need additional identifying information to insure your information is not confused with someone else. We also need to learn more about your situation to make sure you are eligible for services.”

**What basic identifying information is collected about you?**

* Your name
* Your gender
* Your Social Security Number
* Your date of birth

**Finding your Information on the HMIS?**

**Basic identifying information** (name, year of birth, **partial** Social Security Number and gender and your veteran status) can be seen by all Michigan agencies that use HMIS. This information allows us to select the correct record and to better coordinate services for you. All persons using HMIS are trained and certified in privacy.

If you have a specific privacy concern you can ask to close this information so that only our Agency can see this information. Initial here if you **DO NOT** want basic identifying information shared: \_\_\_\_\_\_.

SECTION 2 – Coordination of Care Sharing Plan

Many agencies also use the System to improve services to you through coordination of care. If you are receiving services from multiple agencies that participate in the System, agreement to the Sharing Plan defined below allows for these Agencies to see your information. You will only have to sign this release once and it applies to all Agencies listed below in “The Plan”.

**Your Rights (Instructions)** Put your initials next to the statements that you understand and agree to:

|  |  |
| --- | --- |
| \_\_\_ | I have received a copy of this Agency’s Privacy Notice/script that explains MSHMIS and my rights and responsibilities associated with how information is kept and shared through this system. |
| \_\_\_ | I understand that my written consent allows the information listed in the Sharing Plan to be shared among the agencies listed in the Sharing Plan. All sharing agencies where I am receiving services may update that information as I provide additional or new information. The purpose of sharing my information is to better coordinate care for me and my family. |

|  |  |
| --- | --- |
| \_\_\_ | I understand that the confidentiality of my records is protected by law. I understand that this agency will never give information about me to anyone outside the agency without my specific written consent through a Sharing Plan or as required by law (The regulations are the Federal Law of Confidentiality for Alcohol and Drug Abuse Patients, (42 CFR, Part 2) and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 CRF, Parts 160 & 164) and certain Michigan laws. |
| \_\_\_ | I understand that Agencies included in my Sharing Plan must follow strict privacy guidelines. |
| \_\_\_ | I can withdraw my consent to share at any time; however any information already shared with another agency cannot be taken back. I also understand that the request to discontinue sharing will have to be coordinated between sharing partners. I should tell any agencies that I am seeing included on the Plan when I withdraw my consent. |
| \_\_\_\_ | I understand that I have the right to see my information, request to change it, and to have a copy of that information from the servicing agency by written request. An agency can refuse to change information in my record, but must provide me with a written explanation within 60 days of the request. Agencies are allowed to charge for reproducing a record. |
| \_\_\_ | I understand that the refusal to share information in this system will not be used to deny me services such as emergency assistance, outreach, shelter, or housing assistance. |
| \_\_\_\_ | I understand that some of my information may be disclosed for academic research purposes without identifying information included. My name and other identifying information may be used to match records but will not be released to be used directly in the research unless I sign a separate consent when identifying information is a requirement for the Study (example: so a researcher can contact me). |

**Description of Information Shared through the Coordination of Care Plan**

|  |  |  |
| --- | --- | --- |
| Your gender, race, ethnicity | Homeless status and history | Disabling condition (if applicable) |
| Your family immediate members | Type of housing | Medical information |
| Your phone numbers/contact info | Household income | Mental health |
| Your address – current or past | Domestic violence history | Substance use |
| Marital status | Reasons for homelessness | Pregnancy status |
| Military veteran status | Employment information | Services and referrals provided |
| Program participation dates – entry and exit dates | Scanned copies of your documents necessary for housing assistance | VI-SPDAT and SPDAT scores (individual, family and TAY assessments) |
| Housing case plan goals and case notes | Coordinated Entry screening information |  |

**This information** (listed above) can be seen by all the agencies listed below to help coordinate your care. Any of these agencies can share your information with each other.

|  |  |
| --- | --- |
| * Advent House Ministries | * Child and Family Charities – Gateway Youth Services Division |
| * City of Lansing Human Relations and Community Services Department | * City Rescue Mission of Lansing |
| * Community Mental Health Authority of Clinton, Eaton, Ingham Counties | * Homeless Angels * Holy Cross Services |
| * Haven House | * Housing Services Mid Michigan |
| * Lansing Housing Commission | * Loaves and Fishes Ministries |
| * Mid-Michigan Recovery Services * One Church One Family | * Oakland Livingston Human Service Agency * Volunteers of America, Michigan |

**Instructions:** Check the box next to the statement that you understand and agree to:

* 1. **□** Yes, I agree to share according to the Sharing Plan.
  2. **□** No, I do not agree to the Sharing Plan (Only our agency will able to see all your detailed information.)

SECTION 3 – Outreach Sharing Plan

**Sharing Plan for the purpose of improving outreach to individuals that may qualify for benefits**

Many Michigan community programs have requested to use your information to see if you might qualify for housing or income supports. **Please read each statement below and circle your response(s).**

1. If you don’t have a State ID, the Secretary of State is accepting the HMIS ServicePoint ID card with an agency referral as initial proof of your identity. To do that, the Secretary of State will need to verify that your Card is genuine by looking at your information in HMIS.

*Information that will be shared includes: Name, date of birth and Social Security Number*

**Yes I agree to share my HMIS data for the Secretary of State Project: (Circle Response):** **Yes/No/NA**

1. If you have served in the military and been on active duty, the VA Medical Center would like to contact you about potential housing. With your permission, they will use the information you give this provider (recorded in the HMIS) to contact you.

*Information that will be shared includes: Name, date of birth, homeless status, veteran status, housing history, contact information, chronically homeless status*

**Yes I agree to share my HMIS data for the Veteran’s Project: (Circle Response): Yes/No/NA**

1. Income is important to staying housed. The Department of Health and Human Services is identifying homeless people that may qualify for Social Security Income and/or other State benefits. With your permission, they will use the information you give this provider (recorded in the HMIS) to contact you if you are eligible for benefits.

*Information that will be shared includes: Name, date of birth, coordinated assessment information, homeless status, housing history, contact information, chronically homeless status*

**Yes I agree to share my HMIS data for the SOAR/State Benefit Project: (Circle Response): Yes/No/NA**

1. If you are homeless, you might be eligible for housing in our community. We have a housing review committee that has case managers from many of our agencies. To participate in this process, the agencies will need to see information recorded in HMIS. With your permission, an agency will contact you if that information shows that you may be eligible for local housing services.

A list of specific agencies involved in this process may be had upon request.

*Information that will be shared includes: Name, coordinated assessment information, homeless status, chronically homeless status, veteran status, disability*

**Yes I agree to share my HMIS data for Housing Prioritization: (Circle Response): Yes/No/N**

SECTION 3 – Outreach Sharing Plan (cont’d)

Sharing Plan for the purpose of improving outreach to individuals that may qualify for benefits

A number of community programs working in Michigan have requested to use HMIS data to better identify those that may qualify for housing or income supports. Information shared will only include that information specifically relevant to the benefit and includes contact information. Please read each of the statements below and circle the appropriate response(s).

1. We may need to document your homeless history to see if you are eligible for specific community programs. Your case manager will contact a Representative from the Michigan Coalition against Homelessness (MSHMIS lead agency) to view data recorded in HMIS in order to complete a housing history document. With your permission, these representatives will complete the document and give it to your case manager.

*Information that will be shared includes: HMIS number, Name, date of birth and Social Security Number, housing history, history of shelter stays*

**Yes I agree that MCAH may share data to the Case Manager: (Circle Response): Yes/No/NA**

1. **For Young Adults:** For clients that received services prior to age 18, we may need to document your homeless history to see if you are eligible for specific community programs. Your case manager will contact a Representative from the Michigan Coalition against Homelessness (MSHMIS lead agency) to view data recorded in the HMIS in order to complete a housing history document. **If you are a youth under the age of 24 and have received services from a youth provider while you were under the age of 18**, do you give permission for these Representatives to complete the housing history document to be given to your case manager?

*Information that will be shared includes: HMIS number, Name, date of birth and Social Security Number, housing history, history of shelter stays*

**Yes I agree that MCAH may share data to the Case Manager: (Circle Response): Yes/No/NA**

|  |
| --- |
| **This Release is active for one year effective the date of Signature.**  Client signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,  Signature of guardian or authorized-representative (when required): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship to client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date signed by guardian/authorized representative: \_\_\_\_\_\_ |

Exhibit H

**Memorandum of Understanding** Between Holy Cross Services, Ingham CES And

Homeless Angels

The following MOU describes the agreement between Holy Cross Services (HCS) and Homeless Angels (HA) for coordination of shelter and housing services provided to their homeless participants.

# Coordinated Entry

HA agrees to

1. HA agrees to participate with the Coordinated Entry System in Ingham County, as facilitated by HCS as the Coordinated Entry Agency (CEA).
2. Provide written “Shelter Verification” only for homeless persons who are staying at he Burkewood Inn as part of HA’s program, meaning HA is supporting the financial obligation of the stay. (\*Persons paying their own room rate, or having a family member or friend pay, will not be provided a shelter verification as they do not meet HUD’s definition of homeless.)
3. HCS and HA, together, agree to a standard operating procedure to administer a uniform intake, assessment and rule structure that will address the data requirements for the Homeless Management Information System (HMIS).
4. HA agrees to participate with the Interdisciplinary Team (IDT) which meets on Wednesdays at 12pm at 4414 N. Larch Street, Lansing, MI 48912.

HCS agrees to

1. Enter newly identified participants into the HMIS system and provide a service point card; update HMIS information for previously identified individuals.
2. Conduct a phone or face-to-face interview for assessment and housing plan development with the participant at its office at 430 N Larch St. Lansing, MI 48912
3. HCS will provide an on-site outreach to the Burkewood hotel each week on a schedule as agreed upon by HA and HCS.
4. HCS will include HA as a CE Site for referrals and placement.
5. Provide referrals to internal departments and partnering agencies for food, transportation, medical, dental, behavioral health, substance use treatment, disability benefits, and other resources as needed.
6. Provide housing search support with landlord lists, advocacy, and financial support where eligible.

# Hotel Emergency Program

For service areas that are without shelter facilities or for areas where shelter facilities are at capacity, emergency motel lodging is available for eligible households for up to seven (7) nights per operating year, through the HCS Hotel Emergency Lodging Program (HELP). Extensions may be requested by agencies for households that need additional time in HELP. To be eligible for an extension, the household must be actively seeking housing and working cooperatively with the ESP provider.

HA agrees to

1. Provide Emergency Lodging at the Burkewood Hotel for HCS families at a rate of $48 each night.
2. Invoice HCS monthly, per family unit.
3. Complete referral voucher, per family unit, and return to Shannon Jones, Office Manager, at sjones@ HCS.org

HCS agrees to

1. Make every attempt to practice shelter diversion for households seeking shelter or hotel assistance, prior to providing overnight emergency lodging.
2. Refer eligible families for hotel placement at Burkewood Inn, as administered by HA, and provide case management.
3. To support the ESP goal of moving households into stable housing as quickly as possible and creating a successful partnership with the CE, HCS must make every effort to maintain engagement with households receiving hotel services, have regular communication with the CE, and coordinate services with the CE.
4. Provide names and family information via daily email, of family shelters in Ingham County for placement.
5. Provide monthly reimbursement for families placed at Burkewood Inn through the HELP, based on invoices receive from HA.

HA and HCS agree to adhere to Health Insurance Portability and Accountability Act (HIPAA) confidentiality standards and to provide each other with releases of information as required.

This agreement may be severed by either party by providing at least 30-day prior written notice.

Signed this the day of , 2017

Sharon Dade, Director, New Hope Community Center, Holy Cross Services

Tim Baise, Homeless Angels (HA)

Exhibit I

Capital Region Housing Collaborative

Policies and Procedures Manual

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Exhibit J

# Ingham County Coordinated Entry

Agency (formerly HARA)

###  Need help with rent and utilities?

 **Having trouble finding housing?**

**At 430 N. Larch Street Lansing, MI 48912 from**

**9-5pm at the New Hope Front Desk or call 211 for assistance.**

What is the Coordinated Entry Agency? (CEA)

#### The CEA is a place that you can receive a lot of different services or referrals in one agency. It can be described as a “one-stop” shop and the first point of contact that if you are having problems with housing or other issues.

Services that we provide:

* Assistance with first month’s rent and utilities
* Housing opportunities
* Referrals to other agencies
* Preventative help with evictions
* Rapid rehousing

Look at the schedule on the other side to receive more info!

**Image courtesy of digitalart at FreeDigitalPhotos.net**

Where Are Community Resources?

 City Rescue Mission Women’s and Children’s Shelter of Lansing (Shelter)

2216 S. Cedar St. Lansing, MI 48910 517-485-0145

1st and 3rd Monday from 10am-12pm

 Haven House (Family Shelter)

121 Whitehills Dr. East Lansing, MI 48823 517-337-2731

1st and 3rd Tuesday from 1pm-2:30pm

 Loaves and Fishes Ministries (Overnight Shelter) 831 N. Sycamore St. Lansing, MI 48906

517-676-8400

2nd and 4th Tuesday 9am-10:30am

 55th District Court (Eviction Prevention) 700 Buhl St, Mason, MI 48854

517-676-8400

Every Thursday from 12pm-4pm

 Advent House Ministries (Transitional Housing, Employment Readiness, Nutritional Meals)

743 N MLK Jr Blvd, Lansing, MI 48915 Every Tuesday 10am-12pm (by appt)

*Housing Hour (open to public) 2nd and 4th Tuesday*

Department of Human Services (SNAP, HealthyMI) 5303 S. Cedar St. Lansing, MI 48911

Every Friday (by appt) from 10am-1pm

 EVE (End Violent Encounters-Domestic Abuse Shelter)

P.O Box 14149 Lansing, MI 48901 517-372-5976

2nd and 4th Tuesday at 10am-12pm

Community Services Group Schedule

All community services groups are held in the New Hope classroom

All cla Ce

group classes ar sroom at New H er (430 N. Larc

in the pe Day

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** |
| Shelter Orientation 8:30am | Housing Assistance  1pm | Shelter Orientation 8:30am  n | Health N’ Wellness e  8:30 am  s  t h | Health N’ Wellness  o8:30 am  ) |
| Share a Bike  9am |  | Job Club (Advent  House)  1pm | Health N’ Wellness 2pm | Housing Choice  Voucher (Section 8)  1pm |
| Benefits Screening 10am |  | DHS Assistance 2pm | Benefits Screening 10am |  |
| Housing Assistance 1pm |  | Housing Choice Voucher (Section 8) 2pm |  |  |
|  |  |  |  |  |

1. http://orgcode.nationbuilder.com/spda [↑](#footnote-ref-1)
2. GLHRN Board minutes, July 2015 [↑](#footnote-ref-2)
3. GLHRN Board minutes, October 2015 [↑](#footnote-ref-3)
4. GLHRN Board minutes, August 2016 [↑](#footnote-ref-4)
5. In lieu of revised Technical Standards, in 2015 the requirement for a privacy officer was removed. However the function of data security has been assigned to the assigned Agency Administrator. Reflecting Participation Agreement Language the quarterly review of Provider Visibility has been expressly added to this document. [↑](#footnote-ref-5)
6. Language was added to clarify the HIPAA rule. [↑](#footnote-ref-6)
7. The change reflects changes in the HIPAA rule that allow for Releases the cover a term – rather than a specific date. The date in the electronic ROI will reflect the specific date defined by the term. The term should not be arbitrary but reflect the anticipated term of the agencies planned coordinating activities. [↑](#footnote-ref-7)
8. Recognizes existing practice by participating CoCs. [↑](#footnote-ref-8)
9. Original language focused on “entries” and subsequent practice has changes this to “exits”. [↑](#footnote-ref-9)
10. Clarification of existing policy. [↑](#footnote-ref-10)
11. Specific instruction is available for PATH and HOPWA programs at [www.dyns-services.com](http://www.dyns-services.com) [↑](#footnote-ref-11)
12. Open incomes impact the accuracy or reporting. Reflecting the 2015 data quality review of client income, MSHMIS has updated our guidance regarding the closing of incomes. This change is accompanied with a short training podcaste. [↑](#footnote-ref-12)
13. Data indicates the some providers have regressed in completing discharge destination in the last year and accurately completing this field is vitally important to succeeding. Beyond data entry issues, programs must define processes that collect this information from as many households as possible. [↑](#footnote-ref-13)
14. Additional detail was added for low volume environments that are required to annually update income and employment. [↑](#footnote-ref-14)
15. Updated to reflect the Revised 2014 Data Standards issue in July 2015 and local Data Quality initiatives. [↑](#footnote-ref-15)
16. Path , HOPWA and VA programs use program entry forms that correspond to the data collection requirements of those programs. For Path and HOPWA, please contact [www.dyns-services.com](http://www.dyns-services.com) [↑](#footnote-ref-16)
17. New Guide available on the MSHMIS Certification Site designed to improve communication of training requirements by System’s Role. [↑](#footnote-ref-17)