FRESNO MADERA CONTINUUM OF CARE

COORDINATED ENTRY SYSTEM
POLICIES AND PROCEDURES

The FMCoC CES Policies and Procedures is a living document and subject to change. It will be reviewed and updated as needed, following best practices and FMCoC approval.

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OVERVIEW

These standards will govern the CoC and ESG funded projects in the Fresno Madera Continuum of Care. Each program may focus or operate with some variation; however, they will align with these guiding Coordinated Entry System standards.
The HEARTH Act requires the Fresno Madera Continuum of Care to have written policies and procedures that govern the provision of assistance to individuals and families. These policies and procedures provide guidance to local providers in administering CoC-funded assistance in the following areas:
Policies and procedures for evaluating individuals' and families' eligibility for assistance;
The policies and procedures are not intended to be in lieu of or in place of the Interim Regulations for the HEARTH Act, but are intended to clarify local decisions regarding program administration. All HUD funded providers must follow the Interim Regulations in its entirety.

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PURPOSE:

The Coordinated Entry System Committee was convened by the Fresno Madera Continuum of Care to achieve the following goals:
To bring Fresno Madera Continuum of Care in compliance with Federal Regulations regarding coordinated assessment/entry that require "a centralized or coordinated process designed to coordinate program participant intake, assessment, and provision of referrals. A centralized or coordinated assessment system covers the geographic area, is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool." Per the Regulations, this definition established the basic minimum requirements for the system that must be established within Fresno Madera Continuum of Care.

- Minimize barriers faced by individuals who are homeless in accessing the most appropriate and effective housing services to address their needs.
- Incorporate a "housing first" philosophy in matching homeless individuals with services.
- Use Homeless Management Information System - ServicePoint to maximize existing resources and simplify implementation.

The Coordinated Entry System Committee was created to meet these goals and to develop an appropriate documented process for coordinated entry for Fresno Madera Continuum of Care. As part of this work, the Coordinated Entry System Committee did the following:

- Reviewed best practices research and promising practices from other homeless systems.
- Reviewed assessment tools for service prioritization and diversion.

OVERSIGHT

The coordinated entry system process will be governed by the Fresno Madera Continuum of Care. This group will be responsible for:

- Providing general oversight and management of coordinated entry.
- Investigating and resolving consumer and provider complaints or concerns about the process, other than declined referrals.
- Providing information and feedback to the community at-large regarding the coordinated entry process.

EVALUATION

The Fresno Madera Continuum of Care Coordinated Entry System Committee meets twice a month to review the Coordinated Entry processes, including intake, assessment and referral. The coordinated entry process is evaluated by the FMCoC Evaluation Committee to ensure that it is operating at maximum efficiency and revisions are made to the Policies and Procedures as needed.
Additionally, the FMCoC CES committee will host an annual full day conference to evaluate the effectiveness of the established process. This conference will be open to any service providers (whether they are currently participating in coordinated entry or not) and participating households. This evaluation process will include interviews, surveys, and focus groups; this process will be announced by the FMCoC and open to the public.

Evaluation will include:

- Evaluating the efficiency and effectiveness of the coordinated entry process.
- Reviewing performance data from the coordinated entry process.
- Recommending changes or improvements to the process based on performance data.
- Evaluating the efficiency and effectiveness of the coordinated entry process.
    - Reviewing the Assessment (VI-SPDAT) and our Referral Process (Match Form) to ensure that our coordinated entry system meets the needs of our community.
- Reviewing performance data from the coordinated entry process.

    - All data collected through the HMIS for the Coordinated Entry System will be reviewed
- Recommending changes or improvements to the process based on performance data.
    - We will take feedback from all service providers and participating households

HUD REQUIREMENTS

Under the interim rule for the U.S. Department of Housing and Urban Development's (HUD) CoC program, each CoC must establish and operate a centralized or coordinated assessment system (24 CFR 578.7(a)(8)). HUD defines a centralized or coordinated assessment system, often referred to as a "coordinated entry" system, as "a centralized or coordinated process designed to coordinate program participant intake assessment and provision of referrals. A centralized or coordinated assessment system covers the geographic area, is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool" (24 CFR 578.3).

PARTNER AGENCIES

All programs that receive CoC, ESG, SSVF, or targeted VA funding are required by their funding sources to participate in Coordinated Entry System. All other programs serving persons who are homeless or are at risk of experiencing homelessness are encouraged and welcome to join Coordinated Entry System. In general, partner agencies are responsible for:

- Ensuring that clients seeking assistance have prompt access to screening and assessment in a safe and welcoming environment.
- Carrying out screening and assessment of clients, responding to their immediate needs, using Coordinated Entry System tools and technology, supporting referral of clients per Coordinated Entry System protocols, accepting client referrals per Coordinated Entry System protocols.
- Attending Coordinated Entry System trainings.
- Following Coordinated Entry System policies and procedures.
- For receiving agency – accepting and promptly acting on client referrals through Coordinated Entry System.
- Participating in case conferences requested to resolve housing placement issues or concerns.
- Abide by client eligibility and acceptance determination decision.
- Complying with fair housing legal requirements in all housing transactions and tenant selection plans and procedures.

DATA QUALITY AND PRIVACY

HMIS STANDARDS

Except as otherwise specified, data associated with the Coordinated Entry System should be stored in the FMCoC's Homeless Management Information System (HMIS). All data entered into or accessed or retrieved from the HMIS must be protected and kept private in accordance with the HMIS Data and Technical Standards as announced by the CoC Interim Rule at 24 CFR 578.7(a)(8).

Before collecting any information as part of the Coordinated Entry System, all staff and volunteers must first either

1. Obtain the participant's informed consent to share and store participant information for the purposes of assessing and referring participants through the Coordinated Entry process, or
2. Confirm that such consent has already been obtained and is still active. Whenever possible, the participant's consent should be in written form.

The FMCoC will not deny services to any participant based on that participant's refusal to allow their data to be stored or shared unless a Federal statute requires collection, use, storage, and reporting of a participant's personally identifiable information as a condition of program participation. Where appropriate, non-personally-identifiable information about participants who refuse consent to share personally identifiable data should be logged in an electronic case file that uses pseudonyms, e.g., "Jane Doe," to preserve as much non-personally-identifiable information as possible for statistical purposes.

The consistency, completeness, timelessness and accuracy of data entered into HMIS for the Coordinated Entry System should be checked at least once per month by the Community Coordinator as part of the community's overall efforts to continuously improve data quality. The FMCoC HMIS Administrators will provide training and technical assistance on request to anyone using the HMIS for Coordinated Entry System, who faces obstacles to inputting complete and accurate data, and may recommend and/or require technical assistance for providers who receive a low score on automated data quality reports.

WHAT DATA WILL BE COLLECTED

Data that is required to assess, prioritize, match, and refer a household for housing, homeless services, and/or mainstream resources will be collected by the Coordinated Entry System. This data will include HMIS Universal Data Elements, service prioritization assessment tool questions, and community related data

Data reports needed to assess and evaluate the Coordinated Entry System itself, such as system performance metrics and recidivism data should also be generated by the HMIS . Whenever possible, the Coordinated Entry System should avoid collecting personal data that is not needed for the above purposes.

WHO MAY ACCESS COORDINATED ENTRY DATA

Prior to accessing the Coordinated Entry in HMIS, individuals must complete the Coordinated Entry and VI-SPDAT training and successfully pass the Skilled Assessor test. The Community Coordinator will provide the names of the Skilled Assessor to the HMIS staff. HMIS staff will schedule data entry training with the identified Skilled Assessors. Skilled Assessors will have access to privileged information and are expected to maintain the confidentiality of applicants in line with HMIS data standards.

WHEN PERSONALLY IDENTIFIABLE DATA CAN BE SHARED

It is often useful to share certain kinds of data collected during the Coordinated Entry process:

- Among different homeless service providers
- Between a homeless service provider and a mainstream resource provider such as Medicaid
- Between multiple data systems to reduce duplicative efforts and increase case coordination across providers and funding streams, *or*
- Aggregate date, with the general community for purposes of education and advocacy

However, in doing so, great care must be taken not to share personally identifiable data outside the context of the systems and purpose(s) covered by the client's affirmative consent. Therefore, all entities that routinely share data with or receive data from the Coordinated Entry System must sign data-sharing agreements that obligate the entities to follow comparable privacy standards and that restrict the use of the data being shared to uses that are compatible with clients' consent.

In particular, personally identifiable data must always be used for the benefit of the client to which the data pertains, and not for the general convenience of other government entities. Requests for data made by Child Protective Services, Adult Protective Services, prosecutors, detectives, immigration officials, or by police officers who are not actively cooperating with the CoC through a Team should be refused unless the requesting party displays a valid warrant specifically ordering the release of the data, or with the client's affirmative written consent.

WHEN ANONYMOUS DATA CAN BE SHARED

Data that is truly anonymous can be shared for any legitimate purpose of the CoC, but care must be taken to ensure that data has been reliably stripped of all characteristics that could

conceivably be used to re-associate the data with a particular individual or household. Some characteristics that appear to be anonymous could be personally identifiable within the context of a relatively small community. For example, there may be only one formerly homeless person in the CoC who has a particular birthdate.
Similarly, a piece of data that is not personally identifiable in isolation may become personally identifiable when combined with other (supposedly) anonymous data. For instance, "chronically homeless" is not a personally identifiable characteristic, but if there are only three chronically homeless Hispanic veterans in the CoC, then informed observers may be able to match a case note made about a "chronically homeless Hispanic veteran" with a particular individual, thereby violating that individual's privacy.

DOMESTIC VIOLENCE/PRIVACY POLICIES:

All efforts shall be made to protect the privacy and safety of domestic violence survivors and to uphold client choice by presenting a range of housing and service options. The following procedures are in place to do so.

- Programs which are primarily for survivors of violence are prohibited from contributing client-level data into the HMIS. However, these programs must record client-level data within a comparable internal database and be able to generate aggregate data for inclusion in reports.
- Non-victim service providers shall protect the privacy of individuals and families who are fleeing, or attempting to flee violence, by not including intake/treatment data in HMIS.
- The location of Domestic Violence shelters/programs shall not be made public.
- Staff responsible for coordinated intake/assessment shall receive training on protecting the safety and privacy of individuals who are fleeing, or attempting to flee violence.

For each program participant who has moved to a different Continuum of Care due to imminent threat of further violence under § 578.51(c)(3), the CoC program must retain:

Please remember, whoever has this information, if they are not a DV agency, this information can be gotten via a warrant and can be held against the victim or provide location information regarding the victim. The only agency that can withhold this information through the justice process is a Domestic Violence agency.

Documentation of the original incidence of violence –This may be written observation of the housing or service provider; a letter or other documentation from a victim service provider, social worker, legal assistance provider, pastoral counselor, mental health provider, or other professional from whom the victim has sought assistance; medical or dental records; court

records or law enforcement records; or written certification by the program participant to whom the violence occurred or by the head of household.

Documentation of the reasonable belief of imminent threat of further violence, which would include threats from a third-party, such as a friend or family member of the perpetrator of the violence. This may be written observation by the housing or service provider:

- a letter or other documentation from a victim service provider, social worker, legal assistance provider, pastoral counselor, mental health provider, or other professional from whom the victim has sought assistance;
- current restraining order; recent court order or other court records;
- law enforcement report or records;
- records of communication from the perpetrator of the violence or family members or friends of the perpetrator of the violence, including emails, voicemails, text messages, and social media posts; or a written certification by the program participant to whom the violence occurred or the head of household.

FAIR HOUSING

NON-DISCRIMINATION POLICY

The Fresno Madera Continuum of Care does not tolerate discrimination on the basis of any protected class (including actual or perceived race, color, religion, national origin, sex, age, familial status, disability, sexual orientation, gender identity, or marital status) during any phase of the Coordinated Entry process. Some programs may be forced to limit enrollment based on requirements imposed by their funding sources and/or state or federal law. For example, a HOPWA-funded project might be required to serve only participants who have HIV/AIDS. All such programs will avoid discrimination to the maximum extent allowed by their funding sources and their authorizing legislation. All aspects of the Fresno Madera Coordinated Entry System will comply with all Federal, State, and local Fair Housing laws and regulations.
Participants will not be "steered" toward any particular housing facility or neighborhood because of race, color, national origin, religion, sex, disability, or the presence of children.
All locations where persons are likely to access or attempt to access the Coordinated Entry System will include signs or brochures displayed in prominent locations informing participants of their right to file a discrimination complaint and containing the contact information needed to file a discrimination complaint. The requirements associated with filing a discrimination complaint, if any, will be included on the signs or brochures.
When a discrimination complaint is received, the FMCoC Executive Board will complete an investigation of the complaint within 60 days by attempting to contact and interview a

reasonable number of persons who are likely to have relevant knowledge, and by attempting to collect any documents that are likely to be relevant to the investigation. Within 30 days after completing the investigation, the FMCoC Executive Board will write an adequate report of the investigation's findings, including the investigator's opinion about whether inappropriate discrimination occurred and the action(s) recommended by the investigator to prevent discrimination from occurring in the future. The findings of the investigation will be shared with the Coordinated Entry System Committee. If appropriate, the investigator may recommend that the complainant be re-assessed or re-prioritized for housing or services. The report will be kept on file for two years.

REASONABLE ACCOMMODATIONS AND MODIFICATIONS

All Access sites, Assessment sites, Navigators, and Housing Providers must provide reasonable accommodations and modifications to persons with disabilities to ensure equal access to housing. The duty to provide reasonable accommodation requires Navigators and Providers to make changes to rules, policies, and procedures to allow a person with a disability to use and enjoy a dwelling. Navigators and Providers, however, are not required to undergo an undue financial burden and administrative hardship or make a fundamental alteration in the nature of the programs.

CULTURAL COMPETENCE

Cultural competence involves understanding and appropriately responding to the unique combination of cultural variables, including age, ability, beliefs, ethnicity, experiences, gender identity, gender, linguistic background, national origin, religion, sexual orientation and socioeconomic status. Assessors and navigators are expected to be culturally competent and strongly encouraged to engage in training opportunities to build these skills. As part of this process assessors and navigators are advised to explore how their own values, biases, and beliefs influence their communication and service delivery. This self-reflection will help ensure that assessors and navigators are respectful of the different cultural backgrounds, preferences and practices of participants, and incorporate this information into participant action plans.

Assessors and navigators will continually build their culturally competent knowledge and skills as part of their everyday work, and will have many opportunities to share what they learn with their peers. They are also expected to draw upon their experiences and growing knowledge of

cultural competency to assess the cultural relevance of tools, assessments, and strategies, and to develop referral partnerships with culturally competent partners.

MARKETING

The FMCoC affirmatively markets housing and supportive services to eligible households within the geographic area. Clients are able to access the various access sites and assessment within the FMCoC. Street outreach workers distribute information at places known to be frequented by the target population. In order to ensure access to all members of the community, interpretation services are also offered.

The Fresno Madera Continuum of Care Coordinated Entry System covers the entire Fresno Madera Counties geography, which is the same geography as the FMCoC. The coordinated entry system is well advertised and easily accessed.

The coordinated entry system is widely marketed and available to:

- All eligible persons regardless of race, color, national origin, religion, sex, age, familial status, disability, actual or perceived sexual orientation, gender identity, or marital status;
- All populations and subpopulations in the FMCoC's geographic area, including people experiencing chronic and/or literal homelessness, veterans, families with children, youth, survivors of domestic violence, and individuals/families at imminent risk of homelessness have fair and equal access to the coordinated entry process, regardless of the location or method by which they access the system;
- Individuals with disabilities; and
- Persons with Limited English Proficiency (LEP).

Specific steps FMCoC CES provider(s) are taking to market the coordinated entry system include:

- Monthly email updates to the general community, service providers, and City and County departments;
- Posting of coordinated entry policies and other information on the FMCoC website and the social media platforms of the FMCoC;
- Informational flyers distributed at service locations in the community;
- Providing information about coordinated entry and the homeless response system, as well as access to coordinated entry services in accessible formats, such as large print, audio, Braille, interpreters, and sign language, when necessary. Additionally, some

coordinated entry staff are fluent in various languages and equipped to conduct intake, assessment, and diversion when possible;
- Direct outreach to people on the street and other sites where people experiencing homelessness access services and supports;
- Announcements regarding CES information and updates during FMCoC or other committee meetings related to the homeless response system;
- Educating mainstream service providers (including, but not limited to, County Department of Social Services, County Department of Behavioral Health, County Department of Public Health, Public Housing Authorities, Employment Services, School Districts, Mental Health providers, Health Care providers, Law Enforcement, Faith Based Organizations, Business Community, Landlords, and Substance Abuse providers) about how to refer someone who is literally homeless to the coordinated entry system.

EDUCATION POLICIES

Consistent with the CoC Program Interim Rule 24 CFR §578.23, it is important that all CoC and ESG programs collaborate with local education authorities in identifying and serving families that become homeless. All CoC and ESG programs assisting families with children or unaccompanied youth must:

- Take the educational needs of children into account when placing families in housing and will, to the maximum extent practicable, place families with children as close as possible to their school of origin so as not to disrupt such children's education
- Inform families with children and unaccompanied youth of their educational rights, including providing written materials, help with enrollment and linkage to McKinney Vento Liaisons as part of intake procedures.
- Not require children and unaccompanied youth to enroll in a new school as a condition of receiving services.
- Allow parents or the youth (if unaccompanied) to make decisions about school placement.
- Not require children and unaccompanied youth to attend after-school or educational programs that would replace/interfere with regular day school or prohibit them from staying enrolled in their original school.
- Post notices of student's rights at each program site that serves homeless children and families in appropriate languages.
- Designate staff that will be responsible for:

- Ensuring that homeless children and youth in their programs are in school and are receiving all educational services they are entitled to.
- Coordinating with the CoC, the Department of Social Services, the County Office of Education, the McKinney Vento Coordinator, the McKinney Vento Educational Liaisons, and other mainstream providers as needed.

In order to ensure compliance and to assist providers in meeting these requirements, the CoC will provide training on these issues at least annually and will include compliance with these procedures these in their monitoring processes.

PARTICIPANT ELIGIBILITY AND DOCUMENTATION STANDARDS:

The Fresno Madera Continuum of Care funds the following program types: Permanent Supportive Housing, Transitional Housing, Planning, Rapid Rehousing, and Coordinated Entry. As set forth in the HEARTH Act, there are four categories of eligibility:

1. Literally Homeless,
2. Imminent Risk of Homelessness,
3. Homeless Under Other Federal Statutes (subject to cap), and
4. Fleeing/Attempting to Flee Domestic Violence.

The Fresno Madera Continuum of Care elects to serve categories 1, 2, and 4 due to the shortage of resources for those priority populations and excessive demand.

Documentation must be included in the case file, and/or scanned into the HMIS client record that demonstrates eligibility as follows:

1) Literally Homeless (in order of preference)
   - Third party verification (HMIS print-out, or written referral/certification by another housing or service provider); or
   - Written observation by an outreach worker; or
   - Certification by the individual or head of household seeking assistance stating that (s)he was living on the streets or in shelter;
   - If the provider is using anything other than a Third Party Verification, the case file must include documentation of due diligence to obtain third party verification.
2) Imminent Risk of Homelessness
   - A court order resulting from an eviction action notifying the individual or family that they must leave within 14 days; or
   - For individual and families leaving a hotel or motel – evidence that they lack the financial resources to stay; or

- A documented and verified written or oral statement that the individual or family will be literally homeless within 14 days; and
- Certification that no subsequent residence has been identified; and
- Self-certification or other written documentation that the individual lacks the financial resources and support necessary to obtain permanent housing.

3) NOT APPLICABLE – Homeless Under Other Federal Statute
4) Fleeing/Attempting to Flee DV

For victim service providers:

- An oral statement by the individual or head of household seeking assistance which states: they are fleeing domestic violence; they have no safe place to go to; they have no subsequent residence; and they lack resources. Statement must be documented by a self-certification or a certification by the intake worker.

For non-victim service providers:

- Oral statement by the individual or head of household seeking assistance that they are fleeing. This statement is documented by a self-certification or by the caseworker. Where the safety of the individual or family is not jeopardized, the oral statement must be verified; and
- Certification by the individual or head of household that no subsequent residence has been identified; and
- Self-certification or other written documentation, that the individual or family lacks the financial resources and support networks to obtain other permanent housing.

As defined in the HEARTH Act, eligibility for Permanent Supportive Housing is limited to categories 1 and 4. Participants must also:

- Enter from the street or shelter, or a transitional housing program to which they originally entered from the street or shelter (NOTE: if the project is designated for chronically homeless, they may only enter from the street or shelter. Individuals may lose their chronically homeless designation after they enter a transitional housing program); and
- At least one member of the household must have a disability of long duration, verified either by Social Security or a licensed professional that meets the state criteria for diagnosing and treating that condition.

OUTREACH

Outreach Teams (OTs) will cover the entire Fresno Madera Continuum of Care geographic area to reach out to as many individuals as possible in both city and county. OTs will be responsible for engagement and rapport building with individuals and families who are homeless and are not being served, adverse to services, and/or are underserved by existing community service delivery systems. As a primary Access point into the Coordinated Entry System, the OTs are responsible for locating, engaging, transporting, and referring clients to appropriate services as well as navigating clients through the documentation gathering process. Occasionally, OTs will provide basic survival supplies when available i.e. hygiene packs, blankets, water, snacks, etc. OTs are responsible for connecting clients to physical health, mental health, alcohol and other drug services/programs in the community. OTs will be trained to assess current client needs and make the appropriate referrals for which clients are eligible. OTs are to enter all contacts with clients into the Homeless Management Information System (HMIS) to better establish a Homelessness timeline and to ensure all communication, referrals and services provided to clients are documented. OTs responsibilities include, but are not limited to the following:

- Receive diversion training;
- Responsible for learning about the different Community resources to better assist clients and continue to update information among teammates;
- Receive HMIS Training: data collection and data entry;
- Work in collaboration with the Law Enforcement when requested;
- Respond to encampment referrals from community providers and community constituents;
- Provide continuous coverage of the geographic area to maintain communications with clients, especially, those with a high vulnerability score;
- Receive “Scenarios” training, “engagement” training, etc.;
- Maintain continued communication with other OT members regarding high risk incidents out on the field. i.e., areas to be cautious of and potentially dangers locations;
- OTs should meet to debrief the last 30 minutes of outreach event.

Recommendations:

- All OTs are to wear comfortable clothes and closed-toe shoes while out on the field as you might find yourself going through rigid terrain such as, river banks, canal banks, rocky areas, etc.
- OTs should be alert of their surroundings and in the event that you feel uncomfortable you may leave the area and contact your Community Coordinator.

- Outreach specialist should always be in teams of at least 2 people and be within sight of each other at all time.
- OTs should have some sort of instant messenger to blast out text messages when someone is doing outreach and something dangerous happens/to alert other OT members of incidents.
- OTs are recommended to not wear expensive jewelry and or agency logos. (Representing FMCoC rather than individual agencies.)
- OTs are recommended to use one of the recommended outreach log to better record client contacts/engagement dates into HMIS.
- When transporting a client, a client's belonging should be placed in the trunk of the vehicle until arrival at destination

Following the intake, the OT may complete the VI-SPDAT, an additional assessment tool that will be used by our Coordinated Entry System to prioritize clients based on vulnerability factors and determine what housing interventions best fits the client's needs. OT staff will complete the VI-SPDAT with clients as follows:

- For Adult Only households, the VI-SPDAT will be completed as a part of the client's treatment plan when the household has been homeless for at least 7 days or more;
- Family household with children and transitioned-age youth, at the point of literal homelessness.

VI-SPDAT assessments should be updated when risks and circumstances of the client's life have changed or every 2 years, whichever comes first.

If pre-screening/screening questions determine that a consumer has an emergency need for medical care or shelter, the client will be immediately considered for referral to the appropriate emergency care center, such as a hospital or emergency shelter.

Emergency Services: When Access Points are closed, adults and families have access to available emergency shelter. Since some emergency services are not prioritized through coordinated entry, participants can access those services on a first-come, first-serve basis. However, via direct communications or marketing materials staff at emergency shelters actively connect participants to the Access Points.

For Fresno Madera Continuum of Care Geographic Area
Emergency Housing/Shelter 24 hrs/day:
Fresno County: Contact MAP Point at 559-512-6777
Madera County: Contact Madera Rescue Mission at 559-675-8321

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ACCESS

Access refers to how people experiencing a housing crisis learn that coordinated entry exists and how to access services. One of the primary goals of the Fresno Madera Continuum of Care's (FMCoC) Coordinated Entry System (CES) is to ensure that client access be easy, fast, and offers immediate engagement. Therefore, our Coordinated Entry System offers multiple points of access for people experiencing or at imminent risk of homelessness. Access sites serve as the community connector to the FMCoC's CES and offer direct services or provide warm hand-offs through referrals to all populations and subpopulations in the FMCoC's geographic area, including people experiencing chronic and/or literal homelessness, veterans, families with children, youth, survivors of domestic violence, and individuals/families at imminent risk of homelessness.

Access Sites (physical site and/or street outreach) will complete the Data Collection Form, when an individual/family presents with a housing crisis ***and*** is open to services, to help determine if the household can be diverted from entering the homeless response system by utilizing mainstream resources. Access sites will make referrals to mainstream services and assist in navigating services to the extent possible. If the household is unable to be diverted, the household will be referred to prevention or emergency shelter services (shelter, dv shelter, safe house, or motel voucher). Access sites will consider the unique rights and needs of all populations including people experiencing chronic and/or literal homelessness, veterans, families with children, youth, survivors of domestic violence, and individuals/families at imminent risk of homelessness.

A provider must sign a Fresno Madera Continuum of Care Coordinated Entry Participation Agreement agreeing to the operational guidelines of the coordinated entry process. Physical access sites are to be located near public transportation and in proximity to known homeless populations. They can vary in size and configuration and can be collocated with other service programs. All physical sites must be handicap accessible.

In addition, any agency serving as an access point must coordinate with the appropriate victim services provider around safety planning and must participate in any trainings provided on how to carry out appropriate safety planning and how to ensure trauma-informed, culturally appropriate services.

Access Sites (physical site and/or street outreach) are expected to agree to the following:

- Ensure compliance with data privacy and policies.

- Provide Data Collection Form for all households who request entry into the homeless response system.
  a. If entry meets criteria for diversion, provide information or referrals to prevention and diversion resources.
  b. If entry into the homeless response system is necessary, link directly to Emergency Shelter, and/or to Assessment site.
- For Access site – Provide **at least (1) Access day a week.**
- For Street Outreach participation (HOME Team) – **Attend at least 50% of monthly events.**
- Track and share documentation of screenings by entering the completed Data Collection Form in HMIS (or a comparable database for victim service providers) immediately.
- Attend required FMCoC CES trainings.
- Ensure that no referrals for homeless services are made without first completing the Data Collection Form.
- Provide feedback for annual CES evaluation.
-

Procedure:

1. Identify Housing Crisis
2. Complete Data Collection Form
   a. While completing Data Collection Form, Access staff will empower household to identify possible housing crisis solutions though:
      - Homelessness Prevention
      - Diversion
      - Rapid Exit
3. Inform consumers of CES Rights & Responsibilities & Complete HMIS Release of Information
4. Enter completed Data Collection Form in HMIS (or a comparable database for victim service providers) immediately
5. If no viable safe housing solution could be identified, household will be connected to available emergency shelter.
      - Household will continue to work with shelter staff and/or navigator in identifying housing solutions.
      - If household enters shelter, homeless verification will be requested to be completed at the shelter.
6. If household does not enter shelter, a referral to street outreach will be completed and submitted to Community Coordinator for follow-up.

7. **Training:** All Access staff receive training on Coordinated Entry. Training ensures that policies and procedures are fairly and consistently applied and high-quality services are delivered to households seeking homelessness assistance from access sites. Training opportunities are provided at least once annually to organizations and staff that serve as FMCoC approved access sites. Training provides access site staff with clear direction on how screenings are to be conducted in-line the Coordinated Entry written policies and procedures, to ensure uniform decision-making and referrals.

DIVERSION

Diversion is a strategy that prevents homelessness for people seeking shelter by helping them identify immediate alternate housing arrangements and, if necessary, connecting them with services to help them return to permanent housing. Diversion engages households early in their homeless crisis so they can move quickly into safe housing. It is focused on helping households move past the immediate barriers they face in obtaining safe housing.

Diversion is pursued as a potential solution for households to become housed safely and quickly, without requiring more intensive services. If no realistic options for housing emerge through the Diversion conversation, households continue with the Coordinated Entry System and are assessed and prioritized for deeper housing interventions.

The Fresno Madera Continuum of Care will practice diversion at system entry and throughout the entire CES process.

Diversion will either:

1. Empower individuals/households to identify possible housing solutions based on their own resources. This could include:
   a. Permanent housing on their own
   b. Viable, safe, permanent shared housing with family and/or friends
   c. Viable, safe shared housing with family and/or friends, with a plan for permanency
2. Refer to mainstream resources;
3. Provide the minimum assistance necessary for the shortest time possible;
4. Connect to emergency shelter services; or
5. In rare cases, immediately connect to Vulnerability Assessment (VI-SPDAT).

Utilizing Diversion Strategies:

Who: At minimum all FMCoC Access site staff including but not limited to street outreach, MAP navigators, and shelter staff. Staff trained in the skills of diversion will support households through focused problem-solving. They will deliver expertise, encouragement, and a flexible combination of short-term services.

What: Variety of short-term services, which can include:

- Generating housing leads for households, often by leveraging existing relationships they have with landlords.
- Mediating conflicts between households and landlords, relatives or friends who may be able to offer housing.
- Connecting households to other community resources.

When: Begins as a first step to anyone trying to connect to Coordinated Entry System and continues throughout the entire process.

Where: All FMCoC Approved Access and Assessment sites including street outreach, MAP Points, shelters, etc.

Procedure:

1. **Explain the diversion conversation.**
    a. "Our goal is to learn more about your specific housing situation right now. Together we can identify the best possible way to get you a place to stay tonight and find safe, permanent housing as quickly as possible. That might mean staying in shelter tonight, but we want to avoid that that if at all possible. We will work with you to find a more stable alternative if we can."

If indicated that the place where they stayed is unsafe, ask why it is unsafe. (If fleeing domestic violence, refer them to law enforcement and/or the appropriate local domestic violence provider. *For Fresno County – Marjaree Mason Center (559) 233-4357. For Madera County – 1 (800) 355-8989*

2. **Complete Diversion & Prevention Screening Form**
    a. Submit completed screening tool to Housing Matcher within 72 hours of completion.
    b. If eligible for Homelessness Prevention referral, Housing Matcher will submit response to Diversion Specialist within 72 hours.
3. **Housing planning**
    a. Households that are unable to identify realistic options for housing through Diversion are assessed and prioritized for deeper housing interventions.

Diversion Training:
The Coordinated Entry System Committee will develop and conduct training on diversion, as a part of the CES training protocol. Training materials from OrgCode Consulting, Inc., as well as other best practice models will be utilized. The training curriculum will focus on techniques of effective communications and conflict mediation. Staff will be trained to guide the diversion process along while always letting the households take charge in finding a housing solution.

Self-Resolution is real and possible

Create an environment where self-resolution is normalized and expected rather than the exception.

ASSESSMENT SITES

To ensure easy access to assistance, Coordinated Entry System provides access to assessments, housing, and services from multiple, convenient locations throughout the Fresno Madera Continuum of Care. The homeless person in need may initiate a request for housing by walking into or calling any participating program or through contact with a street outreach program. The minimum requirements for a program to participate as a physical access point are:

- Have user access to HMIS.
- Ensure compliance with data privacy and policies.
- Have at least one trained Assessor and authorized both to use of HMIS and to conduct the VI-SPDAT assessment; this may include a community volunteer who is trained and authorized by the FMCoC, and is connected to a CES participating agency.
- Agree to follow CES policies and procedures, community guidelines for conducting assessments and communicating about coordinated entry.
- Agree to provide additional referrals to other community services, as appropriate, to people completing the assessment.

STANDARDIZED ASSESSMENT TOOL: VI-SPDAT

As mentioned above, Coordinated Entry System uses the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) as the standard assessment tool. The VI-SPDAT is built into HMIS. The VI-SPDAT is completed in HMIS with all individuals and families who are homeless under HUD's definition of homelessness. The assessment can only be

conducted by a qualified agency or program assessor participating in CES and trained in HMIS. The VI-SPDAT is generally conducted no sooner than a seven night stay in an emergency shelter, three street outreach contacts, and/or when a Homeless Verification can be attained.

WHAT IS THE VI-SPDAT?

The VI-SPDAT is a pre-screening, or triage tool that is designed to be used by all providers within a community to quickly assess the health and social needs of homeless persons and match them with the most appropriate support and housing interventions that are available. A triage tool like the VI-SPDAT allows homeless service providers to similarly assess and prioritize the universe of people who are homeless in their community and identify who to treat first based on the acuity (severity) of their needs. It is a brief survey that service providers, outreach workers, and even volunteers can use to determine an acuity score for each homeless person who participates. The scores can then be compared and used to identify and prioritize candidates for different housing interventions based upon their acuity. ***NOTE: The VI-SPDAT score is not used solely for prioritization***. Using the VI-SPDAT, providers can move beyond only assisting those who present at their particular agency and begin to work together to prioritize all homeless people in the community, regardless of where they are assessed, in a consistent and transparent manner.

PRE-SCREENING

As a first step, the individual or family should be asked basic pre-screening questions to determine if they need homelessness assistance, whether they have already received the VI-SPDAT, and whether they are a member of special population requiring specialized assistance. ***If the individual or family is not homeless, the assessment process should not be continued. Rather, they should be provided or directed to other more appropriate services, e.g., prevention services if they are at risk of homelessness.***

If the individual or family does need homelessness assistance, staff should check HMIS to see if they have already received the VI-SPDAT in the past year. If not, or if it seems their situation has changed significantly since the last time, the assessment can proceed.

If the individual or family is: fleeing domestic violence (DV) situations or otherwise meets the criteria of category (4) of the definition of Homelessness1; an unaccompanied youth under 18 years of age; or a veteran of active duty in the U.S. Armed Forces, then the procedures under Unique Procedures for Special Populations below should be followed.

COMMUNICATION

The assessment should be conducted in a setting that promotes safety, privacy, and confidentiality. Staff conducting the assessment should follow community guidelines below for explaining the assessment process and benefits. Key points that may be covered include:

- That the assessment takes about 10 minutes and most responses are “yes” or “no,” or just one word.
- That the collected information will be entered into HMIS, which will help ensure that they will only need to compete the assessment once, that they will go onto the master list, and that they will not have to go around to different agencies getting on separate waiting lists.
- That if they have an existing case manager helping them apply for housing, they should continue working with that case manager.
- That the assessment will help result in a recommended housing intervention.
- That due to limited housing availability, it is unlikely that the recommended intervention will be available immediately, and it is important provide up-to-date contact information for when the intervention does become available, and to immediately call their navigator to inform staff of any contact information changes.
- That the assessment is voluntary, but that completing it will make it easier to provide the assistance needed and will allow them to be placed on the master list for referrals.
- That the assessment will be conducted and entered into HMIS only if a Release of Information (ROI) is signed.

The VI-SPDAT is designed and structured to only use self-report. A person who is being surveyed using the VI-SPDAT should be able to complete it with anyone, not just the people who know her/his case history or have other information from other circumstances or sources. As a self-reported tool, the sequence is vitally important. ***The order of the VI-SPDAT cannot change.***

HOW OFTEN CAN WE DO A NEW VI-SPDAT?

The general policy is 2 years is appropriate to do a new VI-SPDAT (if there have been no breaks in homelessness), but first there should be a discussion with the person seeking assistance about what circumstances have changed and why they are requesting another VI-SPDAT assessment to be completed.
If a person has been housed and re-enters into homelessness, a new VI-SPDAT needs to be completed.
Remember, if you do a new VI-SPDAT you must update the score on the referral so it keeps the client’s situation accurate.

VI-SPDAT AND COORDINATED ENTRY CONSENT

An individual must provide informed consent prior to the VI-SPDAT being completed. You cannot complete a VI-SPDAT with a client without that person’s knowledge and explicit

agreement. You also cannot complete the VI- SPDAT solely through observation or using known information within your organization.

TRAINING AND AUTHORIZATION OF USERS

As mentioned above, the VI-SPDAT can only be conducted by agency staff (or volunteers who are connected to the agency) who have successfully completed training and been authorized by the FMCoC as the Coordinated Entry System lead agency. Trainings are coordinated by CoC staff and include but are not limited to training on:

- Using HMIS
- Completing the VI-SPDAT

MASTER BY NAME LIST

The Master by Name List includes all data fields necessary to measure each of the four Federal benchmarks, found on the Hud Exchange website as well as other fields to support tracking, case conferencing, and rapid movement to permanent housing. The by name list is thought of as a universal registry within HMIS. Each Assessor and Outreach Specialist will receive access via HMIS to enter completed VI-SPDATs and or outreach contacts, after successful data collection and data entry training as well as a signed User Agreement form, for inclusion on the list for purposes of prioritization and housing placement. FMCoC and ESG funded agencies must make and take referrals off of this list for their programs.

BY NAME LIST INACTIVE POLICY

The Inactive Policy is a critical component of maintaining a real-time by-name list as well as a robust Coordinated Entry System. To ensure an efficient assessment and referral process, it is important to ensure that the Coordinated Entry System Navigators and Outreach teams have the ability to contact and connect with households as soon as a housing opportunity is available. Without the policy, the Coordinated Entry System can experience delays in its referral procedures due to the time spent searching for households in the community who they have not been able to reach through multiple attempts, often for many months. Due to this loss of contact it is hard for the system to determine whether these households are still in need of housing. In some situations, these households may have self-resolved their housing crisis or relocated to another area.

If a household has had no contact with any Coordinated Entry Access points, System Navigators and/or Community Outreach for **90 days**, and they have had no services or shelter stays in HMIS for the past **3 months**, the household will be moved from "Active" status to "Inactive-Unknown/Missing" status. Inactive status is defined as no known contact with any service provider in the community for **90 days**. When a client is moved to inactive, he/she is not deleted from the list; clients can change from inactive to active anytime they access services; this will not affect their position on the list. If a household on the inactive list makes contact with the homeless system including outreach workers, drop-in centers, shelters, etc., they are moved from inactive status to active status and can be referred to housing openings once they have fully re-engaged with the system which may include re-assessment of their vulnerability.

FMCoC Navigators and Outreach team members will be responsible for submitting weekly updates to the by-name list and entering data into HMIS. The Community Coordinator will review the updates, and make changes to the household status during the weekly case conferencing meeting.

PRIORITIZING

The Fresno Madera Continuum of Care prioritizes chronically homeless individuals and families and has committed to adopting a Housing First approach in CoC/ESG programs.
For homeless families with children, FMCoC seeks to mediate/prevent homelessness whenever possible, reduce the homeless episode for families through rapid rehousing (RRH) and shelter/transitional housing focused on moving families from homelessness to permanent housing as soon as possible, and permanently house the most vulnerable families, as resources are available. Information is gathered to determine the "best fit" intervention to prioritize families for more intensive services, as needed, using the VI-SPDAT assessment through the Coordinated Entry System. Rapid Re-Housing projects serving homeless families with children will strive to place clients into permanent housing within 30 days of entering homelessness, and will not screen out families based on any criteria that will not impact future housing success, including age, gender or marital status.
For vulnerable, chronically homeless individuals, FMCoC utilizes the VI-SPDAT CoC-wide, which identifies those most at risk of dying on the street and will prioritize placement and services for those highest in need, and the SPDAT, for more in-depth understanding of participants and even more tailored placement and services. Referral systems are already in place and continue to be expanded for greater coverage.

Note: the VISPDAT scores listed above, do not mean a household cannot be referred to a different housing intervention. For example: if a household scores 10 on the Family VI-SPDAT,

but there are no Permanent Supportive Housing slots available, the household may be referred to Transitional housing as a temporary measure if space is available.

If individuals are not chronically homeless, they will be targeted for the rapid rehousing, transitional housing, permanent housing, or income-based housing intervention that they are best matched to. Non-chronically homeless individuals who identify a substance abuse and/or mental health disorder and interest in receiving services for these concerns will be referred to the appropriate residential treatment programs.
The Fresno Madera CoC has adopted the order of priority described in HUD's Notice CPD 14-012.

Order of Priority in CoC Program-funded Permanent Supportive Housing Beds Dedicated to Persons Experiencing Chronic Homelessness and Permanent Supportive Housing Prioritized for Occupancy by Persons Experiencing Chronic Homelessness

A. First Priority–Chronically Homeless Individuals and Families with the Longest History of Homelessness and with the Most Severe Service Needs. A chronically homeless individual or head of household as defined in 24 CFR 578.3 for whom both of the following are true:
    - The chronically homeless individual or head of household of a family has been homeless and living in a place not meant for human habitation, a safe haven, or in an emergency shelter for at least 12 months either continuously or on at least four separate occasions in the last 3 years, where the cumulative total length of the four occasions equals at least 12 months; and
    - The CoC or CoC Program recipient has identified the chronically homeless individual or head of household, who meets all of the criteria in paragraph (1) of the definition for chronically homeless, of the family as having severe service needs (see Section I.D.3. of this Notice for definition of severe service needs).
B. Second Priority–Chronically Homeless Individuals and Families with the Longest History of Homelessness. A chronically homeless individual or head of household, as defined in 24 CFR 578.3, for which both of the following are true:
    - The chronically homeless individual or head of household of a family has been homeless and living in a place not meant for human habitation, a safe haven, or in an emergency shelter for at least 12 months either continuously or on at least four separate occasions in the last 3 years, where the cumulative total length of the four occasions equals at least 12 months; and,

- The CoC or CoC program recipient has not identified the chronically homeless individual or the head of household, who meets all of the criteria in paragraph (1) of the definition for chronically homeless, of the family as having severe service needs.

C. Third Priority–Chronically Homeless Individuals and Families with the Most Severe Service Needs. A chronically homeless individual or head of household as defined in 24 CFR 578.3 for whom both of the following are true:
   - The chronically homeless individual or head of household of a family has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter on at least four separate occasions in the last 3 years, where the total length of those separate occasions equals less than one year; and
   - The CoC or CoC program recipient has identified the chronically homeless individual or the head of household, who meets all of the criteria in paragraph (1) of the definition for chronically homeless, of the family as having severe service needs.
D. Fourth Priority–All Other Chronically Homeless Individuals and Families. A chronically homeless individual or head of household as defined in 24 CFR 578.3 for whom both of the following are true:
   - The chronically homeless individual or head of household of a family has been homeless and living in a place not meant for human habitation, a safe haven, or in an emergency shelter for on at least four separate occasions in the last 3 years, where the cumulative total length the four occasions is less than 12 months; and
   - The CoC or CoC program recipient has not identified the chronically homeless individual or the head of household, who meets all of the criteria in paragraph (1) of the definition for chronically homeless, of the family as having severe service needs

Order of Priority in Permanent Supportive Housing Beds Not Dedicated or Prioritized for Persons Experiencing Chronic Homelessness

A. First Priority–Homeless Individuals and Families with a Disability with the Most Severe Service Needs. An individual or family that is eligible for CoC Program-funded PSH who has been living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter for any period of time, including persons exiting an institution where they have resided for 90 days or less but were living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter immediately prior to entering the institution and has been identified as having the most severe service needs.
B. Second Priority–Homeless Individuals and Families with a Disability with a Long Period of Continuous or Episodic Homelessness. An individual or family that is eligible for CoC

Program-funded PSH who has been living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least 6 months or on at least three separate occasions in the last 3 years where the cumulative total is at least 6 months. This includes persons exiting an institution where they have resided for 90 days or less but were living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter immediately prior to entering the institution and had been living or residing in one of those locations for at least 6 months or on at least three separate occasions in the last 3 years where the cumulative total is at least 6 months.

C. Third Priority–Homeless Individuals and Families with Disability Coming from Places Not Meant for Human Habitation, Safe Havens, or Emergency Shelters. An individual or family that is eligible for CoC Program-funded PSH who has been living in a place not meant for human habitation, a safe haven, or an emergency shelter. This includes persons exiting an institution where they have resided for 90 days or less but were living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter immediately prior to entering the institution.
D. 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 coming from transitional housing, where prior to residing in the transitional housing lived on streets or in an emergency shelter, or safe haven. This priority also includes homeless individuals and homeless households with children with a qualifying disability who were fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking and are living in transitional housing–all are eligible for PSH even if they did not live on the streets, emergency shelters, or safe havens prior to entry in the transitional housing

NAVIGATION

NAVIGATOR

The Navigator will identify and build rapport with homeless individuals and families living on the street, emergency shelter, safe haven, or in other places not meant for human habitation. The Navigator will assist clients in breaking the cycle of homelessness by moving from the street to interim housing, accessing necessary social services, and rapidly obtaining permanent housing. The Navigator will provide individualized client support throughout this entire journey by helping each client address any barriers to obtaining permanent housing. This includes linking with services to increase income (employment or benefit enrollment), identifying and accessing physical health, behavioral health and/or mental health resources as needed. The

Navigator will work closely with the Community Coordinator to track homeless trends and work with the Housing Matcher for appropriate referrals to housing.

- Work with clients to address barriers to housing.
- Perform outreach services, contacting homeless persons in all places where they congregate in the geographic areas of the Fresno Madera Continuum of Care.
- Provide supportive services in a non-judgmental manner.
- Ability to transport clients to appropriate services.
- Provide information, referrals, linkages, and advocacy to assist clients in accessing services and resources.
- Assist clients with procuring necessary documents and services such as identification card, birth certificate, social security income, disability income/verification, certification of homelessness, and other documents as needed.
- Participate in all case-conferencing related to client work and progress.
- Once a housing match is made, work with Housing Matcher to identify appropriate permanent housing options for clients such as subsidized housing, Section 8, Shelter Plus Care, and VASH, as well permanent supportive housing, affordable and market rate housing, and other housing opportunities. Assist clients with housing applications, complete supportive and subsidized housing paperwork, survey rental market for affordable housing, and advocate for clients with prospective landlords.

DOCUMENT READY

Documentation offers a simple example. From birth certificates to proof of military service, people experiencing homelessness must secure a variety of documents to move into housing, and these documents can often be difficult to acquire for those without the contacts or system knowledge to know how to get what they need. Experienced, well connected housing navigators can fast track the process by maintaining an updated list of local agency contacts and key documents required for each local housing and service offering

CASE CONFERENCING

A routine, centralized process in which the Community Coordinator, Housing Matcher, and navigators monitor and advance the progress of various people toward housing. If navigation is a way to connect people experiencing homelessness with navigators, case conferencing connects those navigators to each other so they can strategize around all of their homeless clients' needs at once. This process also allows our community to translate individual data points into a bigger picture snapshot, enabling evaluation, troubleshooting and process

improvement across the entire local housing placement system. The Fresno Madera Continuum of Care has designated the Community Coordinator as the point person to act as the "air traffic controller," coordinating the work of all local housing navigators in real time.

Goal of Case Conferencing

1. To ensure holistic, coordinated, and integrated, assistance across providers for all people experiencing homelessness in the FMCoC;
2. To review progress and barriers related to each person's housing goal;
3. To identify and track systemic barriers and strategize solutions across multiple providers;
4. To clarify roles and responsibilities and reduce duplication of services.

CASE CONFERENCE LOGISTICS

Identification of People to Review: It is important to keep the primary focus on reviewing the most vulnerable persons from the Master By Name List, with greatest barriers to shelter and rapid placement in permanent housing.

Representing Organizations: Agency representation from all housing and service providers will be based on those who serve homeless persons in the community. Recommended agencies include: those who have in-depth knowledge about the status, needs and preferences of each person being reviewed and who are able to make decisions regarding provision of shelter, services or housing assistance. This may be a program director, program manager, coordinator, housing specialist or case manager.

MATCHING

MATCHING TO PROGRAM TYPE

The Housing Matcher will work with Housing Program Administrators, Case Managers, and Navigators with matching homeless clients within the Fresno/Madera Continuum of Care (FMCoC) to housing programs offered within the FMCoC. The Housing Matcher will process Match Forms and facilitate Navigator communications with matched programs to present to homeless clients to better foster client choice. The Housing Matcher will work closely with the Community Coordinator and HMIS Data Administrator to track homeless trends, all the while

working with the Navigators to ensure timely documentation and completion of permanent housing efforts culminating in the successful housing of homeless clients.
Matching Procedures/Processes:

1. Clients that are considered CES Match Form Final submission ready, are to be presented by their Navigator at the weekly Navigators meeting to identify if they are
   - on the BNL,
   - entered into HMIS, and
   - document ready.
2. The Navigator will receive endorsement from the Navigation team to complete and email the match form to the Matcher, Community Coordinator and HMIS Data Administrator.
3. The Matcher will send a reply message to both the Navigator and the Community Coordinator confirming receipt of the Match form and clarifying any missing/incomplete data.
4. The Matcher will run the eligibility matrix within HMIS to identify matches to Housing Programs.
5. The Matcher will consult existing Housing Program censuses and/or contact Housing Program Administrators/Case Managers directly to confirm housing availability.
6. The Matcher will send the Matching Confirmation Final form to the Navigator, Community Coordinator and Housing Program/s to which programs the clients have been matched to.
7. The Navigator will present the Housing Program matches to the client and report to the Matcher when, and to which programs the client has chosen
8. The Matcher will notify the Housing Program Administrator/Case Manager of the clients decision to apply for their program and assist in the coordination of that initial meeting (case staffing) between the Navigator, client and Housing Program official.
9. The Navigator will work with the client to complete all necessary program applications, home finding efforts and any additional documentation as required.
10. Once housing placement is accepted by both the client and the program, the housing provider will notify both the Matcher, HMIS Data Administrator and the Community Coordinator of the housed date.
11. The Matcher will maintain a log of match forms submitted and matches completed. This information will be provided to the Community Coordinator on a weekly basis at the Navigators meeting to reflect housing progress that may then be recorded in the Notes section of the BNL.

Data Management:

- Maintain client related data tracking systems and complete HMIS entries.
- Generate client data for weekly and monthly reports, including outcomes, successes and challenges and submit to Community Coordinator. The VI-SPDAT score and master list are used by CoC staff to sort all individuals and families assessed by housing intervention type. This improves cost efficiency and program effectiveness system-wide. Those with high acuity scores are matched to permanent supportive housing, medium acuity scores to transitional housing, low-medium acuity scores to RRH, and low acuity scores to other appropriate interventions.

HOUSING PROGRAM ELIGIBILITY DETAILS AND BED/UNIT AVAILABILITY

The Housing Matcher will keep an inventory and basic eligibility information for each participating housing program.
Participating agencies that use HMIS enter their basic program inventory and eligibility information into HMIS. All programs use HMIS to update their current bed/unit availability. The eligibility criteria are used, along with the local eligibility limits, to ensure that only eligible clients for a particular program or unit are referred to that program or unit.

In general, participating agencies must work consistently with the Housing Matcher to make sure their inventory, eligibility, and bed/unit availability information is always up-to- date.

Create and share written eligibility standards. Participating provider agencies will provide detailed written guidance for client eligibility and enrollment determinations. Eligibility criteria should be limited to that required by the funder and any requirements beyond those required by the funder will be reviewed and a plan to reduce or eliminate them will be explored with the Evaluation Committee. This may include funder-specific requirements for eligibility and program-defined requirements. These standards will be shared with the Coordinated Entry Manager as well as the Evaluation Committee.

Communicate vacancies: As a general rule, a provider who wishes to fill a homeless-mandated unit from an alternative source based on a belief that the Coordinated Entry System has not provided timely referrals must perform <u>all</u> of the following tasks before unilaterally filling a vacancy:

1) Send an e-mail to the Housing Matcher alerting them that the program has a current vacancy,

2) Wait for a minimum of three business days,
3) Send a second e-mail to the Housing Matcher and to the Coordinated Entry Committee that either explicitly states that no referrals have been received, or that explains why each of the referrals that have been received could not be used to fill the vacancy, AND
4) Wait for an additional four business days without receiving any new referrals.
5) After 7 Calendar days, the agency may divert from using CES as their primary referral source.

Limit enrollment to participants referred through the defined access point(s). Each bed, unit, or voucher that is required to serve someone who is homeless must receive their referrals through the Coordinated Entry System. Any agency filling homeless mandated units from alternative sources will be reviewed by the Evaluation Committee for compliance.

BRIDGE POINT HOUSING

Bridge Point is a 30 day emergency shelter housing option for individual clients working through the Coordinated Entry System. Bridge Housing is available for clients who have an active housing plan (housing will occur within 30 days) in place. Prior to referring a client to Bridge Point, a Match Form should have been submitted to the Housing Matcher.

PROCEDURES

- Client must be assigned to a navigator or designated agency staff
- Navigators or assigned agency staff are to submit Bridge Point referral to bridge point
- Housing plan/destination must be notated on referral form
- All clients are to have a VI-SPDAT completed and have documents necessary to transition to housing before entry into Bridge Point
- Navigators must review Bridge Point acceptance agreement with client (client and navigator must sign)
- Case staffing must be conducted within 72 hours of client entry into Bridge Point to include housing exit strategy (client, bridge point staff, and navigator must be present)
- Navigators must make weekly contact with his/her client
- Sign in/out sheet must be completed upon entering Bridge Point (staff name, client, number of hours with client)
- Communicate with Bridge staff on progress of client

- Clients to be at Bridge point less than 30 days. Discharge date will be 30 days after entry. Navigators will be responsible for enforcing the discharge date and will be contacted by Bridge Point staff the week prior to discharge date.

PROVISIONS

Clients needing additional days at Bridge Point must have a Bridge Point referral re-submitted by navigator.

- Extensions will be in 2 week increments based on housing progress and approval of bridge point staff.
- Extensions to not exceed 30 days

Clients who are not actively searching for housing and/or not following their navigators instructions and are to be discharged from Bridge Point will be instructed to leave by the referring agency or their navigator.

UNIQUE PROCEDURES FOR SPECIAL POPULATIONS

VICTIMS FLEEING OR ATTEMPTING TO FLEE DOMESTIC VIOLENCE:

Victim and non-victim housing/service agencies must prioritize safety and equitable access to housing/services for persons fleeing or attempting to flee domestic violence, dating violence, sexual assault, stalking, or human trafficking (DV), while ensuring that client choice is upheld. Therefore, the screening process includes the following "yes" or "no" questions:

1. "Are you currently residing in, or trying to leave, an intimate partner who threatens you or makes you fearful?" (If yes, ask the following question):
2. "Do you want services that are specifically geared to domestic violence survivors OR do you need a confidential location to stay?"

If the client answers "yes" to either or both questions, the client must be offered assistance to contact the appropriate domestic violence assistance provider as follows:

If in Fresno County:
Marjaree Mason Center 24-Hour Emergency Hotline at 559-233-4357
If in Madera County:
Community Action Partnership of Madera at 800-355-8989

It is important to understand, as a protection to a DV victim fleeing their home, that the law protects DV agencies and the victims within confidentiality parameters, beyond all other regulations. **In order to truly protect the victim from legal recourse or uncovering their location, a domestic violence agency legislatively has this authority.** Domestic violence certified counselors working in the employ of a DV agency (only) carry confidentiality rights through the justice and law enforcement systems. Further, the Domestic Violence Safe House and network of DV agencies within the state/nation; offer security from the abuser including 24-hour live surveillance of the interior and exterior grounds, gates, fences of their grounds-to protect the victim from being located or the abuser reaching the victim or family

Whether or not the client wishes to be connected to DV services, the client must be offered equitable access to the full housing/services system available through Coordinated Entry System, in accordance with all protocols described in this manual. In such cases, the assessment can be conducted by paper or using an "anonymous" client assessment if possible and desired by the client.

To help ensure equitable access while emphasizing safety, victim service providers may elect or not elect to administer the CES assessment process (including prescreening and the VI-SPDAT) for clients seeking other housing/services available through CES. However, the victim service provider should have a standardized policy governing when and how they elect to use the Coordinated Entry System assessment process, and it should have a process for referring the client to another agency that does administer the VI-SPDAT. The pre-screening and VI-SPDAT may only be administered on paper, and in no circumstances can client identifying information be entered into the master list or HMIS. Rather, the VI- SPDAT score and a unique identifier must be provided to CoC staff, and the victim service agency must destroy any paper copies of the VI-SPDAT and pre-screening form.

VETERANS

The screening process will include following "yes" or "no" questions:

1. Have you served in the Armed Forces of the United States? (If yes, ask the following question):
2. Were you a Reservist?
3. Do you want Veteran-specific services?

If the client indicates, "yes", the Veteran must be referred to the appropriate VA Center for appropriate assessment and services.
If the client does not wish to seek Veteran-specific housing/services, the client will have access to housing/services system available through CES, in accordance with all protocols described in this manual. In such cases the client must be fully informed that the decision not to seek Veteran-specific housing/services may significantly limit his/her chances of receiving timely housing/services and that HUD rules limit access to CoC-funded housing if VA-funded or other Veteran-eligible housing is available to that Veteran.

For Fresno Madera Continuum of Care Geographic Area:

24-Hour Hotline for Homeless Vets 1-877-4-AID-VET (4243-838)
24-Hour Veteran Crisis Hotline 1-800-273-8255 option 1

UNACCOMPANIED YOUTH UNDER 18

Unaccompanied Youth are defined as youth ages 12-18 (18 if in a high school or equivalent program); who are unaccompanied by a parent or guardian and are without shelter where appropriate care and supervision are available, whose parent or guardian is unable or unwilling to provide shelter and care, or who lack a fixed, regular and adequate nighttime residence.

Since 1992, Sanctuary Youth Shelter has been the area's recognized safe place center for runaway, homeless, exploited or displaced youth. The shelter is located in a central area of Fresno, accessible 24 hours a day, 7 days a week. The shelter will address the immediate needs of the youth such as shelter, clothing, meals, counseling and referrals with additional case

managed care that will focus on family reunification, strengthening family bonds or transitioning to safe and appropriate alternative living arrangements.

Youth are able to gain access to the Sanctuary Youth Shelter on a referral or walk-in basis, or by accessing one of over 300 Safe Place sites located in the Fresno area.

Eligibility
Runaway and/or homeless youth:

- Must be between the ages of 12-18 (18 If in a high school or equivalent program);
- Must not be under the influence of drugs or alcohol at the time of entry;
- Must not be on formal probation;

Procedure:

1. When an unaccompanied youth is encountered by a street outreach team, or if they enter an FMCoC approved access site, the screening process will include following "yes" or "no" question:
   a. Are you under the age of 18?
   b. If the client answers "yes," the client must referred to and offered assistance to contact Community Human Services Safe Place for appropriate assessment and services as follows:

For Fresno Madera Continuum of Care Geographic Area:
Fresno EOC Sanctuary Youth Shelter at 559-498-8543.

2. Fresno EOC Sanctuary will complete a criminal background check on unaccompanied youth.
   a. If there is a history a history of violence, serious mental illness, sexual offenses, or arson, he/she will be referred to County of Fresno Department of Child Welfare
   b. If unaccompanied youth is on probation or a dependent of the County, he/she will be referred to County of Fresno Probation Department and/or County of Fresno Department of Child Welfare.
3. Screening/Intake form will be completed on unaccompanied youth
   a. Data will be entered into Homeless Management Information System
4. Unaccompanied youth will meet with a case worker to develop a strength-based case plan to identify an appropriate housing intervention.

a. Through diversion strategies, he/she will be empowered to identify possible housing solutions that could include:
    - Viable, safe, permanent shared housing with family and/or friends
    - Viable, safe shared housing with family and/or friends, with a plan for permanency
b. If no viable safe housing solution could be identified, he/she will be entered into the 21 day emergency shelter.
    - He/she will continue to work with case worker in identifying housing solutions.

5. Unaccompanied youth will be connected with viable safe, permanent shared housing with family and/or friends. Case worker will complete follow-up with him/her at:
    - 30 days
    - 60 days
    - 90 days
6. He/she will be exited from program, following the 90 day follow up.

STANDARDS FOR ADMINISTERING ASSISTANCE

RAPID REHOUSING ASSISTANCE
Rapid re-housing assistance, operating in a Continuum of Care and/or Housing First model, is offered without preconditions (such as employment, income, absence of criminal record, or sobriety) and the resources and services provided are typically tailored to the unique needs of the household.

GOAL OF ASSISTANCE:
After receipt of assistance, a household is able to remain stably housed.

SUBSIDY AMOUNT/LENGTH OF TIME/CALCULATION:
Rental subsidies provided are based on client income. Initial assistance can be as much as 100% of rent depending on client income. Client will pay a percentage of their income in rent based on the program's assessment of the client's financial and family situation.
Rental assistance would decline in steps based upon a fixed timeline at the program's discretion based upon the client's financial and family situation.

SUBSIDY ENDING:

The goal is for households to "graduate" from the program once they no longer meet the eligibility requirements of the program's funding source and/or a Case Manager determines assistance can be terminated, whichever comes first.
An assessment tool is used regularly to determine the need for ongoing assistance.
If the household does not attain any of these goals, assistance ends at 24 months (or earlier time as set by the program).

MOVE IN ASSISTANCE:

Move-In Assistance will be targeted to households who are assessed as able to maintain their unit after the assistance. The amount of move-in assistance is determined by the program, within the limits set by the program's funding source.
Move-In Assistance may be provided as one-time assistance or in tandem with Rental Assistance/Rental Subsidies.

RAPID REHOUSING ELIGIBILITY REQUIREMENTS

In order to qualify for rapid rehousing, households must fall within the target population as well as satisfy the following criteria:

- Meet the current HUD definition of literally homeless for Rapid Re-housing services
- Be the highest priority household available
- Other eligibility criteria created at the program level

HOUSING REQUIREMENTS FOR RAPID REHOUSING

All housing supported by rapid rehousing resources must meet all HUD requirements, including but not limited to, Housing Quality Standards, rent reasonableness standards, FMR (as relevant), and others.

SERVICE REQUIREMENTS/COMPONENTS FOR RAPID REHOUSING

Case Managers will provide intensive case management services in order to assist households to successfully retain housing and move off the subsidy and into self-sufficiency. Services will be provided at the program offices and Case Managers will conduct home visits when appropriate.
All clients may receive follow-up services for up to 6 months to ensure stability and assess the effectiveness of RRH programs.

HOMELESSNESS PREVENTION SERVICES

The Coordinated Entry Process will be utilized for persons seeking homelessness prevention services funded with the ESG Program in accordance with the FMCoC Written Standards, which have been established in accordance with 24 CFR 576.400(e) and 24 CFR 578.7(a)(9)
The FMCoC Written Standards outline the basic requirements for homelessness prevention programs funded with other funds such as ESG (State and Federal Entitlement).

PERMANENT SUPPORTIVE HOUSING

Permanent Supportive Housing is community-based housing without a designated length of stay.
All CoC funded PSH programs must enter into a lease agreement with tenants that must be at least one year in duration and renewable. The lease agreement must observe Fair Housing regulations.
Participants in PSH rental assistance programs are expected to pay the higher of 30% of their income (monthly, adjusted) or 10% of their gross monthly income toward rent (including utilities). If the participant has zero income, the participants are not required to pay rent, but their supportive services partner is expected to work with them to secure income (either earned or unearned) as soon as possible. In no circumstance can a tenant be charged an amount above the rent calculation standard established by HUD.
Participants must meet with a case manager once per month and be reevaluated once per year.
Participants in leasing programs may be charged an occupancy charge up to 30% of the monthly adjusted income; 10% of the family's gross income; or the portion of the family's welfare assistance.
CoC-funded PSH projects are strongly encouraged to prioritize or dedicate beds to chronically homeless individuals and families, including chronically homeless youth and domestic violence survivors.

TRANSITIONAL HOUSING

Transitional Housing facilitates the movement of homeless individuals and families to PH within 24 months of entering TH.
All CoC funded TH programs must enter into a lease or occupancy agreement with tenants that must be at least one month in duration. The lease agreement must observe Fair Housing regulations.
Participants in TH rental assistance programs are expected to pay the higher of 30% of their income (monthly, adjusted) or 10% of monthly gross income toward rent (including utilities). If the participant has zero income, the participants are not required to pay rent, but their supportive services partner is expected to work with them to secure income (either earned or

unearned) as soon as possible. In no circumstance can a tenant be charged an amount above the Rent Reasonableness standard established by HUD. Rents collected from residents of TH may be reserved in whole or part to assist the residents from they are collected to move to PH. Participants in leasing programs may be charged an occupancy charge up to 30% of the monthly adjusted income; 10% of the family's gross income; or the portion of the family's welfare assistance.

DECLINED REFERRALS AND GRIEVANCE PROCEDURES

Provider Declines Referral
There will be times when programs will not accept a referral after interviewing the individual. Refusals are acceptable only in certain situations, including:

- The referred individual/family does not meet the program's eligibility criteria.
- The referred individual/family would be a danger to others or themselves if allowed to stay at this particular housing program.

The HMIS administrator and the Housing Matcher will be informed of declines within 24 hours or 1 business day of the decision.

Individual Declines Referral
Individuals or families being referred have the right to refuse acceptance into any program. These individuals/families will remain on the By Name List as open under Coordinated Entry. There will not be a limit to the amount of times a referred individual/family can refuse to enter into programs.

If the referred individual/family has already gone through a program or does not want to work with the program/agency, the housing program can still contact the referred individual/family by phone and the individual is able to decline the interview. The individual/family will still remain on the By Name List and if the housing program, as a result, needs another individual/family to contact, the housing program will follow up with the Housing Matcher to request an additional name.

Agency Grievances
If an agency has concerns regarding the Coordinated Entry System process, they will inform the FMCoC CES Committee Chair of their concerns via e-mail. The Committee Chair will then schedule a representative of the agency to meet with the FMCoC CES in order to discuss and

resolve the concern. If the agency is not satisfied with the decision of the FMCoC CES Committee, they will be able to file a grievance with the Fresno Madera Continuum of Care Executive Board of Directors. The FMCoC Board of Directors decision will stand and the decision will be passed to the FMCoC CES Committee Chair and changes made, if necessary, to comply with the Board's decision.

Consumer Grievances
Individuals/families are informed of their right to file a grievance if they feel their rights have been violated. This is completed at the various Access sites (physical and street outreach). If the grievance is with the Coordinated Entry Assessment Site that has completed the VI-SPDAT assessment, the individual would be directed to that agency's grievance policy. If the grievance is against the housing program who denied the individual entry into housing, the individual is able to file a grievance with that housing program using their agency's grievance policy. If the grievance is regarding the coordinated entry process as a whole, the individual is able to file a grievance which would then be directed to the Fresno Madera Continuum of Care Coordinated Entry System Committee to hear the grievance and respond. Anyone who is on the FMCoC CES Committee who would have had direct contact with the coordinated entry process would not be able to provide input regarding the grievance. If the referred individual is not satisfied with the decision of the FMCoC CES Committee, they will be able to file a grievance with the Fresno Madera Continuum of Care Board of Directors. The decision of the FMCoC Board of Directors will stand and the decision will be passed to the FMCoC CES Committee Chair and the individual who filed the grievance

COORDINATED ENTRY GRIEVANCES are grievances that are related to CE policies and/or procedures. Grievances related to CE policies and/or procedures shall be directed to:
Ana Cisneros, FMCoC CES Committee Chair acisneros@kingsview.org 559-515-1333, 2045 Grant St. Selma, CA 93662
Chelsey Ramirez-Hernandez, FMCoC CES Committee Vice Chair chelsey.ramirez@westcare.com 559-470-4801, 1900 N. Gateway Blvd Fresno, CA 93727

WRITTEN PROCESS FOR TERMINATION OF ASSISTANCE

All programs that offer housing assistance to individuals or families funded by the Continuum of Care must provide a written explanation of a tenant's rights and responsibilities that includes an explanation of program requirements and the consequences and appeal rights should a violation occur. The violation notification must be provided in writing to the participant with an accompanying right to an independent hearing (where the review officer is not directly involved

in the program administration) to review the program's decision to terminate assistance to the recipient. Written notification of the outcome of the hearing/final decision will be provided within thirty (30) days of the conclusion of the hearing.

DEFINITIONS

Acuity - When utilizing the VI-SPDAT Prescreens (triage tool), acuity speaks to the presence of a presenting issue based on the prescreen score. In the case of an evidence- informed common assessment tool like the VI-SPDAT, *acuity* is expressed as a number with a higher number representing more complex, co-occurring issues that are likely to impact overall housing stability.

Bridge Housing – Bridge housing helps clients to move immediately out of homelessness and into a temporary setting until permanent housing is available. Bridge housing may be appropriate to address barriers such as limited finances, unavailability of appropriate housing programs, and lack of vacant housing stock. When a household is recommended for Permanent Supportive Housing but no beds are currently available, the individual may be referred to "bridge housing" in other program types, and/or for any other available CoC resource that would be of use to the household. Transfers between Rapid Rehousing and Permanent Supportive Housing are allowable by HUD so long as the individual meets the eligibility criteria under the specific program and the requirements for the receiving project under the Notice of Funding Availability (NOFA) for the year the project was awarded.

Chronically Homeless (Final Definition 24 CFR 578.3, effective January 15, 2016) -
A "homeless individual with a disability," who: (i) lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and (ii) has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least 12 months or on at least 4 separate occasions in the last 3 years where the combined occasions must total at least 12 months
Occasions separated by a break of at least 7 nights
Stays in an institution of fewer than 90 days do not constitute a break
An individual who has been residing in an institutional care facility for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
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 paragraphs (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Common Assessment Tool - A comprehensive and standardized assessment tool used for the purposes of housing prioritization and placement within a Coordinated Entry System. The FMCoC has adopted the VI-SPDAT (Vulnerability Index Service Prioritization Decision Assistance Tool) as the Common Assessment Tool.

Coordinated Entry – "A centralized or coordinated process designed to coordinate program participant intake, assessment, and provision of referrals across a geographic area. The system covers the geographic area (designated by the CoC), is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool." 24 CFR Section 578.7. It is the responsibility of each CoC to implement Coordinated Entry in their geographic area.

Emergency Shelter - Emergency shelter includes any facility run by a provider agency with overnight sleeping accommodations, the primary purpose of which is to provide temporary shelter for persons experiencing homelessness.

Disabling Condition – (1) a condition that: (i) is expected to be long-continuing or of indefinite duration; (ii) substantially impedes the individual's ability to live independently; (iii) could be improved by the provision of more suitable housing conditions; and (iv) is a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury; or (2) a development disability, as defined above; or (3) the disease of Acquired Immunodeficiency Syndrome (AIDS) or any conditions arising from the etiologic agent for Acquired Immunodeficiency Syndrome, including infection with the Human Immunodeficiency Virus (HIV). 24 CFR 583.5.

Diversion – Diversion is a strategy that prevents homelessness for people seeking shelter by helping them identify immediate alternate housing arrangements and, if necessary, connecting them with services and financial assistance to help them return to permanent housing.

Fresno Madera Continuum of Care Homeless Management Information System (HMIS) - HMIS uses a software program from Bowman Systems called ServicePoint. HMIS is a client information database that provides a standardized assessment of client needs, creates individualized service plans, and records the use of housing and services. Communities can use the data to determine the utilization of services of participating agencies, identify gaps in the local service continuum, and develop outcome measurements. HMIS is designed to collect data and provide information on persons in compliance with all federal and state requirements regarding client confidentiality and data security. HMIS will meet the data collection specifications mandated by HUD and/or other funders. HMIS will provide a system for the

collection of information on services and programs provided to clients CoC wide, as well as provide referral capabilities and client historical data. HMIS can improve the services and programs offered to clients in Fresno Madera Continuum of Care by providing documented assurances of what service levels are met and in demand throughout the various types of agencies and programs in the FMCoC.

Literally Homeless - An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:

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

Low Barrier – Households are not screened 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. Housing and homeless programs agree to the low barrier screening criteria in partnership with the CES process.

Homelessness Prevention – A program targeted to individuals and families at risk of homelessness. Specifically, this includes those that meet the criteria under the "at risk of homelessness" definition at 576.2, as well as those who meet the criteria in Category 2, 3, and 4 of the "homeless definition and have an annual income *below 30%* of family median income for the area.

Household - includes, but is not limited to the following, regardless of actual or perceived sexual orientation, gender identity, or marital status:

- A single person, who may be an elderly person, displaced person, disabled person, near-elderly person, or any other single person; or
- A group of persons residing together, and such group includes, but is not limited to:

- A family with or without children (a child who is temporarily away from the home because of placement in foster care is considered a member of the family);
- An elderly family;
- A near- elderly family;
- A disabled family; (v) A displaced family; and
- The remaining member of a tenant family. 24 CFR 5.403.

Housing First – An approach to **quickly and successfully connect** individuals and families experiencing homelessness **to permanent housing *without preconditions* and barriers to program/housing entry**, such as sobriety, treatment or service participation requirements. Supportive services such as housing-focused case management are **offered** to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to permanent housing entry.

Master By Name List – A list generated by VI-SPDAT and/or outreach contact entry into HMIS that includes all individuals experiencing homelessness.

Permanent Supportive Housing (PSH) – means community-based housing without a designated length of stay, and includes both permanent supportive housing. Permanent supportive housing means long term permanent housing in which supportive services are provided to assist homeless persons with a disability to live independently. 24 CFR 578.3. The definition of rapid re-housing appears below.

Rapid Re-Housing (RRH) –An intervention designed to help individuals and families exit homelessness as quickly as possible, return to permanent housing, and achieve stability in that housing. The core components of a rapid re-housing program are housing identification and relocation, short-and/or medium term rental assistance and move-in (financial) assistance, and case management and housing stabilization services. This assistance is subject to the definitions and requirements set forth in 24CFR§576.2 "Homeless" paragraph (1) and paragraph (4) who are residing in a place set forth in (1), 24CFR§576.105, 24CFR§576.106 and 24CFR§576.400. (24CFR§576.104 *& Core Components of Rapid Re-Housing,* National Alliance to End Homelessness).

SSVF: Supportive Services for Veteran Families, a U.S. Department of Veterans Affairs program that provides supportive services grants to assist very low-income Veteran families residing in or transitioning to permanent housing, to promote housing stability.

Transitional Housing (TH) – housing to facilitate the movement of individuals and families experiencing homelessness into permanent housing within 24 months. 24 CFR 578.3.

VI-SPDAT – (Vulnerability Index-Service Prioritization Decision Assistance Tool) the evidence-based Common Assessment or Prescreen Triage Tool utilized by all projects in the Fresno Madera Continuum of Care to determine initial acuity (the presence of an issue) and utilized for housing triage, prioritization and housing placement.