Coordinated Entry (CE)

Client Prioritization & Resource Referral

Homeless Alliance™
of Western New York

Agenda

Introduction to Coordinated Entry

Topic 1: Understanding Homeless Services

Topic 2: Client Eligibility for Projects

Topic 3: Coordinated Entry Process

Topic 4: Prioritization, Referral, & Engagement

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Introduction

Coordinated Entry (CE) was created to make it easier for communities to evaluate and prioritize people who are experiencing homelessness, helping them access housing resources more efficiently.

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History

2014

Initial phase

Discussion with community partners to resolve funding and get buy-in system wide

2015

CE Lead established

Used Buffalo ESG to funding to create a CE lead

2017

HUD Notice released

HUD starts requiring CoCs to implement Coordinated Entry and provide specific guideline

2018

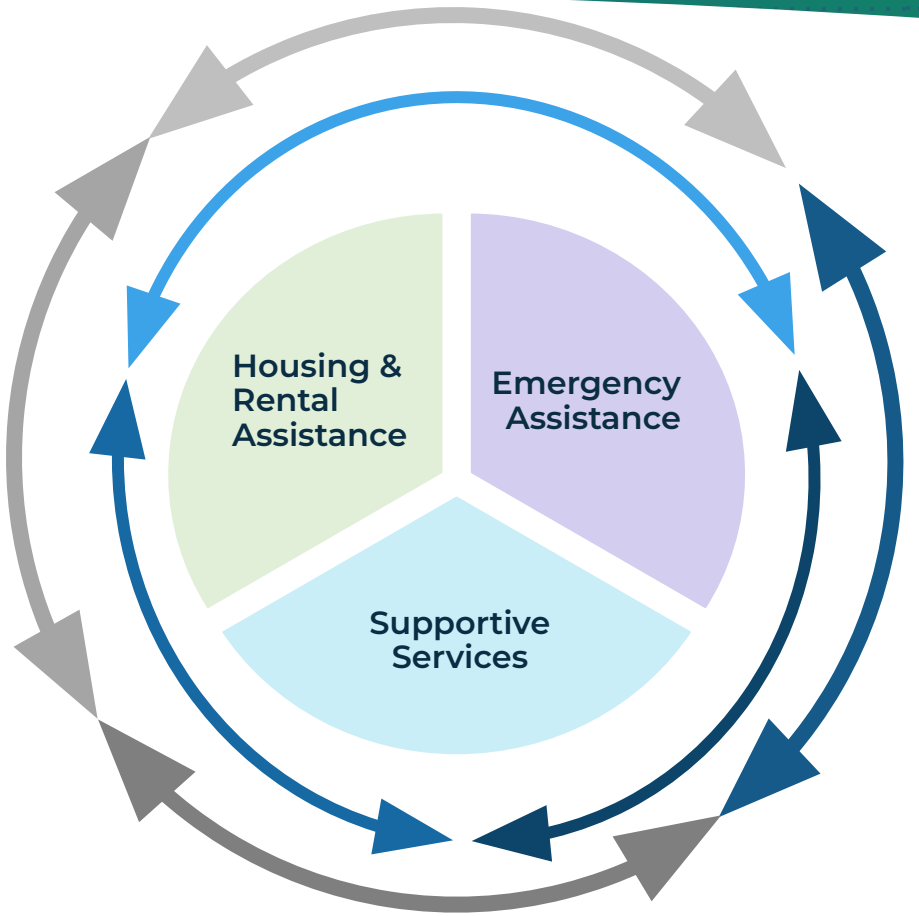
Local Policy Established

Local policies and procedures were created and approved by community partners

What is Coordinated Entry?

Coordinated Entry (CE) is a process that assesses and prioritizes homeless individuals and families in our community.

The primary purpose of CE is to foster a system that provides fair access to resources across the CoC.



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What does Coordinated Entry do?

Client-centered

Leverages a person-centered approach by focusing on objective measurements of clients' needs.

Equitable

Ensures the neutrality of service providers so those with the greatest need get top priority.

Collaborative

Promotes community coordination and decision-making to ensure effective resource utilization.

What happens without Coordinated Entry?

Clients seeking assistance during a housing crisis often struggle to navigate the local homeless services network. Without a coordinated approach, clients are often impacted by:

Inefficient Resource Use

A first come, first serve approach taking precedence over a needs-based model because it requires minimal effort.

Client Cherry-picking

Organizations pre-selecting their “ideal” clients through strange criteria or inappropriate requests.

Silos

Inexperienced case workers having uneven knowledge of the available services and resources in the area often leading to under utilization.

Understanding Homeless Services

Funding Programs and Project Types

HUD Grant Programs

The **U.S. Department of Housing and Urban Development (HUD)** encourages local communities to address housing needs for anyone experiencing homelessness in their area through a two coordinated and comprehensive **grant programs**:

- **Emergency Solutions Grants (ESG) Program:** Assists clients in quickly regaining stability after experiencing a housing crisis and/or homelessness.
- **Continuum of Care (CoC) Program:** leverage community-based solutions to rehouse homeless individuals and families while attempting to minimize trauma & dislocation, promoting access to mainstream programs, and optimizing clients' self-sufficiency.

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HUD Funded Service Programs

These programs are funded by ESG, only

Emergency Shelters (ES)

Emergency Shelter (ES) activities are designed to increase the quantity and quality of temporary shelters provided to homeless people

Street Outreach (SO)

Street Outreach (SO) activities are designed to meet the immediate needs of people experiencing homelessness in unsheltered locations by connecting them with emergency shelter, housing, or critical services, and providing them with urgent, non-facility-based care.

Homelessness Prevention (HP)

Homelessness Prevention (HP) activities are designed to prevent an individual or family from moving into an emergency shelter or living in a public or private place not meant for human habitation.

HUD Funded Housing Programs

Permanent Supportive Housing (PSH)	Rapid Rehousing (RRH)	Joint Transitional and Rapid rehousing(TH-RRH)
PSH is long-term housing in which housing assistance (e.g., long-term leasing or rental assistance) and supportive services are provided to assist households with at least one member (adult or child) with a disability in achieving housing stability. Must have a diagnosed disability.	Rapid rehousing (RRH) RRH provides short-term rental assistance and services to individuals and families.	Joint TH-RRH provide a safe place for people to stay – transitional housing – with financial assistance and wrap around supportive services determined by program participants to help them move to permanent housing as quickly as possible. Locally TH-RRH targets youth and survivors experiencing domestic violences.

Homeless Management Information System

The database used to record this data across the entire region is called the Homeless Management Information System (HMIS). By utilizing one central database (HMIS) providers can coordinate care more effectively and efficiently amongst each other.

Homeless Management Information System

A single Lead Agency provides HMIS administration and support for the entire CoC region. In Western New York (NY-508 including Erie, Niagara, Genesee, Orleans, and Wyoming counties) our lead agency is the Homeless Alliance of WNY.

Coordinated Entry Process

Access & Assess

Street Outreach (SO)

Emergency Shelters (ES)

Other community programs

Prioritize

Coordinated Entry (CE)

Refer

Permanent Housing (PH)

Supportive Services Only (SSO)

Transitional Housing (TH)

Evaluate and Refine

Coordinated Entry Oversight Committee

HUD's homeless services projects can be organized according to where they operate within the Coordinated Entry (CE) Process.

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Client Eligibility for Projects

Client Eligibility and Project Access

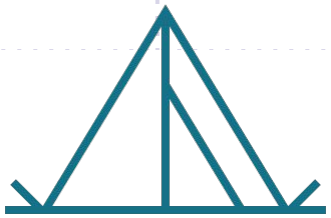
Guiding Principles: Equal Access

Projects funded through federal programs must comply with the non-discrimination and equal opportunity policies of federal civil rights laws.

Protected characteristics:

- Race
- Color
- Religion
- Gender Identity
- Sexual Orientation
- National Origin
- Spoken Language(s)
- Disability
- Marital or Familial Status

Although there may be eligibility requirements for participation in certain projects that serve special populations, providers may not prohibit access or refuse assessment or referral to any person seeking services based on a protected characteristic.



Category 1:
Literally Homeless

Definition:

Individuals or families who lack a fixed, regular, and adequate nighttime residence.

Client Situations

Has a primary nighttime residence that is a public or private place not meant for human habitation.

- Outdoors or at an encampment
- Abandoned buildings or housing without utilities
- Vehicles

Is living in a publicly or privately operated shelter designated to provide temporary living arrangements:

- Shelters
- Transitional Housing
- Hotels & Motels paid for by a charitable or government program

Is leaving an institution where they resided:

- For 90 days or less, AND
- Was in an emergency shelter or place not meant for human habitation immediately before entering.

Category 1 Subcategory: Chronically Homeless

Definition

A homeless individual with a disability lives in a place not meant for human habitation, or in an emergency shelter:

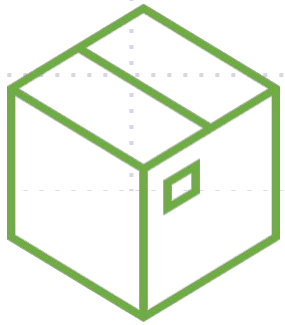
A: Continuously for at least **one year** (12 months).

Or

B: On **4 or more separate occasions** during the last 3 years, which add up to one year.

Disability includes:

- **Substance use disorder**
- **Serious mental illness**
- **Developmental disability**
- **Post traumatic stress disorder**
- **Cognitive impairment from brain injury**
- **Chronic physical illness or disability**



Category 2:
Imminent Risk of Becoming Homeless

Definition

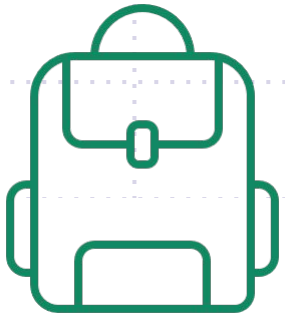
Individuals or families who will imminently lose their primary nighttime residence.

Client Situations

Residence will be **lost within 14 days** of the date of application for homeless assistance.

No subsequent residence has been identified.

The **individual or family lacks the resources or support networks** needed to obtain other permanent housing.



Category 3:
Homeless Under Other Federal Statutes

Definition

Unaccompanied youth under 25 years of age, or families with children and youth who do not otherwise qualify as homeless under HUD's definition.

Client Situations

Clients who are defined as homeless under other federal statutes cannot be served at HUD-funded programs but are **eligible for assistance from ESG programs.**

Has not had a lease, ownership interest, or occupancy agreement in **permanent housing during the 60 days prior** to the homeless assistance application.

Has experienced persistent instability, measured by **two moves or more during the preceding 60 days.**

Can be expected to continue in such status for an extended period due to **special needs or barriers.**

Category 4: Fleeing & Attempting to Flee Domestic Violence

Definition

Any individual or family who is experiencing **trauma or a lack of safety** related to, or **fleeing or attempting to flee** :

- **Domestic Violence**
- **Dating Violence**
- **Sexual Assault**
- **Stalking**

Client Situations

Includes dangerous, traumatic, or life-threatening conditions of violence against the individual, or a live-in family member, including where the health and safety of children is jeopardized.

Have no other safe residence.

Lack the resources or support networks to obtain other safe permanent housing.

HOMELESS

Category 1: Literally Homeless (under HUD definition)	Individuals or families who lack a fixed, regular, and adequate nighttime residence.	**Served by… CoC, ESG, & YHDP Programs** Emergency Shelters (ES) Joint Transitional and Rapid Rehousing (TH-RRH) Permanent Supportive Housing (PSH) Rapid Rehousing (RRH) Safe Havens (SH) Street Outreach (SO) Supportive Services (SSO)
Subcategory Chronically Homeless	Those with disabilities who have been homeless for 12 months in 3 years.	
Category 3: Homeless (under other Federal statutes)	Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under HUD's definition.	Served by programs funded by other federal initiatives (ineligible for CoC or YHDP programs)

AT-RISK

Category 2: Imminent Risk	Individuals or families who will imminently lose their primary nighttime residence.	**Served by… CoC & ESG Programs** Homelessness Prevention (HP) Supportive Services Only (SSO) **For YHDP see Category 1.**
Category 4: Trauma & Fleeing Domestic Violence (DV)	Any individual or family experiencing trauma or a lack of safety due to domestic violence, dating violence, sexual assault, stalking. (These individuals may or may not be fleeing.)	**Served by… CoC & ESG Programs Victim Service Providers (VSP)** Emergency Shelters (ES) Joint Transitional and Rapid Rehousing (TH-RRH) Permanent Supportive Housing (PSH) Rapid Rehousing (RRH) Safe Havens (SH) Street Outreach (SO) Supportive Services (SSO)

Coordinated Entry Process

Understanding how it works

The Coordinated Entry Process

Access

Access refers to how people experiencing a housing crisis or homelessness learn that Coordinated Entry exists and access homeless services.

Assessment

Assessment includes identifying the client's HUD Category, documenting the barriers the person faces to being permanently housed, as well as any characteristics that might make them more vulnerable.

Prioritization

Once a person experiencing a housing crisis has been assessed, the coordinated entry process moves on to determining their priority for housing and supportive services.

Referral

Individuals and families at the top of the priority list will be offered placement with a housing or supportive services project once space becomes available.

Access Overview

Access points are places - either virtual or physical - where an individual or family in need of assistance accesses the coordinated entry process. All Access Points follow the same principles, so community members experiencing homelessness can expect the same care regardless of which access point they use to enter the homeless services system.

Many access points provide emergency services, while some just offer information. Anyone in need of housing services can access information and eligibility criteria through one of the Access points listed below.

WNY Access Points

Emergency Solutions
- Emergency shelters
- Street Outreach & Drop-In
- Homelessness Prevention

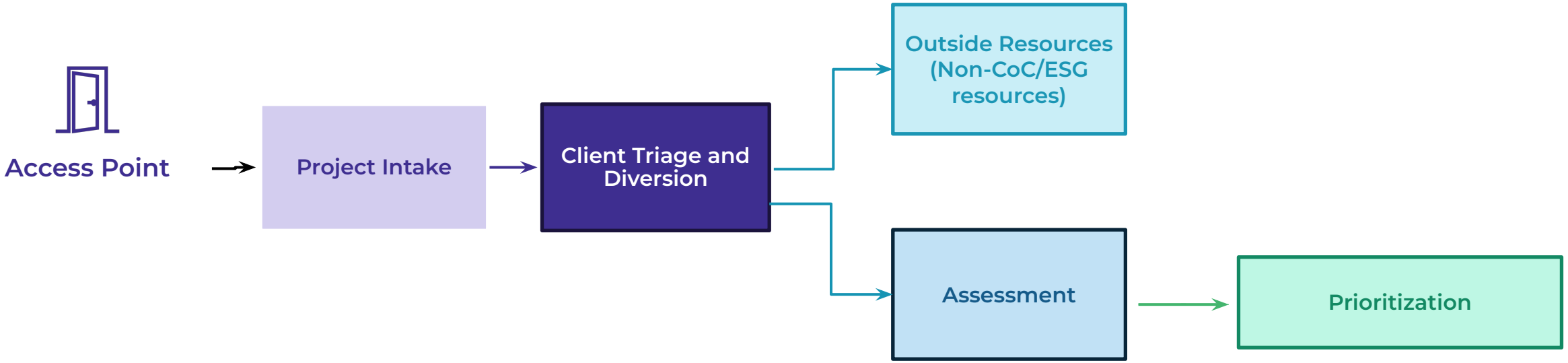
Veteran Services Providers

Victim Service Providers
- Domestic violence services
- Human trafficking services

Community Resources
- Social Services
- Libraries & Community centers
- Food pantries

Access: Triage & Diversion

In addition to providing first-line services and information to those in crisis, access points triage clients to either be assessed for placement on the priority list or diverted to other services. Clients that are able to resolve their current crisis with minimal supportive services are not assessed and diverted.



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Diversion

Diversion is intended to provide clients with low barriers and a high likelihood of resolving their own housing crisis with the resources they need to do so.

Assessed Clients with Low VI Scores

Clients from Categories 1 or 4 who do not score 4 or above on the appropriate VI Assessment will not be considered for referral. These clients should seek other resources if they cannot self resolve.

Introduction: Why is prioritization necessary?

Why not just send everyone to the By-name list?

Most communities have limited resources. Because of this, **only 20% of all clients can be referred.** The Coordinated Entry process prioritizes clients with the greatest need for housing assistance. It is important to find alternative ways to help the remaining 80% of clients who are not prioritized.

Remember, **the By-name List is a priority list, not a waiting list.** Length of time spent on the list does not guarantee eventual access to housing assistance.

The unfortunate truth is that many will never be served by CoC funded program.

Assessment Overview

The Coordinated Entry process uses the same triage and assessment methods across our CoC. The intention is to achieve fair access to services for all community members.

Non-contributing Factors

Clients **cannot be screened out** due to perceived barriers, including:

- Income
- Substance Use
- Criminal History
- Credit Score
- Sexual Orientation
- Disability

Assessment: Tools

The CoC is required to utilized a standardized tool to assess people's vulnerability.

Adults without children	Families with children	Unaccompanied Youth & Young Adults	Victims of domestic/dating violence, sexual assault, stalking, human trafficking.	Those at imminent risk of homelessness
Vulnerability assessment for adults without children	Vulnerability assessment for Families with children	Vulnerability assessment for Youth 18-24	Vulnerability assessment for DV	Prevention Assessment

Coordinated Entry Assessor Training is offered by the CE lead agency.

Prioritization: Process Overview

When a CoC faces a scarcity of needed housing and services resources, it is especially important that it use Coordinated Entry to prioritize people for assistance. **Coordinated Entry (CE) Lead Agencies are special projects funded by HUD to maintain a priority list of clients and support the service providers who use the list for case conferencing meetings.**

CE Lead Agencies in NY-508

- Erie County
- Niagara County
- Genesee, Orleans, & Wyoming Counties

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Prioritization: By-name Lists

The priority list or "By-name List" is a dynamic list of clients who have been assessed through the CE process. Client's placement on the list are constantly shifting as new community members enter and leave the homeless services network. Making efficient and effective referrals requires information about the person's history, barriers to housing, and level of vulnerability, as well as data about the availability of projects of various types in the CoC.

By Name List includes:

- HMIS ID #
- VI Assessment Score
- Length Of Time Homeless
- Disability Status
- Veteran Status
- DV/HT Experiences
- Household Composition
- Referral Status
- Linked Provider

Referral: Available Openings

The clients with the highest priority will be referred to appropriate housing openings.

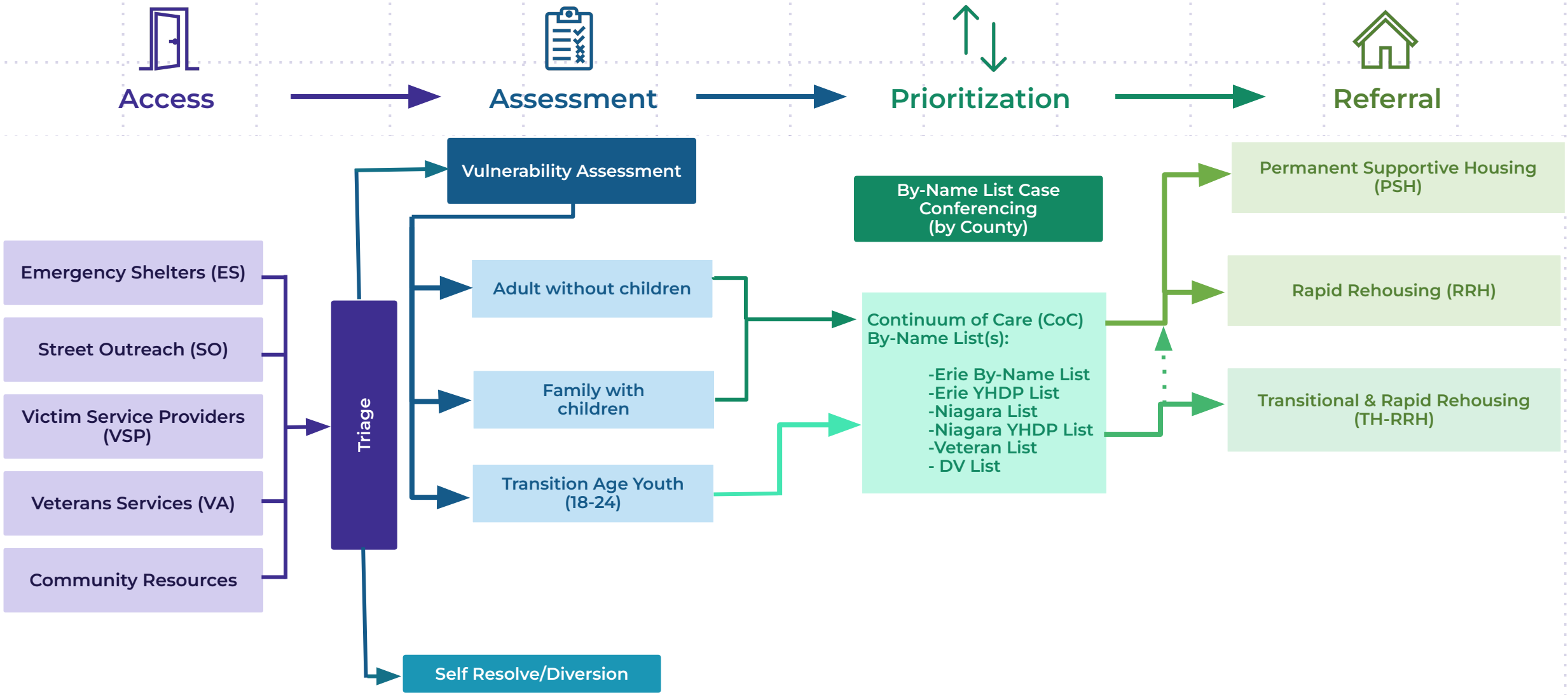
Housing providers inform the CE Lead Agency when there are availabilities in a project and the CE Lead Agency will follow CoC Coordinated Entry policy and procedure to refer the next prioritized and eligible person to the program.

- Both the housing provider and referring provider will receive a Letter of Referral as a formal acknowledgement of the referral.
- From here, the housing provider will attempt to contact the client.

Referral: Contact & Engagement

- Housing Providers have 45 days to contact, engage and enroll a client. At the first point of contact, both the client and the provider may decide to decline the referral.
    - If a client is inactive for over 30 days, the housing providers could return the referral/ CE lead can retrieve the referral.
- If both parties decide to move forward with the referral, the client will Engage with the program pending a review of their eligibility documentation.
- After a person is housed, housing providers have up to 180 days to obtain third-party documentation of homelessness.
- PSH Housing provider have 45 days to document client's disability. If the client does not have a qualifying disability, they will be returned to the priority list.

HUD Coordinated Entry Process & Alternatives



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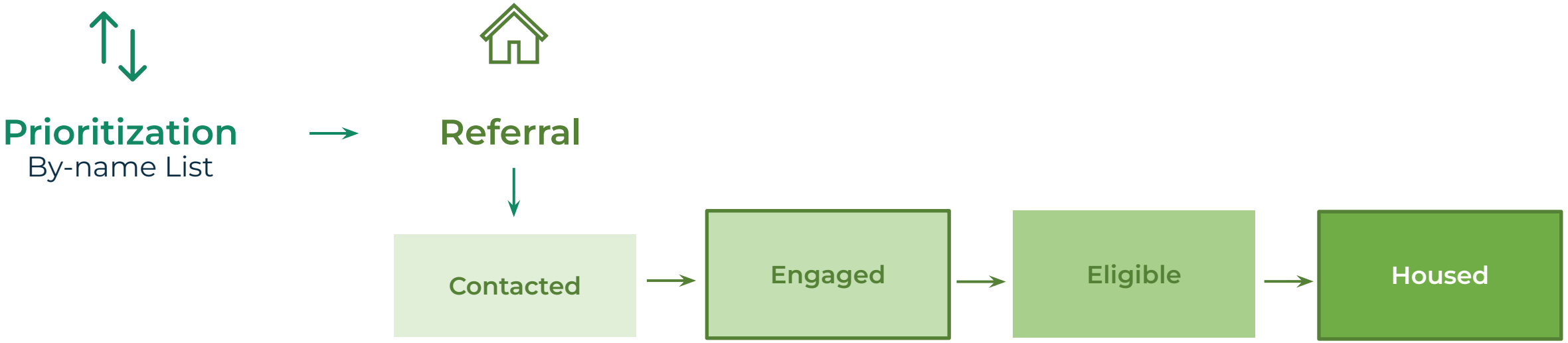
Prioritization, Referral, & Engagement

Local policies and practices for housing

Referral Workflow Overview



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Prioritization: Scoring & Ranks

Rank	Time Spent Homeless	Time Frame	Total Homeless Episodes	VI Score
1: PSH Priority 1	≥ 12 months	Past 3 years	1 or 4	≥ 9
2: PSH Priority 2	> 12 months		2 or 3	
3: PSH Priority 3	9 – 12 months		≥ 1	
4: PSH Priority 4	Any			
5: PSH Priority 5	N/A, Living in TH			
1: RRH Priority 1	≥ 6 months	Past year	≥ 1	4 - 9
2: RRH Priority 2	3 – 6 months			
3: RRH Priority 3	< 3 months			
4: RRH Special Accommodations	N/A, Losing Section 8			≥ 10

Priority for referrals is given to those who have the longest homeless history and most vulnerable based on the CE assessment. For clients who have matching VI scores and time spent homeless, the tie breaking criteria includes:

- Households with children
- Unaccompanied youth
- Unsheltered individuals or families

By-name Meetings

What is the by-name meeting?

By-name meetings are hosted regularly. During this meeting, participants conduct collaborative case conferencing using the client information provided during the assessment process.

The participants include…

- Access Points & Assessors
- Community Partners (DSS, OMH,)
- CoC /CE Leads
- Funding Agencies (HUD, VA)
- Housing Providers (TH-RRH, RRH, PSH)

Referral: Requesting Clients

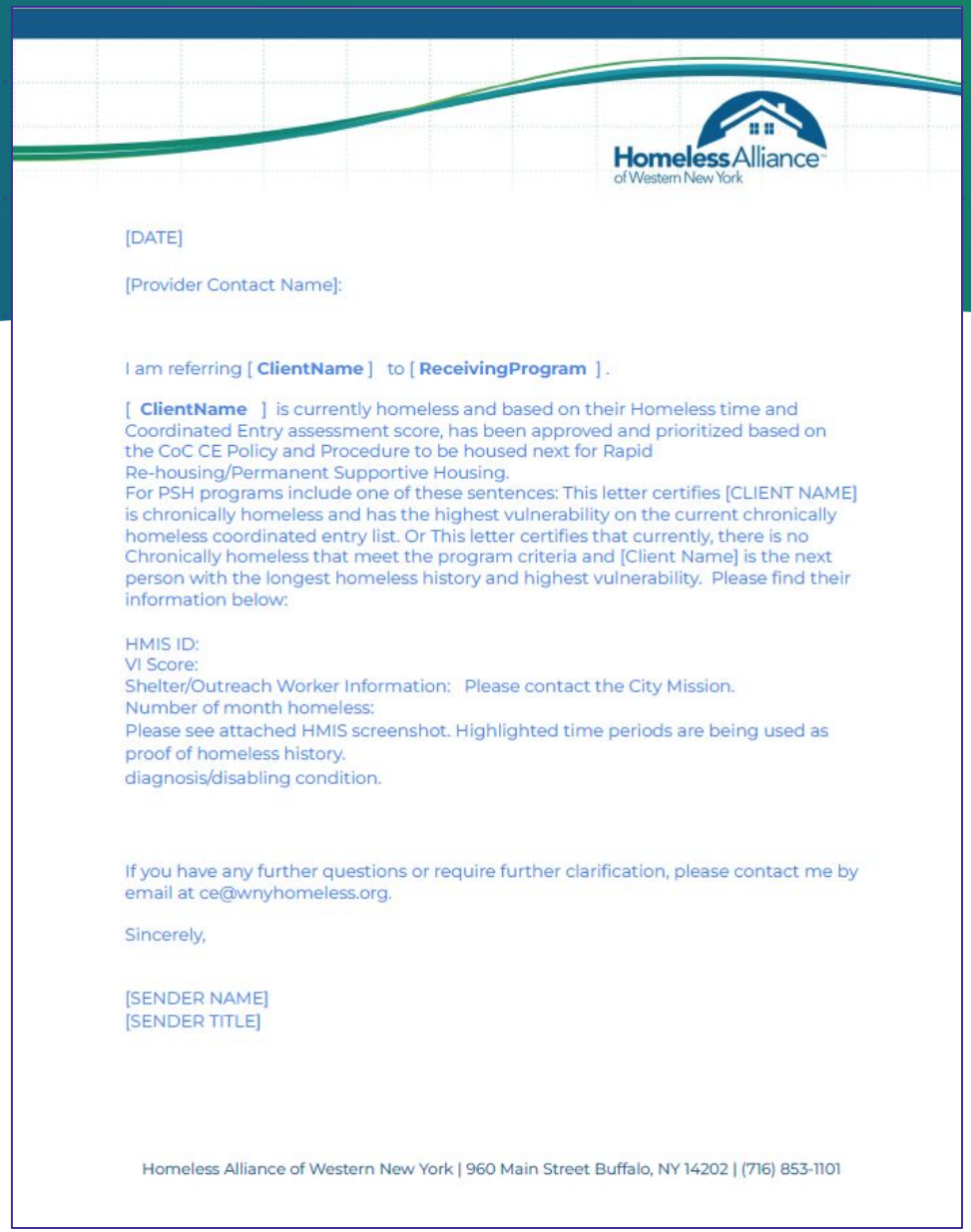
How to request, when to request,

1. Housing Agency requests referral from CE Lead.
2. The CE Lead will respond within 72 hours with a letter of referral for a CE participating client/household.
3. The Housing agency acknowledge the receipt of the referral through email to CE Lead.

Referral: Letter

Key Elements on the referral letter:

- Client info and Contacts
- Confirming the person is the most vulnerable person on the list with Coordinated Entry score and length of time homeless
- Print out of homeless history from HMIS if possible
- Disability information if possible



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[DATE]

[Provider Contact Name]:

I am referring [**ClientName**] to [**ReceivingProgram**] .

[**ClientName**] is currently homeless and based on their Homeless time and Coordinated Entry assessment score, has been approved and prioritized based on the CoC CE Policy and Procedure to be housed next for Rapid Re-housing/Permanent Supportive Housing.
For PSH programs include one of these sentences: This letter certifies [CLIENT NAME] is chronically homeless and has the highest vulnerability on the current chronically homeless coordinated entry list. Or This letter certifies that currently, there is no Chronically homeless that meet the program criteria and [Client Name] is the next person with the longest homeless history and highest vulnerability. Please find their information below:

HMIS ID:
VI Score:
Shelter/Outreach Worker Information: Please contact the City Mission.
Number of month homeless:
Please see attached HMIS screenshot. Highlighted time periods are being used as proof of homeless history.
diagnosis/disabling condition.

If you have any further questions or require further clarification, please contact me by email at ce@wnyhomeless.org.

Sincerely,

[SENDER NAME]
[SENDER TITLE]

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Contacting Clients

Sometimes contacting clients experiencing homelessness can be a challenge- creativity may be necessary!

Strategies for contacting clients (if you're still having trouble)

- Attend By-name meetings
- Use flex hours
- Contact access point location (shelters, outreach, etc)
- Contact the referral (CE Lead) agency for assistance

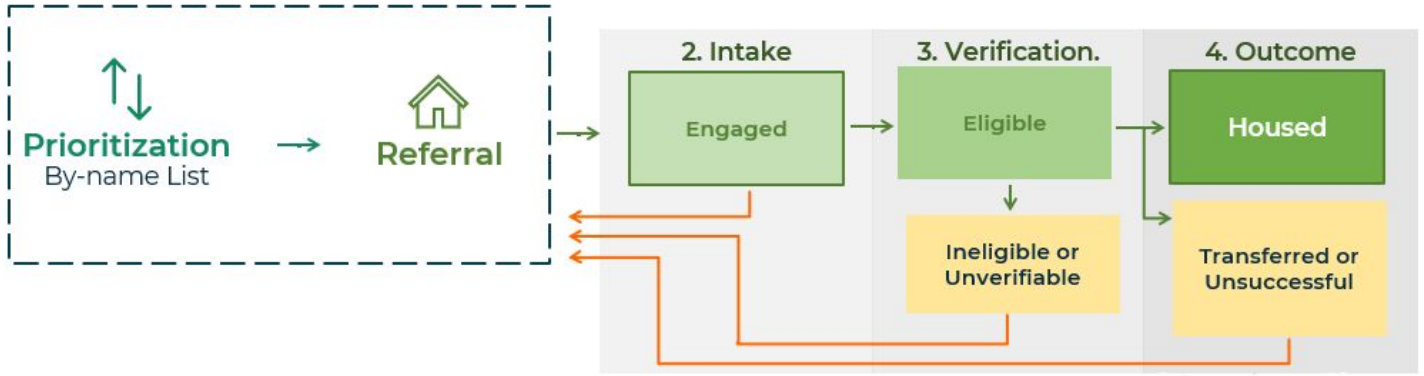
Engagement

Engagement is defined as: when a provider has met with a referred client and is consistently staying in contact with the client and/or working towards an agreed upon housing goal.

Usually, the first goal after engagement is establishing program eligibility.

Unsuccessful Referrals

Not every CE referral is successful



Contact (pre-engagement):

- Participant declines referral
- Participant is no longer homeless
- Participant MIA: If an agency is unable to contact a participant within 30 days, they should notify the CE Lead

Verification (post-engagement):

- Client does not meet the project's eligibility requirements, as established by the funder

Return/Decline (post-engagement):

- Project demonstrates adequate efforts but still can't house the participant

Eligibility Verification

Verifying the client's category of homelessness and collecting documentation that proves their eligibility for your project must be collected as required by your federal funding agency. Specifics depend on both your funding agency and the type of project you are running.

Examples:

- Evidence of time spent homeless/ shelter stays
- Verification of current legal/financial/benefits situation or status
- Institutional discharge paperwork
- Disability diagnosis (for PSH projects)

Types of Documentation

Third-Party

requires an entirely independent party to verify the client's experience.

Written observation by an outreach worker

Written verification by another housing or service provider

Institutional discharge paperwork

Second-Party

is someone related to the client (family/case manager/employer) declaring what the client has experienced.

Written statement from a family member, etc.

Written record of intake worker's due diligence to obtain third-party evidence is required for second-party verifications (YHDP programs only)

First-Party

is the client self-confirming what they have experienced in writing.

Statement by the person or head of household seeking assistance certifying that they were living on the streets or in a shelter

Third-party documentation is always preferred*.

Cannot be required for youth under the age of 25.

Housing

Housing programs have **60 days to place clients in a permanent housing situation** after engaging and verifying project eligibility.

A person is housed when they are physically moved into an apartment or other permanent form of housing. Once a person experiencing homelessness has been housed in the program, they will retain their apartment unless it has been vacated without notice for more than thirty (30) days.

Once a client is housed, they are formally removed from the By-name list.

Important Context for Service Providers

- **Be honest** about their situation to keep expectations in check. If someone scores low, they need to understand that they may never be helped by the Coordinated Entry system or a CoC housing project.
- **Be transparent** and provide information for follow up.
- **Talk about what to do** if their situation changes.
- **Participate** in By-name/case conferencing meeting.

Rapid-Rehousing (RRH)

Rapid Rehousing (RRH) is a short-term rental assistance program that emphasizes

- Housing Search & Relocation Services
- Short- & Medium-term Rental Assistance

The goal of these projects is to move people experiencing homelessness into permanent housing as quickly as possible.

Permanent Supportive Housing (PSH)

Permanent Supportive Housing (PSH) is long term leasing or rental assistance program, and supportive services are provided to assist households with at least one member with a disability to achieve housing stability. The goal of PSH is to allow individuals with disabilities to live as independently as possible.

Clients must have a diagnosable disability in one of the following categories to be eligible for referral:

- Substance use disorder
- Serious mental illness
- Developmental disability
- Post-traumatic stress disorder
- Cognitive impairments resulting from a brain injury
- Chronic physical illness or disability

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Leveraging All Resources

While CoC housing programs are a valuable resource, they are not the only housing resource available in our community

- We need to leverage all housing resources in our community (housing authority properties, SPOA programs, site-based subsidized housing, etc.)
- Remember, a Coordinated Entry referral is never guaranteed. Don't rely on this as a single solution for your clients.

Transfer and Disengagement

Even after a client is housed, at any point may no longer meet the program's eligibility:

1. Need higher level of care (e.g. max out of RRH 2 years limitations)
2. Violation of program policy (such as arson, refusal to pay, violence)

However, housing providers are expected to attempt to meet their client's needs before requesting a transfer or disengaging with the client. Strategies include:

Engaging with Access Point:

Case workers from shelter or outreach who make the initial referral should be treated as a valuable resource and tool and should be reached out to for support

Providing Housing Options:

Some clients may not be thriving in a particular building, area, or neighborhood due to environmental circumstances. Altering this environment through moving or arranging other accommodations is a possible solution.

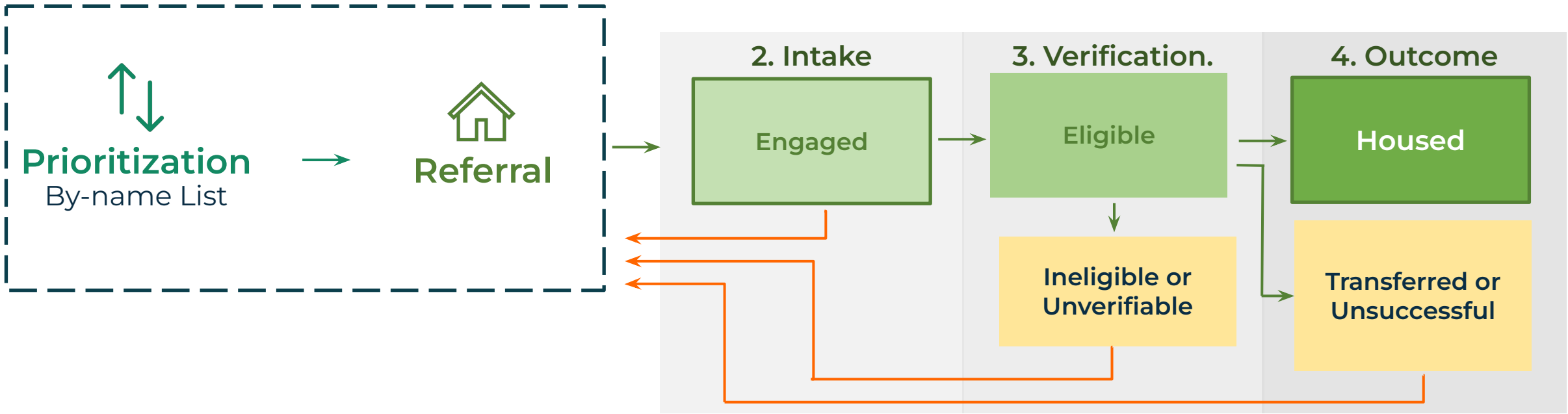
Linkages to Resources/Supports:

Steps must be taken by the housing provider to attempt to link the client with needed resources in the community including Care Coordination, Health Home services, ACT, APS, and other behavioral health treatment.

Contacting Crisis Services/Emergency Services:

If a client is a threat to themselves or others and may need hospitalization, the housing provider should contact Crisis Services (or other emergency services such as 911) to push for an emergency intervention that would lead to stabilization.

Housing Workflow Overview



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How do we work together as a community to improve CE?

Resource Collaboration

Projects work collaboratively with other providers identify alternative resources or creative solutions.

Housing Navigation

We maintain housing navigation resources, to assist clients in accessing available housing options outside of the Coordinated Entry system.

Collaboration and Partnerships

Our Homeless Services Network collaborates with community organizations, local government agencies, and other stakeholders to pool resources and create housing pathways for clients who are most in need.

Prevention and Diversion Services

Invest in prevention and diversion services to help individuals and families at risk of homelessness before they enter the crisis phase. This approach can help reduce the number of clients who face prioritization challenges in the Coordinated Entry process.

Data Analysis and Program Improvement

Continuously analyze Coordinated Entry data to identify potential gaps or biases in the prioritization process. Use this information to inform program improvements and make the system more equitable and responsive to clients' needs.

In Summary

Coordinated Entry was created to make it easier for communities to evaluate and prioritize people who are experiencing homelessness, helping them access housing resources more efficiently and to improve fairness.

It is a dynamic, fluid process that serves the most vulnerable in our community find a home. By working together we can reduce, and end, homelessness.

We acknowledge that this work isn't easy. We are grateful for the incredible work you do every day to change lives.

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of Western New York