

Coordinated Entry Policy and Procedure

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Introduction

The US Department of Housing and Urban Development’s (HUD) primary goals for coordinated entry (CE) processes are that assistance be allocated as effectively as possible and that it be easily accessible no matter where or how persons experiencing homelessness present. Coordinated entry processes help communities prioritize assistance, especially Federally funded homeless housing programs and prevention, based on vulnerability and severity of service needs to ensure that people who need assistance the most can receive it in a timely manner. Coordinated entry processes also provide information about service needs and gaps to help communities plan their assistance and identify needed resources.

The [HUD Coordinated Entry Policy Brief](#) describes all key qualities of effective coordinated entry and it is our community’s goal to achieve a high functioning and effective coordinated entry process

that embraces a Housing First, low barrier, person-centered, and fair and equal access to all people approach. Goals of the CE process:

This manual is designed to be used for the operation of Coordinated Entry in Erie, Niagara, Genesee, Orleans, and Wyoming Counties. All ESG or CoC funded projects must participate in Coordinated Entry system and only take referral from Coordinated Entry. All CE participants should follow this manual and provide the same person centered, trauma -informed and non-discriminatory services.

Non Discrimination and Equal Access

CoC Program and ESG Program funded projects must comply with non-discrimination and equal opportunity policies of Federal civil rights laws. Although there may be certain eligibility requirements for participation in certain programs (i.e. have a long term disability for permanent supportive housing), providers may not prohibit access or refuse assessment or referral to any person seeking services. In addition, individuals may not be screened out of the CE process or refused assistance due to lack of income, history of substance use or criminal activity, domestic violence history, resistance to services, disability, poor credit, lease violations, or lack of employment history.

The CE process must comply with applicable civil rights and fair housing laws and requirements, including but not limited to the following:

- *Fair Housing Act* prohibits discriminatory housing practices based on race, color, religion, sex, national origin, disability, or familial status.
- *Section 054 of the Rehabilitation Act* prohibits discrimination on the basis of disability under any program or activity receiving Federal financial assistance.
- *Title VI of the Civil Rights Act* prohibits discrimination on the basis of race, color, or national origin under any program or activity receiving Federal financial assistance. Title VI, Prohibition against National Origin Discrimination affecting Limited English Proficient Persons contains strategies for ensuring appropriate access to those whose first language is not English.
- *Title II of the Americans with Disabilities Act* prohibits public entities, which includes state and local governments, and special purpose districts, from discriminating against individuals with disabilities in all their services, programs, and activities, which include housing, and housing-related services such as housing search and referral assistance. Title III of the Americans with Disabilities Act prohibits private entities that own, lease, and operate places of public accommodation, which include shelters, social service establishments, and other public accommodations providing housing, from discriminating on the basis of disability.

In addition, HUD's Equal Access rule at 24 CFR 5.105(a)(2) prohibits discriminatory eligibility determinations in HUD-assisted or HUD-insured housing programs based on actual or perceived sexual orientation, gender identity, or marital status, including any projects funded by the CoC program, ESG program, and Housing Opportunities for Persons with Aids (HOPWA) program. CoC and ESG projects

should take special consideration to protect the rights of all individuals regardless of gender identity, which includes allowing individuals to file a complaint if they feel they have been discriminated against. Individuals must be made aware of their rights when accessing services, preferably in a written format.

Data Collection and Client Consent

Homeless Management Information System (HMIS) is used to manage Coordinated Entry and produce a priority list, with the exception of persons residing in a victim service facility. Victim services provider (defined by VAWA) is prohibited to enter client level data into HMIS. All HMIS participating programs will follow the privacy protocol under CoC's [HMIS Policy and Procedure Manual](#). For a quick guide on what information should be entered in HMIS to complete a referral in HMIS, please refer to [Coordinated Entry HMIS Guide](#).

All data collected from persons experiencing homelessness will be put into Homeless Management Information System that only trained staff have access to. Consent from the client is needed to share any information collected or documented. The assessment process does not require disclosure of disability or diagnosis, and an individual may refuse to disclose any information, however based on program criteria, e.g. a long term disability is required for permanent supportive housing, refusing disclosure of certain information may limit the clients' options for services that they are eligible for. [A consent form](#) to share HMIS data with Homeless Alliance of Western New York or other partner agencies can be found under Homeless Alliance website under HMIS tab. All client and provider consent forms should be uploaded to HMIS.

Overview of the Coordinated Entry Process

The CE process has several components that flow into one another in order to make the process smoother, simpler, and standardized. The process is as follows:

- 1) Special populations: Veteran, Youth and young adults, People experiencing domestic violence/trafficking
- 2) Prevention, diversion and accessing shelter
- 3) Engaging with an Access Point
- 4) Coordinated Entry Assessments
- 5) Prioritization - Documenting priority on the By-Name List
- 6) Referral - Based on eligibility, referring a client to the appropriate housing project

Coordinated Entry for Special Population

There are special resources dedicated to these special populations: veteran, youth and young adults as well as people experiencing domestic violence or trafficking. Hence we dedicate this chapter to address these resources, eligibility, priority, and how to access them. However, special populations can also be referred to

general homeless resources if availability is limited. All homeless access points should be aware of these resources to better serve clients.

Veteran

Veteran Definition: A person who served in the active Military, Naval, Air Service, regardless of length of service, and who was discharged or released there from, excluding any one who received a dishonorable discharge or was discharged or dismissed by reason of a General court-martial (PL 114-315; 38 USC § 2002(b)).

Available Veteran Resources

Verified Veterans will be eligible for assistance with housing in these main categories, but not limited to:

- SSVF (Supportive Services for Veteran Families) provides assistance to veterans and their families who are homeless or at-risk of homelessness. SSVF is a housing-first program funded through the U.S. Department of Veteran Affairs.
- GPD (Grant Per Diem) is a service-enriched transitional housing program.
- HUD-VASH (Veterans Affairs Supportive Housing) is permanent supportive housing. This program is administered by the U.S. Department of Veteran Affairs.

County Resources

- Erie County Veteran Services
- Niagara County Veteran Services
- Genesee County Veteran Services
- Orleans County Veteran Services
- Wyoming County Veteran Services

Eligibility for Veterans Services: Access to some types of housing services are depending on verification of veteran status as defined. Some veteran housing services may have different requirements for eligibility for services.

Verification of veteran homelessness can be obtained from the VA Healthcare for Homeless Veterans Service, from an SSVF (Supportive Services for Veterans and Families) provider, or other Veterans service provider.

If a homeless Veteran is not eligible for services through the VA or SSVF, they will be referred to the mainstream homeless system for assessment and services.

More Resources on Eligibility for Veterans can be found:

- Veterans Affairs: Veterans Experiencing Homelessness
- SSVF Program Guide (December 2018)

Access Point for Veterans into Coordinated Entry

Veterans can enter Coordinated Entry through all mainstream shelters, outreach, and prevention services in addition to veteran specific access points:

Healthcare for Homeless Veterans	One-Stop Center of WNY www.vocwny.org	Soldier-On www.wesoldieron.org
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1325 Main Street Buffalo, NY 14209 www.buffalo.va.gov Drop-in Center: M-F 8:30am-3pm P:716-862-8885 F:716-883-8420	Walk-ins or Schedule appointment P:716-898-0110 Buffalo: M-F 8:30am-4:30pm 1280 Main Street, Suite 204 Buffalo, NY 14209 Lockport: M-Th 8:30am -4:30pm 140 Genesee Street Lockport, NY 14094	Client intake line: 1-866-406-8449 WNY Field Director: Ilian Galan lgalan@wesoldieron.org 413-387-3085
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Veteran Emergency Shelter

Information regarding available emergency shelters can be accessed through the VA Medical Center.

Healthcare for Homeless Veterans program can provide referrals and assessments for potential placement at locations designated for homeless Veterans in the community.

Veteran Outreach Services:

Contact Healthcare for Homeless Veterans, Soldier-On, or Veterans One-Stop Center of WNY.

Veteran Homeless Prevention:

Contact Healthcare for Homeless Veterans or SSVF providers. *If not eligible for Veteran services, contact the local Department of Social Services.

Veteran Hotlines:

- Veterans Crisis Line 24/7: 1-800-273-8255 Press 1 or text 838255. www.VeteransCrisisLine.net
- Health Care: 1-877-222-VETS(8387)
- Benefits: 1-800-827-1000
- VA Inspector General: 1-800-488-8244

Coordinated Entry Procedure for SSVF Resources

Primary Procedures for Client Intake:

- All SSVF contacts made by traditional means such as: walk-ins, Community outreach and referrals will be handled by the contacting agency.
- Eligibility will be determined by the agency completing the intake and will be done in accordance with the requirements put forth in the most recent Department of Veteran Affairs SSVF program guide, and special guidelines that are given from time to time by the VA
- All intakes for Rapid Rehousing (RRH) require a VI-SPDAT starting July 1, 2020.
- All intakes for Homeless Prevention (HP) do not require VI-SPDAT but are recommended for data comparison starting July 1, 2020.
- In the event that intake cannot be started within 24 hours of contact or the partner has exhausted all funding for the period, the Veteran is to be referred using the Overload procedures.

Overload Procedures for Client Intake:

- Contact the Veteran One Stop ASAP via phone or email (Jamie Reid: 716-898-0110 ext.104, jreid@vocwny.org) and inform them that you have a Contact that needs CE placement. The coordinator will reassign the contact to provide intake within 24hours.
- If there is no Partner immediately available for reassignment, the coordinator will attempt to reach out to all Partners. Using current records and input from partners they will determine how to assist the Veteran best based on their needs and the needs of those currently enrolled in SSVF.
- In the event that there is a lack of available funding in the Partner program, the Partner must notify the coordinator, all clients will be forwarded to the CE Manager for re-assignment until additional funding becomes available.
- In the event that there is a regional lack of funding all contacts will be referred to the coordinator where they will be ranked based on VI score. They will then be assigned to partners based on this ranking and fair distribution.

BY Name List and Veteran By Name Meeting:

- There will be a bi-weekly meeting every 2nd and 4th Friday, hosted by Veteran One-Stop that will be used to review, refer and update all available information on the By Name List.
- Veteran One-Stop will run reports on HMIS periodically throughout the work week.
- These reports will be used to maintain a comprehensive list of all veterans in need of or receiving services in the WNY region as well as their status.
- If a contact is made through the By Name List it will be assigned to the first available Partner.

Youth And Young Adult

Unaccompanied Youth Ages 12 - 24

Youth Homelessness Demonstration Program (YHDP) funded programs target youth who are experiencing homelessness, including those who are unaccompanied and pregnant or parenting, where no member of the household is older than 24. YHDP funded projects as well as CoC funded youth TH-RRH are allowed to serve HUD definition of homeless Categories 1 (Literally homeless), 2 (at imminent risk of homelessness), and 4 (fleeing/attempting to flee DV).

The Youth Homelessness Demonstration Program has enabled our CoC to create youth and young adult (YYA) specific access points for Coordinated Entry (CE) and expand our housing resources for unaccompanied youth in Erie and Niagara Counties. Both Counties utilize the same CE procedure of assessment, prioritization, and referral, however the access points and specific program details differ. Each county will have separate CE Leads and Outreach Teams specific to each county and conduct separate youth by-name meetings. The YYA CE Lead agency for Erie County is Restoration Society, Inc. The YYA CE Lead agency for Niagara County is Heart, Love, & Soul. The designated youth Outreach Team for Erie County is BestSelf Behavioral Health. The designated Outreach Team for Niagara County is a collaboration between Pinnacle Community Services and Heart, Love & Soul.

Access Points for Coordinated Entry-Youth and Young Adult (YYA) Specific

Unaccompanied YYA may access the following services for diversion screening / access to Coordinated Entry. Unaccompanied YYA ages 18-24 can also access CE through any CoC access point.

Erie County

24/hr hotline for YYA (12-24) / Emergency

Shelter access (12-17)

Compass House 24/hr Hotline

716.886.0935

Youth and Young Adult Support Services and

Coordinated Entry HUB (18-24)

Compass House Resource Center

1451 Main Street Buffalo NY 14209

716.886.1351

9am - 10pm

Youth and Young Adult Drop-In Center (16-24)

BestSelf Behavioral Health - Safe Space

Overnight Drop-In Center

430 Niagara Street Buffalo, NY 14213

716.566.1870

11pm - 7am

Family Engagement Team (12-24)

BestSelf Behavioral Health

1050 Niagara Street Buffalo NY 14213

716.710.4393

Niagara County

Youth Resource Hub (18-24)

Community Missions

1622 Falls Street, Niagara Falls, NY 14303

716.285.3403

Family Engagement Team (12-24)

Pinnacle Community Services

1552 Main Street, Niagara Falls, NY 14305

716.285.6984

Diversion and Emergency Response

Unaccompanied YYA who present as homeless at youth specific access points will be screened with the NY-508 Prevention/Diversion Screening Tool (Appendix I) immediately.

Unaccompanied YYA who present as homeless at a non-youth specific access point will be screened with NY-508 Prevention/Diversion Screening Tool within one week. Non-youth specific access point agencies may either conduct the assessment by a trained screener, contact the Outreach Team, or refer the unaccompanied YYA to a youth specific access point.

The NY-508 Prevention/Diversion Screening Tool allows the trained screener to assess if the YYA can be successfully diverted from utilizing crisis housing and self-resolve, referred to the Family Engagement Team for family mediation, or is in need of crisis shelter and/or TAY-VI-SPDAT screening.

Diversion

If the YYA is able to safely return to family/friends and will be stably housed, the YYA will be connected to appropriate services for their specific situation, but will not be enrolled in YHDP services.

Enrollment in Family Engagement Team

YYA may be enrolled in the Family Engagement Team when it is determined that the YYA can safely reside with an identified support while the FET provides services to resolve family conflict and as program availability allows.

Emergency Shelter or Drop-In Center

If the YYA is experiencing literal homelessness or cannot be diverted or enrolled in the Family Engagement Team, they will be referred to one of the emergency shelter or crisis services below:

Erie County

Compass House Emergency Shelter (12-17)

370 Linwood Avenue, Buffalo, NY 14209
716.886.0935

BestSelf Sage Space Overnight Drop-In Center (16-24)

430 Niagara Street Buffalo, NY 14213
716.566.1870
11pm - 7am

Erie County DSS Emergency Shelter (18-24)

158 Pearl St
Buffalo, NY 14202
716.834.3131
After 4pm: 2-1-1

Niagara County

Casey House Emergency Shelter (12-17)

710 Cedar Ave, Niagara Falls, NY 14301
716.285.7125

Community Missions Emergency Shelter (18-24)

1570 Buffalo Ave, Niagara Falls, NY 14303
716.285.3403

Niagara County DSS Emergency Shelter (18-24)

301 10th Street, Niagara Falls, NY 14302
716.285.3515

The YYA may also contact Compass House 24 hour hotline for assistance (716.886.0935).

All emergency shelters serving young adults (18-24), must conduct or have the designated outreach team conduct the TAY-VI-SPDAT no later than 7 days upon entry in emergency shelter services. Emergency shelters serving youth (under 18) that have clients that turn 18 years of age while staying at the youth emergency shelter will conduct or have the designated outreach team conduct the TAY-VI-SPDAT when there are no other resources in place to stably house the YYA. YYA who turn 18 while in emergency shelter serving youth may stay for a maximum of 2 weeks after their 18th birthday.

Prioritization and Eligibility

Family Engagement Team (FET):

YYA ages 12-24 are eligible for the Family Engagement Team if they meet Category 1 or 2 of homelessness AND the FET is able to make contact with a safe support the YYA can reside with while the FET works to resolve household conflict. Category 1 or 2 homeless status will need to be verified. The program is meant to divert YYA from utilizing emergency shelter or CE by resolving the conflict or inadequate access to resources causing the YYA's housing

instability. The FET will conduct case conferencing to discuss their program's specific clients and their needs.

Joint-Transitional Rapid Rehousing

YYA ages 16-24 meeting Category 1 or 2 homelessness status are eligible in Erie and only youth age over 18 are eligible in Niagara. While Niagara TH program can accommodate pregnant or parenting YYA, Erie TH program can only serve youth without children. Family reunification will first be attempted for all youth that enter shelter. Youth under 18 that reside in shelter who are currently a ward of the state will be connected to their child welfare case worker, and those formerly a ward of the state will be assisted to reconnect with foster care if they wish. Youth not currently or formerly a ward of the state will be connected with the child welfare system if necessary. If that intervention was not successful and they age out of shelter, transitional housing could assist them. Youth who are at-risk could also utilize TH as crisis housing when it is available and when other options are not available/based on youth choice. The TH program will then utilize the NY-508 Prevention/Diversion Screening Tool as soon as possible to try to divert them into safe placements/ link them to resources available. If diversion is not an option, a TAY-VI-SPDAT should be conducted. Youth 18-24 are prioritized utilizing the TAY-VI-SPDAT and length of homeless history (see CoC Rapid Rehousing prioritization pg. 18). Eligible youth can choose to reside in Transitional housing or Rapid Rehousing when resources are available. They can also choose to exit transitional housing and move into rapid rehousing if rapid rehousing is available.

Referral Process

YYA ages 12-24 meeting Category 1 homelessness are placed on the general by-name list as well as the youth by-name list. Minor youth age 17 and under are assigned a unique anonymous ID without personally identifying information to protect confidentiality and only information pertinent to a referral is discussed.

Erie and Niagara County have separate YYA By-Name Committees that meet every other week to discuss referrals and hold case conferences. These committees include YHDP funded agencies, outreach team members, CE Lead Agencies, and HAWNY. All staff representatives from these agencies must have appropriate HMIS sharing capabilities to be present at these meetings.

The CE Leads will formally send referrals discussed at the By-Name meetings to the proper agencies post-meeting. Referrals from the CE Leads may also be sent out at any time as necessary.

Domestic Violence/trafficking survivors

An individual or family who is fleeing or is attempting to flee domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against

the individual or a family member, including a child, may contact the following 24-hour hotlines or shelters for assistance. This list may not be exhaustive. Not all listed are CE participating programs.

Erie County	Niagara County	GOW Counties
<p><i>Haven House</i></p> <p>Individuals and families experiencing domestic violence may receive transportation to shelter. Phone: 716-884-6000 (24-hour Emergency Hotline) Address: Buffalo, NY. Location is confidential to the public</p>	<p><i>Family and Children’s service of Niagara, Inc.</i></p> <p>PASSAGE 24-hr Phone Hotline: (716) 299-0909, 24-hour Emergency Hotline) Address: 1522 Main Street, Niagara Falls, NY 14305</p>	<p><i>The YWCA of Batavia</i></p> <p>Phone: 585-343-5808 (585-343-7513, 24-hour emergency hotline) Address: 301 North St, Batavia, NY 14020</p>
<p><i>Crisis Services</i></p> <p>100 River Rock Drive – Suite 300 Buffalo, New York 14207 24-hr Phone Hotline: 716-834-3131</p>	<p><i>YWCA of Niagara</i></p> <p>Phone: 716-433-6716 (24-hour emergency hotline) Address: Lockport, NY. Location is confidential to the public</p>	<p><i>Pathstone Domestic Violence at Albion, NY</i></p> <p>DV services hotline. Phone: (585) 589-8733 Address: Albion, NY. Confidential to the public</p>
<p>Response for Erie County!</p> <p>24-hr Phone Hotline: 716-862-HELP (4357)</p>	<p><i>Niagara County Department of Mental Health</i></p> <p>24-hr Crisis Phone Hotline: (716) 285-3515</p>	<p><i>RESTORE Sexual Assault Services</i> (Wyoming County Department of Social Services) at Warsaw NY Phone: (800) 527-1757 (24-hour emergency hotline) Address: 4 West Buffalo Street, Warsaw, NY 14569 (May transport clients to shelters)</p>
<p><i>LGBT Domestic Violence Committee of WNY</i></p> <p>c/o the Pride Center of WNY 200 South Elmwood Avenue Buffalo, NY 14201 (716) 852-7743</p>		<p><i>Wyoming County Crisis Services</i> Phone: 1-800-724-8583</p>

Human Trafficking Victim Services:

International Institute of Buffalo 716-883-1900*304 Address: 864 Delaware Ave. Buffalo, NY

The Human Trafficking Survivor Support Services assists individuals who have been trafficked by means of labor and/or sex. Through appropriate interpretation and translation services, clients receive assistance from an advocate. Depending on the specific needs, services can provide safety planning,

emotional support, access to basic necessities, access to English classes, linkages to legal support, linkages to medical and mental health services, and general victim advocacy with law enforcement and the criminal justice system.

To access CoC funded or ESG funded non-DV specific housing programs within the CoC

1. Victim services program staff may conduct the CE assessment and the following information will be provided to the Coordinated Entry lead in order to complete the referral process: A case file code (this should not include any personally identifiable information), CE assessment score (score only), household composition (or bedroom request), number of months homeless, Veteran status, and long term disability status (Yes/No). This information will not be entered into HMIS. Victim services program staff will be responsible to update the client information (for example, left shelter or found housing) and to play a role as linkage between CE lead and client, and for the future between the referred agency and the client to ensure the client's privacy is being protected. Referred agency staff should be notified if a victim services facility may not release information about the client because of revocation of releases.

2. Clients of victim services providers can access the Coordinated Entry system through any of the access points or contact the CE lead directly. The CE access points will follow the privacy procedures afforded clients experiencing domestic violence and informed client consent will be obtained if any personal identifying information is collected. No client will be refused assistance if they decline to participate in HMIS. This section will be updated once further guidance is provided by HUD.

Dedicated DV TH-RRH or RRH Procedure for Erie County

There are two homeless housing programs within Erie County that are dedicated to serving survivors of domestic violence: Hispanic United of Buffalo Rapid Rehousing (accept Category 1) and Children and Family Services Joint Transitional and Rapid Rehousing (Accept both Category 1 and 4). These programs will follow the procedure below regarding prioritizing the referrals they accept.

All domestic violence community partners can refer clients who are in need of housing and who meet HUD's homeless definition (Category 1 or Category 4) to Haven House's DV Hotline (716-884-6000). Hotline staff will make a referral to Haven House's case manager to conduct both the VI and danger assessments within 48 business hours. All survivors who are self-identified in shelters will also be surveyed using the danger assessment by trained shelter staff.

A client file number, the # of bedrooms needed, VI score, danger assessment score, and agency contact info will be provided to CE lead coordinator. No personally identifiable information should be provided, nor the client's contact information. The CE lead coordinator will refer clients with the highest combined score based on the VI and danger assessments to the DV-dedicated program when there is an opening. The CE lead will provide the client file number, the # of bedrooms needed, VI score, danger assessment score, and the referring agency's contact info to the housing program. The housing program will then

contact the referred agency to arrange a meeting with clients in a safe location. The housing provider will make sure the clients meet the program entry criteria at the point of enrollment. When there is no opening in the DV program, the rest of the clients will be prioritized based on regular procedure.

We recommend that DV service providers shall obtain a release of information from clients where it is possible that includes Haven house. In situations where the client no longer needs housing assistance, the referring agency shall contact the Haven House or CE Lead coordinator to remove the client from the list.

Homelessness Prevention Services

Persons at-risk of experiencing homelessness may be eligible for temporary financial assistance to prevent becoming homeless. These individuals should report to Department of Social Services (DSS) to be screened for eligibility and seen by an eligibility worker. After completing an application, the individual will be advised where to report based on the type of assistance they are applying for. It is not guaranteed the person will be seen the same day by an eligibility worker. The individual may be required to provide verification of identity, citizenship status, age, address, household composition, expenses, income, resources and employability. They may be required to have their photograph and/or fingerprints taken. An individual may also be eligible for temporary assistance if they have received a notice of eviction, reside in a home deemed uninhabitable, or have received a utility shut-off notice. More details and eligibility requirements can be found on each county's local Department of Social Services website.

There are several projects operating in Western New York that assist those most at risk of homelessness. Emergency Solutions Grant (ESG) funded prevention programs include:

City of Buffalo: Catholic Charities at Washington ave. office. The agencies determine eligibility based on whether exhaust mainstream benefits and prioritizing people who score higher in the prevention VI-SPDAT.

Erie County: Restoration Society offers prevention assistance to household who meet the at risk of homeless definition and currently reside in [Erie County ESG Consortium area](#).

City of Niagara Falls: Community Mission and YWCA of Niagara Frontier offers a one time rental arrear payment for individuals who are facing eviction. The agency determines eligibility based on funding availability, client income, habitability of housing, and VI-SPDAT score. Follow up case management will be provided to avoid future eviction.

All Counties: Neighborhood legal services (<http://www.nls.org/>): Neighborhood Legal Services is a non-profit based in Western New York that assists tenants retain their housing and apply for housing assistance. Neighborhood Legal Services is available in all NY-508 counties and has offices in Buffalo, Niagara Falls, and Batavia.

Neighborhood Legal Services Locations:

<p>Buffalo Office 237 Main Street, 4th floor Buffalo, New York 14203 Phone: (716) 847-0650 Fax: (716) 847-0227</p>	<p>Niagara Falls Office 225 Old Falls Street, 3rd Floor Niagara Falls, New York 14303 Phone: (716) 284-8831 Fax: (716) 284-8040</p>	<p>Batavia Office 45 Main Street Batavia, New York 14020 Phone: (585) 343-5450 Fax: (585) 343-5503</p>
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Accessing Emergency Shelter

New York state is a Right-to-Shelter state, meaning the local Social Services agency will grant temporary shelter pending the completion of investigation of a person’s eligibility in an immediate need situation. Lack of shelter as well as threat of eviction, pending eviction, and homelessness are considered to be an emergency situation. Lack of shelter is an immediate need. There is no prioritization for shelter. Everyone who needs shelter and is determined to be eligible will be placed immediately.

A person experiencing homelessness has several options to access shelter. First, they may access an emergency shelter that accepts walk-ins. When a person accesses emergency shelter through a CE participating walk-in shelter, they will be assessed and referred appropriately. If a person utilizes DSS or 211, diversion or prevention assistance may be offered where possible. If homelessness cannot be avoided using diversion or prevention method, the client will be placed in a shelter or motel. Street outreach teams also regularly search on the street to engage with clients who are least likely to seek assistance.

There are several shelters where homeless persons must be approved for placement in Erie County by DSS before entering the program. These include: Back to Basic, My Place Home, Salvation Army Family Shelter, Faith Based Fellowship, Family Promise, Haven House, a portion of beds at Buffalo City Mission Men’s Center (25 beds), and Matt Urban Hope House. In rural areas without any shelter, DSS has to place eligible persons experiencing homelessness in a hotel/motel. If shelters are full, DSS has an obligation to place clients requiring shelter into a hotel/motel.

1. Accessing Emergency Shelter through Department of Social Services

If applying for emergency housing, the person will be seen by an eligibility worker the same day (during normal business hours) and will usually be given a decision the same day. If the person has no place to stay, DSS must place them in an emergency shelter or in a hotel/motel if all local shelters are

full. Individuals may be required to provide verification of identity, citizenship status, age, address, household composition, expenses, income, resources, or employability verification. Additional documentation may be needed depending on the person's status. They may also be required to have their photograph or fingerprints taken. Each DSS is wheelchair accessible and individuals speaking a language other than English are entitled to language assistance. A DSS caseworker will link each individual to the appropriate public assistance and other benefits to which they are entitled.

Erie County Department of Social Service address: Rath Building 158 Pearl St., Buffalo, NY 14202

Person(s) experiencing homelessness must go to the Rath Building, located at 158 Pearl Street between 8AM and 4PM and be screened for eligibility by the Emergency Housing unit. For additional information you may call the DSS Call Center at (716) 858-2714.

- After hours, weekend and Holiday placements can be made by calling 211.

Niagara County Department of Social Services: 20 East Avenue, Lockport, NY 14094 or 301-10th Street, Niagara Falls, NY 14303 Regular business hour:8AM -4PM.

- After hours, weekend and holiday placements can be made by Community Mission of Niagara Frontier, Inc. (716) 285-3403

Genesee County Department of Social Services: 5130 East Main Street in Batavia, NY 14020. Regular business hours (8:30AM-5PM) at (585) 344-2580.

- Person(s) experiencing homelessness must go to the Salvation Army of Genesee County, located at 529 E. Main Street, Batavia, NY between 8AM and 4PM. After normal business hours, a person experiencing homelessness should contact the Salvation Army by calling a 24/7 Emergency number (585) 775-5488 or County Sheriff's Department to be assisted with finding shelter.

Orleans County Department of Social Services : 14016 Route 31 West, Albion, NY 14411 regular daytime hours (8:30AM to 5PM) by calling (585) 589-7000.

- After normal business hours, a person experiencing homelessness should contact the County Sheriff's Department to be assisted with finding shelter.

Wyoming County Department of Social Service: 466 North Main Street, Warsaw, NY 14569. Regular business hours: (8:30AM to 4:30PM) (585) 786-8900.

- After normal business hours, a person experiencing homelessness should contact the Wyoming County Community Hospital to be assisted with finding emergency shelter. The hospital can be reached at (585) 786-2233 or the County Sheriff's Department.

2. Shelters that accept walk-ins

Persons experiencing homelessness may visit any of the following providers and expect to receive assistance. Although they may not be eligible to stay temporarily or long-term at the provider

they choose to contact or visit initially, they will be referred to a provider that can deliver the appropriate services for their situation.

Erie County Shelters (Adults)	Niagara County Shelters (Adults)
<p><i>Buffalo City Mission</i> Serves men ages 18 and older. Phone: 716-854-8181 Address: 100 E Tupper St, Buffalo, NY 14203</p>	<p><i>Community Missions of the Niagara Frontier</i> Serves individuals 18 and older. Phone: 716-285-3403 Address: 1590 Buffalo Ave, Niagara Falls, NY 14303</p>
<p><i>St. Luke’s Mission of Mercy</i> Serves individuals 18 and older Phone: 716-894-4476 Address: 325 Walden Avenue Buffalo, NY, 14211</p>	<p><i>Niagara Gospel Rescue Mission</i> Serves men ages 18 and older Phone: 716-282-0432 Address: 1317 Portage Rd, Niagara Falls, NY 14301</p>
<p><i>Little Portion Friary (Closed in August)</i> Serves individuals 18 and older Phone: 716-882-5705 Address: 1305 Main St, Buffalo, NY 14209</p>	<p><i>Lockport Cares</i> Serves men and women ages 18 and older and their children. Phone: 716-438-2273 Address: 192 Genesee St Lockport, NY 14094</p>
<p><i>Cornerstone Manor (A part of Buffalo City Mission)</i> Serves women ages 18 and older and their children. Phone: (716) 854-8181 Address: 150 E North St, Buffalo, NY 14203</p>	
Erie County Youth Shelter	Niagara County Youth Shelter
<p><i>Compass House Runaway Homeless Youth Hotline (in Erie County) Phone: 716-886-0935</i></p>	<p><i>Casey House Runaway Youth Hotline (in Niagara County) Phone: 716-285-6984</i></p>
Genesee and Orleans County	Wyoming County
<p><i>Genesee Department of Mental Health</i> 5130 East Main Street Road, Suite 2 Batavia, New York 14020-349 Phone: (585) 589-3260 <i>Orleans Department of Mental Health</i> 14014 Route 31 West Albion, New York 14411 Phone: (585) 589-3260 extension 3292 Salvation Army of Genesee County 529 E. Main Street Batavia NY 14020 Phone: (585) 786-2233</p>	<p><i>Community Action for Wyoming County</i> Open 830am-5pm 6470 State Route 20A Perry, NY 14530 Phone: (585) 237-2600</p>

<i>Community Action of Orleans and Genesee</i>	
(Those not eligible for DSS motel/hotel placement)	
409 East State Street	5073 Clinton Street
Albion, NY 14411	Batavia, NY 14020
Phone: (585) 589-5605	(585) 343 7798

4. Veterans experiencing homelessness: Access services/shelter

A veteran experiencing homelessness in Western New York, in addition to the mainstream services for those experiencing homelessness, also has access to additional shelter and permanent housing resources. Emergency shelter designated for veterans is available through the Veteran Affairs Medical Center, accessed by referral through the Healthcare for Homeless Veterans program at 1325 Main St. Buffalo, NY 14209 or calling 716-862-8885. The sites of the contract housing are Eagle Star (2620 Main Road – Route 5, East Pembroke, New York 14056) and Cornerstone Manor (150 East North Street, Buffalo, NY 14203). Access to some types of housing are dependent on being on active duty and/or discharge status; the VA Healthcare for Homeless Veterans program will verify eligibility. If a homeless Veteran is not eligible for services through the VA they will be referred to the mainstream homeless service system for assessment and services.

5. Code Blue & services during winter months

Buffalo/Erie County: Through the Code Blue Collaborative, a partnership of multiple agencies, shelter and warming center assistance is coordinated throughout the city of Buffalo and rural Erie County for individuals experiencing homelessness. The NFTA Bus Station at 181 Ellicott acts as a main Code Blue hub where those seeking shelter each night are triaged to various forms of transportation (van, bus, etc.) in order to access Code Blue shelters throughout the city. Outreach is also conducted across Buffalo in order to locate and/or engage other individuals who are unaware of Code Blue services or are refusing to seek shelter.

Overnight shelters:Code Blue runs primarily from Nov 15-March 15, from 8pm-8am and occurs when the temperature (with windchill) drops to 15 Degrees or below. During a Code Blue, Harbor House, Rural Outreach Center and St Luke’s is open to accommodate individuals and provide safe, warm, emergency shelter for that night. People can also seek shelter through those shelters who take walk ins listed in page 7-8.

Code Blue 32 runs from Nov 15 through April 30th, from 8pm-8am and occurs when the temperature (with windchill) drops to 32 degrees or below. During a Code Blue 32, Rural outreach center and Harbor House are open to accommodate individuals and provide safe, warm, emergency shelter.

Day warming centers:From Nov 15th through April 30th, from 8am-8pm when the temperature (with windchill) drops to 32 degrees or below. Harbor House in Erie County allows those seeking shelter

to access a safe, warm location where individuals can seek basic needs and housing related services at 241 Genesee St, Buffalo, NY 14204.

Regardless of temperature, during winter months, individual who doesn't have a safe place to go could contact location below in Niagara, Orleans, Genesee or Wyoming County.

Orleans County: Individuals should contact the local Sheriff's Department at 3 South Main Street, Suite 2 Courthouse Square Albion, NY 14411 or Orleans County Department of Social Services at 14016 Route 31 West, Albion, NY 14411

Genesee County: Individuals should contact the Salvation Army of Genesee County at 529 E. Main Street, Batavia NY 14020 or the local Sheriff's Department at 165 Park Rd, Batavia, NY 14020.

Wyoming County: Individuals seeking temporary shelter from the cold may contact the county Sheriff's department. The Sheriff's department located at 151 N Main St, Warsaw, NY 14569 provides a space for those seeking shelter to stay for the night or Wyoming County Department of Social Service at 466 North Main Street, Warsaw, NY 14569.

Niagara Falls/Niagara County:

Warming Centers (Daytime)

- Community Missions – 1570 Buffalo Ave. – 285-3403 – 24 hours/7 days Daily
- Heart, Love & Soul – 939 Ontario Ave. – 282-5687 – 7:30 a.m. – 1:30 p.m.; Open Last two Saturdays each month; Closed Sundays
- John Duke Center – 1201 Hyde Park Blvd. – 297-9324 – M-F 8:30 a.m. – 3:30 p.m. Th – 8:30 a.m. – 8:30 p.m.; Closed Weekends
- Niagara Falls Public Library – Main St. Branch – 1425 Main St. – 286-4894 – M-W 9 a.m.-9 p.m.; Th-Sat. 9 a.m.-5 p.m.; Closed Sunday
- Niagara Falls Public Library – LaSalle Branch – 8728 Buffalo Ave. - 283-8309 - M-W 10 a.m.-8 p.m.; Th-Sat. 10 a.m.-5 p.m.; Closed Sunday
- Niagara Gospel Rescue Mission – 1317 Portage Ave. – 205-8805 8 a.m. – 7 p.m. Daily

Niagara Falls Overnight Shelters

- Community Missions – 1570 Buffalo Ave. – 285-3403 (Men, Women & Children)
- Niagara Gospel Rescue Mission – 1317 Portage Ave. – 205-8805 (Men only overnight)

Eastern Niagara County: The Salvation Army at 50 Cottage Street, Lockport NY (phone number is 716-434-1276) is open when temperature is below 15 degree.

Access Points for Coordinated Entry

Access points are places—either virtual or physical—where an individual or family in need of assistance accesses the coordinated entry process. Access points may only serve to provide information regarding available resources and assist in executing the referral process for persons experiencing homelessness. Access points may not be able to make final decisions or determinations on housing placement.

All Access Points will be consistent with the Coordinated Entry (CE) process, so that persons experiencing homelessness receive the same care regardless of which access point they use to enter the system. People who are homeless and in need of housing services can access information and eligibility criteria through one of the Access points listed below. Persons experiencing homelessness who are looking to be part of the CE process must be assessed at one of the Access Points or through an Outreach Team. Access points could provide reasonable accommodation for Individuals with disabilities, for example, provide multiple languages interpreters. See Appendix F for resources.

At each Access Points, persons experiencing homelessness can expect:

- To Be treated with respect and dignity
- Equal access to information and advice about housing assistance for which they are eligible in order to assist them in making informed choices.
- To receive integrated services through all of the participating agencies and programs.
- A referral based on their priority status to an opening in a program. For Permanent Supportive Housing (PSH) qualified programs, assistance will be provided to obtain any additional needed documentation for program eligibility.

Persons experiencing homelessness can access services:

By Phone

Harbor House Coordinated Entry Line: 716-842-4184 ext 131.

In Person- Hubs and participating partners

A person experiencing homelessness or fleeing domestic violence should expect to receive the same basic assistance and initial brief or comprehensive assessment at each provider location, with the exception of DSS. If a person reports to DSS they will be screened using a DSS assessment and will not necessarily be documented in HMIS. DSS may refer a person to a CE provider if deemed appropriate. (For a list of local CE providers, see Appendix.)

Buffalo/Erie County:

Hubs

- All populations: Harbor House Resource Center at 241 Genesee St in the City of Buffalo. This location can be contacted at 842-4184. Monday through Friday 9:00AM to 3:00PM, Saturday and Sunday 9:00AM – 7:00AM.
- Youth and young adults (under 25 years old): Compass house Resource Center 1451 Main st. Buffalo 716-884-3066
- Veteran: VA office and Veterans one-stop 1280 Main st. Buffalo NY 14209

Service Providers/Shelters participate in CE system as access points include:

Partner Shelters

- Back to Basics
- Buffalo City Mission
- Buffalo Cornerstone Manor
- Compass House Shelter
- Haven House*
- Hope House
- Little Portions Friary
- Salvation Army
- St.Lukes
- Temple of Christ

Community Partners

- Friends of the Night People
- Matt Urban Hope Center
- Catholic Charities on Washington St.
- NFTA Downtown Bus station, 181 Ellicott St. - Nicole Arlain (Matt Urban Outreach) is typically available Mondays 1pm-2pm (Code Blue 3pm-4pm), Tuesday, Wednesday and Thursday 1pm-2pm, and Fridays 6am-7am and 1pm-2pm. Call 716-536-7906.

Niagara Falls/Lockport/Niagara County:

Hub

- Community Missions of Niagara Frontier, Inc. 716-285-3403

Genesee, Orleans, and Wyoming County

Hub

- Independent Living-Genesee regional office. 319 E. Main st. Batavia NY 14020. This location can be contacted at (585) 815-8501 Ext 400. (Open Monday - Friday 8:30 am to 5:00 pm)
 - Wyoming regional office 2407 Main Street, Warsaw, NY 14569. Hours Monday from 1 pm to 5 pm - Tuesday to Friday 9:00 am to 5:00 pm

Other CE Participating Providers

- Community Action for Wyoming County
- Community Action of Orleans and Genesee

Street Outreach

Street Outreach teams conduct face to face outreach in the street, bus stations, public libraries, parks, and other locations and regularly assess persons experiencing homelessness where they are, during nontraditional hours. All street outreach teams are trained to utilize the Coordinated Entry Assessments and follow the Coordinated Entry procedure the same as any site based access point. (See Appendix B for contact information)

Web

Visit Homeless Alliance of Western New York's web page on [Coordinated Entry](#).

Assessment and Triage

The CoC has adopted the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) that was developed by OrgCode Consulting, to triage persons experiencing homelessness based on assessed vulnerability. Other considerable factors include: Chronically homeless status, homeless history, victim status, veteran status, and family composition. The intention of the prioritization is to achieve fair, equitable, and equal access to services within the community. It should not screen people out due to perceived barriers, such as income, substance use, criminal history, poor credit, sexual orientation, or disability.

Households without children experiencing homelessness

- [Vulnerability Index and Service Prioritization Decision Assistance Tool\(VI-SPDAT\)](#)

Households with children experiencing homelessness

- [Vulnerability Index and Family Service Prioritization Decision Assistance Tool \(VI-F-SPDAT\)](#)

Unaccompanied Youth under 25 experiencing homelessness

- [Transition Age Youth\(TAY-VI-SPDAT\)](#)

At Risk clients(Homeless definition category 2,3,4):

- **Household with children:** [Prevention-VI-SPDAT-v1-Family](#)
- **Household without children:** [Prevention-VI-SPDAT-for-Singles_v1](#)

If a person experiencing homelessness presents to a service provider or institution and it is confirmed they are experiencing homelessness, a trained staff member from that facility shall conduct a VI-SPDAT assessment. If no staff is trained to conduct the assessment, they can contact a local outreach team or Coordinated Entry lead to complete the assessment. (See Appendix B for contact information).

The local Assessment Team consisting of a CE Lead staff, outreach team, shelter staff or other trained service providers use the above assessment tools to assess persons experiencing homelessness who are living on the street or in shelters. The assessment tools are located and documented in HMIS. The exception is clients residing in a VAWA funded facility. These clients are not to be entered into HMIS. See [Confidentiality: VAWA and FVPSA](#) for more information.

Assessor Training

Coordinated Entry Assessor Training will be provided at least annually by CE Lead Agencies. The purpose of the training is to provide all staff administering assessments with access to official materials that clearly describe the methods by which assessments are to be conducted with fidelity to the CoC's coordinated entry process. All staff who administer the Coordinated Entry Assessment (outreach teams, shelters, or community partners, e.g. hospital discharge planner or food pantry staff) should complete the training. Training materials can be found on the HAWNY website as well as OrgCode.com.

The training must include:

1. A review of CoC's written CE policies and procedures, including any adopted variations for specific subpopulations
2. Requirements for use of the assessment information to determine prioritization
3. The criteria for uniform decision-making and referrals
4. Client consent and privacy protections.

Training materials are posted on [HAWNY website](#). Materials included for assessor training

- Assessment script
- Acknowledgement page
- Release of Information/Client Consent
- [CE Consumer Brochure](#)

Prioritization

Permanent Supportive Housing

1. First priority is given to individuals or families experiencing chronic homelessness. The order of referral is based on their VI-SPDAT/VI-F-SPDAT score.

When there are no individuals or families experiencing **chronic homelessness on the priority list, the order of priority will continue as follows:*

2. First Priority—Homeless Individuals and Families with a Disability with Long Periods of Episodic Homelessness and Severe Service Needs

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

3. Homeless Individuals and Families with a Disability with Severe Service Needs.

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

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

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

5. Homeless Individuals and Families with a Disability Coming from Transitional Housing.

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

All referrals must be based upon the Order of Priority and no waiver will be given to any individuals who do not meet the criteria outlined above. Based on the order of priority, people who are eligible for PSH but who cannot receive PSH due to overcapacity will be given a choice to be placed in Rapid Rehousing. Rapid rehousing agencies will conduct a re-evaluation using the VI-SPDAT every 3 months and determine if RRH meets the client's needs. If not, the client will remain on the PSH list until the next available bed is open.

A person who has a high VI score may be referred to Rapid Rehousing/CTI if appropriate. Situations include but are not limited to: experiencing homelessness for the first time; having a disability that is not severe or having only minor physical or medical disabling conditions; having other resources/supports; not having any history of experiencing unsheltered homelessness. However, Rapid Rehousing/CTI should reassess the person experiencing homelessness and determine if PSH would be more appropriate for the person.

**All PSH clients must have an eligible disability. (This chart has not yet approved by the membership)*

Rank	Priority	Tie breakers	Tie breakers
1	Chronic (homeless continuously for at least 12 months or on at least 4 separate occasions in the last 3 years)	1. VI Score 2. Length Time Homeless	1. Household with children /unaccompanied youth under 25 2. unsheltered
2	Non-Chronic; homeless MORE than 12 mo. in 3 years w/DISABILITY	1. VI Score 2. Length Time Homeless	1. Household with children /unaccompanied youth under 25 2. unsheltered
3	Non-Chronic; homeless between 9-12 mo. w/DISABILITY & VI Score MORE than 10	1. VI Score 2. Length Time Homeless	1. Household with children /unaccompanied youth under 25 2. unsheltered
4	Non-Chronic; VI score 10 or MORE w/DISABILITY	1. VI Score 2. Length Time Homeless	1. Household with children /unaccompanied youth under 25 2. unsheltered
5	VI score 10 or more and currently resides at TH	1. VI Score 2. Length Time Homeless	1. Household with children /unaccompanied youth under 25 2. unsheltered

Rapid Rehousing

ESG client: Below 30% AMI at annual reevaluation. CoC clients: Below 50% AMI.

Rank	Subpopulation	Secondary Prioritization	Tie Breaker
1	Homeless 6+ months (within 12 months) & VI Score 4-9	1. Length Time Homeless 2. VI score	1. Household with children /unaccompanied youth under 25 2. unsheltered

2	Homeless 3-6 months (within 12 months) & VI Score 4-9	1. Length Time Homeless 2. VI score	1. Household with children /unaccompanied youth under 25 2. unsheltered
3	Less than 3 months (within 12 months) & VI Score 4-9	1. VI score 2. Length Time Homeless	1. Household with children /unaccompanied youth under 25 2. unsheltered
Special Accommodations	VI score over 10, or homeless households who are about to lose Section 8 or requested Emergency Transfer Plan** CASE BY CASE BASIS Depends on funding availability	1. VI score 2. Length Time Homeless	1. Household with children /unaccompanied youth under 25 2. unsheltered

**Each region may, based on their region's need, determine additional priority in addition to those listed above. For example, people who with a disability, experiencing domestic violence, high utilization of crisis services, etc.*

***Per CoC Written Standards, clients in CoC-funded housing programs can request to be emergency transferred when they experience domestic violence, dating violence, sexual assaults, or stalking. All clients who request to be emergency transferred shall be prioritized to receive Rapid Rehousing/TH-RRH assistance as soon as a voucher becomes available. A Permanent Supportive Housing voucher may be granted when a client meets the original program requirements of Permanent Supportive Housing.*

****CoC TH-RRH eligible clients could choose to reside in transitional housing or Rapid rehousing and choose to transfer between these two components when they are available.*

Referral Process

Once a person experiencing homelessness is assessed and prioritized, they will be referred to an appropriate agency based on several determining factors including their priority status, housing needs, and proof of eligibility. Persons experiencing homelessness who are not eligible or who may not rank high in the vulnerable index should continually be served through shelter or outreach programs, in order to find housing through mainstream resources. All CoC programs need to follow the Referral Process and the Order of Priority discussed in this chapter. All participants of PSH must have a documented disability. Participants need to also meet any project specific requirements, for example, having a Serious and Persistent Mental Illness (SPMI) for Erie County Department of Mental Health funded beds.

Eligibility and Process Key Terms

PSH Eligibility Determination: Based on the CoC written standards, the Coordinated Entry Lead will ensure the documentation is in place before a person experiencing homelessness is referred to PSH providers. Documentation that is necessary in this stage includes:

Proof of disability **when possible***.

And

A completed CE Assessment

And

1. If a person is prioritized based on the 1st, 2nd or 3rd order, history of homelessness, SPOA consent if the individual has mental illness, client consent and a PSH referral sheet are required, or
2. If a person is prioritized based on score, current homelessness verification and SPOA consent if the individual has mental illness/client consent are required.

*All outreach teams, shelter case managers, referred housing providers are responsible to obtain the proof of disability.

Rapid Rehousing (RRH) / Transitional Housing with Joint Rapid Rehousing (TH-RRH) determination:

Based on the CoC written standards, the Coordinated Entry Lead will ensure the documentation is in place before a person experiencing homelessness is referred to RRH.

Proof of Income

AND

A completed CE Assessment

AND

Homelessness Verification

Referral Process

Standard Referral Steps/Responsibilities for CE Lead

	Step	Timeliness Standard
Step 1	All Rapid Re-Housing, and Permanent Supportive Housing Programs are required to notify the Coordinated Entry Lead via email - The notification must include specific details of the vacancy including the program name, unit size, and eligibility requirements.	48 business hours of unit/bed availability

Step 2	CE Lead will start the process of locating the highest appropriate client for the vacancy.	2 Business Days
Step 3	If contact is not made, the CE Lead will move on to the next highest appropriate client for the vacancy.	2 Business Days
Step 4	Once contacted, the client decides whether or not to accept referral	Immediately
Step 5	If the referral is declined, CE Lead move on to the next highest-ranking appropriate client.	Immediately
Step 6	If the referral is accepted, CE Lead will record the referral within the By Name Priority List; do an interim update on HMIS and follow up with receiving program as needed.	Immediately
Step 7	CE Lead will email the receiving program the official referral letter(Appendix J), and will also attach the letter to HMIS	2 Business Days.

Priority List

A list of client’s HMIS ID who are currently homeless along with other program eligibility criteria, e.g. VI score, length of time homeless, disability(Yes/No), veteran status, DV status, household composition. The list also includes their referral status and linked case manager. Although the list includes all the eligible clients, please note, it is a priority list, not a waitlist. Not all people on this list will be served. Persons experiencing homelessness are freely allowed to decide what information they provide during the assessment process, or to refuse to answer assessment questions. Refusing to provide certain priority information may result in ranking lower in priority. Assessor will be informing persons experiencing homelessness and allowing them to make the decision. However, refusing to provide certain information will not result in rejection of services based on the information are given. Priority list is active and all partners involved in the Coordinated Entry process try their best to update information in HMIS. Case conferencing is conducted twice a month through the Homeless Coalition Outreach Committee for Erie waitlist and it is being reviewed by service providers in Niagara and GOW

Housing declined by Client

A person is able to decline services they are offered. For example, if a client is eligible for Permanent Supported Housing (PSH) but declines housing, the outreach team will continue to engage with them. They will not be assigned to the PSH providers, however they will remain on a “Decline for Housing” list and an outreach/shelter worker will be assigned to continually engage with them. Evidence of outreach efforts and continued engagement should be recorded on each occasion in HMIS.

Completed Referral

Persons are referred when they have been assigned to a PSH agency by the Assessment Team Lead/SPOA in writing or through SPOA. Referral date and referred agency should be recorded in HMIS. Upon referral, the CE Team Lead will provide CE referral letters/email detailing clients homeless status, priority, and **disability information where possible** if it is a PSH referral to housing agency. One client could be referred to more than one agency, especially those who are deemed hardest to serve. All assigned agencies should be aware that such client is working with multiple agencies.

Engagement period

PSH providers have 45 days to engage with the client. 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. If no progress is made (no contact with client when a client is still actively experiencing homelessness) and the agency is not able to place a person in bridge housing or not able to arrange an apartment, the PSH provider will receive a Negative Disengagement Notice and the client will be referred to another agency. If an agency is unable to locate or engage with a person experiencing homelessness within 45 days they must immediately notify the CE Lead upon disengagement.

*Please note that during the engagement period, a unit/voucher will be held for the person experiencing homelessness and they will not be disqualified if they are temporarily housed with a subsidy in the interim wait period.

*72-hour rule: If there is more than one person on a PSH agency’s referral list and there is only one apartment available, the PSH provider will present the apartment to the highest ranked client. If the client cannot be found or is not willing to take the apartment within 72 hours, then the agency will move on to the next client while still working with the original client.

When PSH providers supply evidence of adequate efforts to engage with a person experiencing homelessness (e.g. showing the client more than 3 apartments, or have looked for the client with outreach teams) but are unable to house the person, the Assessment Team Lead can make a decision on re-referring such client to another agency, or placing the client back on the referral list for further engagement attempts, or placed on the refusing list. It will not be counted as “Negative Disengagement”.

Housed

A person is housed when they are physically moved into an apartment or other permanent form of housing. The agency will also open this case in HMIS at this point in time. 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. After a person is housed, the housing providers

have up to 180 days to obtain third-party documentation of homelessness. PSH Housing providers also have 45 days to obtain proof of diagnosis. Details refer to Appendix D.

**For persons experiencing homelessness who are housed but have passed away, have become incarcerated, or institutionalized temporarily, the housing provider may pay for the apartment for up to 90 days.*

Disenrollment (Positive and Negative)

Positive disenrollment is often also called Graduation from programs, which means a person is able to live independently, e.g. getting housing choice voucher or other subsidy and no longer need PSH. Other reasonable disenrollment includes circumstances in which client is violent against staff or other participants, incarcerated over 90 days, in need of higher level of care, or a client abandoned the apartment; Agencies should not evict a client due to the following reasons: failure to participate in supportive services; failure to make progress on a service plan; loss of income or failure to improve income; domestic violence; or any other activities not cover in a lease agreement typically found in the project's geographic area. These instances are referred to as Negative Disenrollment.

**Any disenrollment or discharge that is not to a permanent housing destination must be discussed in a case conference with CoC, PSH providers, and the outreach committee before the client is exited from the program.*

Transfer

A transfer describes a process where a client enrolled in one housing program is moved or transferred to another housing program. Transfers take place when there is a presentation of strong evidence indicating that a particular type of housing is unfit based on a client's needs, safety, and overall well-being.

CoC and ESG funded Housing providers, including Rapid Rehousing, Transitional Housing and Permanent Supportive Housing will need to submit Appendix G Discharge Form when referrals or individuals are discharged from their respective programs (under certain circumstances), and Appendix F Transfer Request Form when a provider wishes to facilitate and complete a program to program transfer between COC programs. Discharging a client without submitting a Transfer/Discharge Request Form, when necessary, will be viewed as a negative discharge. Exceptions/waivers are listed in each form.

The Coordinated Entry Referral Committee, a subcommittee of the CE Oversight Committee, will review all the transfer requests and discharge forms on a monthly basis. Decisions (transfers) and recommendations will be made in monthly meeting. A letter from the Chair of the Committee will be sent to the requested agency within a week of the meeting. Client transfer from a program with different program requirements (for example from a non-Chronically homeless dedicated bed to a dedicated bed) should be reviewed by HUD local CPD representative to ensure eligibility and documentation is meeting the program requirements.

Housing providers are recommended to follow these steps before they request to transfer or discharge a person and start documenting the actions. Housing providers should discuss the client in monthly

Outreach or Rapid Rehousing Committee case conferences and not wait until the last minute to submit this request.

1. Engagement with initial referral source e.g. shelter or outreach provider: 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.

2. Providing Housing options and choices: 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.

3. 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.

4. Crisis Services/Emergency Services: In the event that a client is a threat to themselves or others and may be in need of hospitalization, the housing provider should contact Crisis Services (or other emergency services such as 911) in order to push for an emergency intervention that would lead to stabilization.

Missing (MIA)

If a client has no contact with any agency staff (not only the PSH provider who homeless individual is assigned to, but any shelter, outreach team, or other clients) for at least 30 days (For CH individuals, the MIA standard is 90 days), then a client will be marked as missing and become inactive on any list they are on. However, their name will not be taken off the list until we know they are housed. If the person experiences homelessness again, their status will change from MIA back to active and the Assessment Team will reassess them if necessary.

Referral process for Veterans

Veteran who are eligible for VA services should access Coordinated entry through VA. Veterans who are experiencing homelessness are identified at intake by street outreach programs, the Dept. of Social Services, or at shelter entry. If a person identifies as a Veteran, they are referred to the VA for confirmation of their status. This referral is either directly to the VA, or through HMIS. The VA will assess a client for eligibility and will then be referred to the appropriate provider for housing assistance through VASH, GPD, SSVF, or into the CoC's coordinated entry assessment process for RRH or PSH. There is a bi-weekly Veteran by name meeting with a list generated by HMIS and attended by all Veteran housing providers and members of the CE staff to ensure all Veterans are properly referred and receive appropriate services. For CoC and ESG funded programs, only veterans will only be given priority/preference if the following situations occur: 1. funding shortage of VA funding, no voucher is available. 2. What's available through VA is not appropriate or adequate to meet client's need. 3. The Veteran is eligible for VA services.

Community Education and Marketing

The CE leads identifies and collaborates with homeless services agencies within the CoC geographic area as well as other partners (for example the hospital and criminal justice system) to provide education about the coordinated entry process. Formal community training is held at least annually to ensure partners understand the coordinated entry process and program availability and eligibility requirements. Educational opportunities are communicated through Homeless Coalition and Homeless Alliance email lists.

Evaluation

Ongoing planning and consultation concerning the implementation of Coordinated Entry are facilitated during Outreach, PSH, and RRH monthly meetings. A Provider survey is conducted annually, and an anonymous Client Survey (two separate Client Surveys are created: CE client survey for shelter, outreach and drop in center participants; CE client survey for RRH, PSH, TH and SH participants) is conducted quarterly and are administered by the Coordinated Entry Oversight Committee. The participants selected to participate in the evaluation must include individuals and families currently engaged in the CE process or who have been referred to housing through the CE process in the last year. The surveys are provided in both electronic and paper format. To ensure client confidentiality, surveys do not ask participants to provide any personally identifiable information. All feedback will be reviewed by the CoC committee and an action plan will be created accordingly.

CE monitor reports are produced at least quarterly using HMIS data and administered by the C E lead to ensure referrals are made fairly and to address any service gaps.

Appeal

Coordinated Entry Appeal Process

Coordinated Entry Appeal Engagement Process			
	1. Client appeals to the denial of placement	2. Provider Appeals to placement	3. Client Appeals to score/placement
Example Situation	Client is matched to RRH Matt Urban through CE. After intake, client is denied placement by RRH Matt Urban.		Client is denied for CE placement to Matt Urban, prefers placement into Catholic Charities.
1st step	Housing Provider (Program Director) manages appeal internally between client and Case Manager.		CEL program director manages appeal internally.
2nd step	If decision is not satisfied, appeal will be forwarded to CoC lead. CoC lead will mediate among the parties.		
3rd step	If mediation failed, appeal will be forwarded to CE Oversight Committee. Oversight committee will make the final decision.		

1. Client Appeal Score or Placement

- a. A Client must make a request in writing and deliver it to the Coordinated Entry Lead in person, via mail, or via email if:
 - i. The client disagrees with Coordinated Entry's placement
 - ii. The client has reason to believe the score is misconducted
 - iii. The client is denied assessment or services for refusing to provide certain pieces of information, unless the information is necessary to establish or document program eligibility per the applicable program regulation or the client is denied services.
 - iv. The client is denied services for refusing to allow their data to be shared unless Federal statute requires collection, use, storage, and reporting of a participant's personally identifiable information (PII) as a condition of program participation.
 - v. The client is denied access to the coordinated entry process coordinated entry process on the basis that the participant is or has been a victim of domestic violence, dating violence, sexual assault or stalking. Further, section 578.103(b) of the CoC program rule requires that records containing PII are kept secure and confidential and the address of any family violence project not be made public.
- b. Coordinated Entry lead will respond within 3 days, either by scheduling a hearing or review the placement/score to accommodate the client's request.
- c. The Program Director of the Coordinated Entry Lead must schedule a hearing within 7 days and send the written notice to the client and the assigned case manager. The notice for the assigned case manager must include a copy of the client's request.
- d. The Program Director of the Coordinated Entry Lead will conduct the hearing in-person or over the phone. The client and assigned case manager must be given the opportunity to provide written and oral objections or justifications for the score or placement decision.
- e. The Program Director of the Coordinated Entry Lead will be responsible for making the final decision within 3 days. The Program Director will provide a written notice of the final decision to the client and the assigned case manager.

2. Provider Appeal Placement

- a. When housing provider disagrees with Coordinated Entry's placement, a formal letter/email must be submitted to the Coordinated Entry Lead with reasons of denying placement.
- b. The Program Director of the Coordinated Entry Lead must respond within 3 days and schedule a hearing and send the written notice to Housing Provider and the Coordinated Entry Lead case manager within 7 days.
- c. The Program Director of the Coordinated Entry Lead will conduct the hearing in-person or over the phone. The Housing Provider and the Coordinated Entry Lead case manager must be given the opportunity to provide written and oral objections or justifications for the placement decision.
- d. The Program Director of the Coordinated Entry Lead will be responsible for making the final decision within 3 days. The Program Director will provide a written notice of the final decision to the Housing Provider and the Coordinated Entry Lead case manager.

3. Client Appeal Denial of Placement

- a. The Housing Provider must notify the client and the Coordinated Entry Lead verbally and with a written notice of the client's application and program denial notice with reasons of denial
- b. Client/CE Lead must submit a formal letter for an appeal.
- c. The client/CE Lead is required to follow the Housing Provider's appeals process.
- d. The Housing Provider is required to notify the client and the Coordinated Entry Lead with a written notice of the final decision within 2 weeks.

4. Additional Step

If the Client or Housing Provider has exhausted the above options, and they still disagree with the decision that the Program Director made, the client will then notify the CoC Lead Agency on the first appeal.

- a. The CoC Lead Agency will then mediate between the Client, Housing Providers and the Coordinated Entry Lead within 7 days.
- b. If mediation fails, the CoC Lead Agency will then submit an appeal to the Oversight Committee.
- c. The Oversight Committee must schedule a hearing and send the written notice to the affected parties within 7 days.
- d. A minimum of three members of the Oversight Committee will conduct the hearing in-person or over the phone with the affected parties. All affected parties must be given the opportunity to provide written and oral objections or justifications for the appeal decision.
- e. A minimum of three members of the Oversight Committee will be responsible for making the final decision within 3 days. The Oversight Committee will provide a written notice of the final decision to all affected parties.

Oversight and Management

Coordinated Entry Oversight Committee:

Members of the Coordinated Entry Oversight Committee are recruited to represent all homeless services providers, especially those who are involved in Coordinated Entry, including at least one representative from each program type: permanent supportive housing, transitional housing, outreach, shelter, youth services, Veteran services, DV service providers, a consumer, community partner, Niagara County, the GOW service area and the CE lead. This committee meets at least quarterly. The purposes of the committee are:

- Providing general oversight and support to the coordinated entry system in accordance with the CoC approved Written Standards.
- Responsible for developing and maintaining a process to receive and respond to grievances of participants and housing providers. Grievances that cannot be resolved by the coordinated entry lead agency and all provider appealed referrals will be forwarded to the oversight committee for resolution.
- Review and make final decision on Coordinated Entry related appeal.
- Evaluate the efficiency and effectiveness of the coordinated entry process by reviewing performance data and solicit feedback from participating projects and from households that participated in coordinated entry at least annually.
- Create an action plan to address issues identified through the oversight or evaluation of Coordinated Entry.
- Conducting an annual review of the Coordinated Entry Protocol.
- Establishing detailed client prioritization for receiving CoC or ESG funded program assistance based upon the approved CoC Written Standards.

- Review and approve policy changes or protocol improvements submitted by the coordinated entry lead agencies and subpopulation committees before the Board of the Homeless Alliance for final approval.

Members

The Oversight committee is comprised of a specific number of representatives. The designations are as follows:

Representative	Number of Seats
CoC Lead / HMIS Lead	1
Veteran CE	1
Domestic Violence Provider	1
Coordinated Entry Lead	4
Shelter	2
Permanent Supportive Housing	2
Rapid Rehousing	2
Outreach	1
Youth Provider	1
Community Partner	1
GOW	1
Niagara County	1
Consumer	1

**Representatives must participate at least ¾ of the meeting within a year. When absent, more than 2 times consecutively, CoC lead will contact the representative. If there is no response, membership will be terminated. Members meet at least bi-monthly and may meet more frequent when needed.*

CE Transfer Committee:

Purpose: Review and approve transfer requests to ensure requests are appropriate and to facilitate possible transfer once it is approved.

To ensure quality service and due diligence is being delivered within the CoC; Housing providers should only request to transfer a client after the provider has exhausted all other possible solutions for the issue(s) at hand and if they

believe that transferring the client to another program can improve the client’s situation. Prior to submitting a transfer request, all clients should be brought up at the Outreach Committee’s twice monthly meetings. These meetings are held at The Matt Urban Hope Center, located at 385 Paderewski Drive, Buffalo, on the First and Third Wednesday of every month at 9AM. Niagara County’s case conference meet on a weekly basis.

During these case conferences, providers are encouraged to bring up clients who may be struggling as well as identify barriers that the client may be facing. The case conference will facilitate possible solutions to help resolve whatever issues have arisen in housing. The goal of case conferencing prior to requesting a transfer is to find possible solutions for the client that can help them remain at their current housing provider.

This means that an individual or family may transfer from one housing program to another under the CoC Program.

This could occur under the following circumstances:

- If there were another housing program that better meet the preferences and service needs of the program participant;
- The current housing program in which the individual or family is enrolled in has lost their funding.

* Transfers requested solely due to lack of income will not be reviewed

The CE Transfer Subcommittee will have a chair; this chair will be one of two CE Leads.

Representative	Number of Seats
CE Lead(s)	2
Shelter	1
Outreach (Outreach Committee Chair)	1
Permanent Supportive Housing	1

Rapid Rehousing	1
Erie County Dept. Mental Health	1

Process:

The provider must contact the CE lead and request a transfer using the Transfer Request Form on the CE Policy and Procedure, detailing the reasons why the program participant needs to be transferred. The CoC Referral committee will review the request and determine within one week on whether to transfer, and will communicate this decision with the housing provider.

Program transfers may be made from rapid re-housing to permanent supportive housing so long as the household meets the Permanent Supporting Housing project’s specific eligibility criteria and program requirements.

*Members of the Oversight Committee will have power in voting and determining nominated representatives to the positions.

* Representatives must participate at least 75% of the meetings within a year. When absent, more than 2 times consecutively, CE Transfer Chair will contact the representative. If there is no response, membership will be terminated & Oversight committee will take the lead on locating a new representative.

* Members will meet monthly (Every last Monday of the month, from 2pm-3pm) and may meet more frequently or via email when needed.

* Identifying information on the Transfer Request Forms will be redacted, in order to limit concerns of a conflict of interest with clients enrolled in programs whose staff are representatives on the committee.

Appendix A: Common Acronyms

CE: Coordinated Entry

CH: Persons experiencing chronic homelessness

CoC: Continuum of Care

CTI: Critical Time Intervention. A housing program similar to Rapid Rehousing but funded by the Department of Mental Health.

ECDMH: Erie County Department of Mental Health

ES: Emergency Shelter

ESG: Emergency Solution Grant

GOW: Genesee, Orleans and Wyoming Counties

HAWNY: Homeless Alliance of Western New York, which is the CoC collaborative applicant and HMIS administrator

HMIS: Homeless Management Information System, it is an online database

MIA: Missing in action

SPOA: Single Point of Access and Accountability that Erie County Department of Mental Health administers

PH: Permanent Housing

PSH: Permanent Supportive Housing

RRH: Rapid Rehousing

TH: Transitional Housing

VA: U.S. Department of Veterans Affairs

VI-S-PDAT: Vulnerability Index Service Prioritization Decision Assistance Tool

VI-F-SPDAT: Vulnerability Index and Family Service Prioritization Decision Assistance Tool

TAY-VI-SPDAT: Transition Age Youth - Vulnerability Index - Service Prioritization Decision Assistance Tool

Appendix B: Coordinated Entry Lead and Outreach contact

Coordinated Entry Leads

Currently due to funding & program limitation, each region may have its own priority list. Coordinated entry leads are people or agencies who are responsible for administering the priority list and making referrals.

Coordinated Entry Lead (Erie County)

Jacob Hoffman <jhoffman@rsiwny.org> 716-208-3748

Youth (Erie County)

Compass House Resource Center 716-884-3066

Coordinated Entry Lead (Niagara County)

Amira Akpaloo <a.akpaloo@heartloveandsoul.org> 716-282-5687

Rapid Rehousing (Genesee, Orleans, Wyoming Counties)

Independent Living-Genesee regional office. 113 Main st. Batavia NY 14020. (585) 815-8501.

Outreach teams

Persons with mental illness (Erie County)

Best-self Yudanny Garcia <YGarcia@bestselfwny.org>

Persons experiencing homelessness (Erie County)

Matt Urban **Skylar Diamond** **sdiamond@urbanctr.org**

Persons experiencing homelessness (Niagara County)

Appendix C: Homeless, at-risk of homelessness, and chronically homeless definition¹

Homeless Definition

Category 1	Literally Homeless	<p>(1) Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:</p> <ul style="list-style-type: none"> (i) Has a primary nighttime residence that is a public or private place not meant for human habitation; (ii) Is living in a 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 and local government programs); or (iii) Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution
Category 2	Imminent Risk of Homelessness	<p>(2) Individual or family who will imminently lose their primary nighttime residence, provided that:</p> <ul style="list-style-type: none"> (i) Residence will be lost within 14 days of the date of application for homeless assistance; (ii) No subsequent residence has been identified; and (iii) The individual or family lacks the resources or support networks needed to obtain other permanent housing
Category 3	Homeless under other Federal statutes	<p>(3) Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who:</p> <ul style="list-style-type: none"> (i) Are defined as homeless under the other listed federal statutes; (ii) Have not had a lease, ownership interest, or occupancy agreement in permanent housing during the 60 days prior to the homeless assistance application; (iii) Have experienced persistent instability as measured by two moves or more during in the preceding 60 days; and (iv) Can be expected to continue in such status for an extended period of time due to special needs or barriers

¹

https://www.hudexchange.info/resources/documents/HomelessDefinition_RecordkeepingRequirementsandCriteria.pdf

Category 4	Fleeing/ Attempting to Flee DV	(4) Any individual or family who: (i) Is fleeing, or is attempting to flee, domestic violence; (ii) Has no other residence; and (iii) Lacks the resources or support networks to obtain other permanent housing
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**All Permanent Supportive Housing Program and most Rapid Rehousing programs will only accept clients who meet the category 1, literally homeless definition. Certain Rapid Rehousing program will accept clients who meet the category 4, fleeing/attempting to flee DV definition. Emergency Solution Grant (ESG) funded Prevention program can only assist clients who meet category 2 or 4.*

At-Risk of Homelessness Definition

Category 1	Individuals & Families	An individual or family who: (i) Has an annual income below 30% of median family income for the area; <u>AND</u> (ii) Does not have sufficient resources or support networks immediately available to prevent them from moving to an emergency shelter or another place defined in Category 1 of the “homeless” definition; <u>AND</u> (iii) Meets one of the following conditions: (A) Has moved because of economic reasons 2 or more times during the 60 days immediately preceding the application for assistance; OR (B) Is living in the home of another because of economic hardship; OR (C) Has been notified that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance; OR (D) Lives in a hotel or motel and the cost is not paid for by charitable organizations or by Federal, State, or local government programs for low-income individuals; OR (E) Lives in an SRO or efficiency apartment unit in which there reside more than 2 persons or lives in a larger housing unit in which there reside more than one and a half persons per room; OR (F) Is exiting a publicly funded institution or system of care; OR (G) Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient’s approved Con Plan
Category 2	Unaccompanied Children & Youth	A child or youth who does not qualify as homeless under the homeless definition, but qualifies as homeless under another Federal statute
Category 3	Families with Children & Youth	An unaccompanied youth who does not qualify as homeless under the homeless definition, but qualifies as homeless under section 725(2) of the McKinney-Vento Homeless Assistance Act, and the parent(s) or guardian(s) or that child or youth if living with him or her.

Chronically Homeless Definition

The definition of “chronically homeless²”, as stated in Definition of Chronically Homeless final rule is:

(a) A “homeless individual with a disability,” as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:

- i. lives in a place not meant for human habitation (ex. on the street), or is staying in a safe haven or emergency shelter; and
- ii. Has been homeless and living as described in paragraph (a)(i) continuously for at least 12 months or on at least four separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (a)(i). Stays in institutional care facilities for fewer than 90 days will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering an institutional care facility;

(b) An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (a) of this definition, before entering the facility;

(c) A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (a) or (b) of this definition (as described in Section I.D.2.(a) of this Notice), including a family whose composition has fluctuated while the head of household has been homeless.

Appendix D Homelessness Verification requirements

Homeless documentation recording requirements:

Category 1	Literally Homeless	<ul style="list-style-type: none">● Written observation by the outreach worker; or● Written referral by another housing or service provider; or● Certification by the individual or head of household seeking assistance stating that they were living on the streets or in shelter;● For individuals exiting an institution - one of the forms of evidence above and:
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² <https://www.hudexchange.info/resources/documents/Defining-Chronically-Homeless-Final-Rule.pdf>

		<ul style="list-style-type: none"> ○ Discharge paperwork or writer/oral referral; or ○ Written record of intake worker's due diligence to obtain above evidence and certification by individual that they exited institution
Category 2	Imminent Risk of Homelessness	<ul style="list-style-type: none"> ● A court order resulting from an eviction action notifying the individual or family that they must leave; or ● For individuals and families leaving a hotel/motel - evidence that they lack the financial resources to stay; or ● A documented and verified oral statement; and ● Certification that no subsequent residence has been identified; and ● Self-certification or other written documentation that the individual lack the financial resources and support necessary to obtain permanent housing
Category 3	Homeless under other Federal statutes	<ul style="list-style-type: none"> ● Certification by the nonprofit or state or local government that the individual or head of household seeking assistance met the criteria of homelessness under another federal statute; and ● Certification of no PH in the last 60 days; and ● Certification by the individual or head of household, and any available supporting documentation, that they have moved two or more times in the past 60 days; and ● Documentation of special needs or 2 or more barriers
Category 4	Fleeing/ Attempting to Flee DV	<ul style="list-style-type: none"> ● For victim service providers: <ul style="list-style-type: none"> ○ An oral statement by the individual or head of household seeking assistance which states: they are fleeing and have no subsequent residence, and they lack resources. Statement must be documented by a self-certification by the intake worker. ● For non-victim service providers: <ul style="list-style-type: none"> ○ 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 ○ Self-certification, or other written documentation, that they individual or family lacks the financial resources and support networks to obtain other permanent housing

Chronically Homeless Recordkeeping Requirement

- At least 9 months of time experiencing homelessness should be documented by third party; up to 3 months can be documented by self-certification alone
- Where third party absolutely cannot be obtained, up to the full time can be documented by self-certification
 - Provider must document attempts at collecting third party and the conditions the individual or family is living in. AND

- No more than 25% of individuals and families assisted in a project can have more than 3 months documented by self-certification
- One documented encounter in a month, assume the client experienced homelessness for entire month unless there is evidence of a break (e.g., a stay in TH)

Acceptable Third-Party Documentation:

- Individual record of a stay in emergency shelter, street outreach from HMIS or comparable database
- Written observation from outreach worker of encounters with household and description of where household was residing
- Written observation of community member: Community members include police officers, owners of businesses, etc. NOT friends/family
- Written referral by another housing or service provider

Documenting Disability:

Qualifying disability must be documented by one of the following:

- Written verification of disability from licensed professional
- Written verification from SSA
- Receipt of disability check
- Intake staff-recorded observation (must be supported by evidence above within 45 days of entry)
- Appendix G listed credentials for diagnosing addictions and mental health disability

Appendix E: Service Map

By clicking this [Service Map](#), you can browse on Google Map to find Department of Social Services, and shelters or code blue warming centers that accepts walk-ins that are close to you. You can also find Coordinated Entry hubs that are referred in this documents.

Appendix F: Resources

[CE Checklist](#)

[Notice Establishing Additional Requirements for a Continuum of Care Centralized or Coordinated Assessment System](#)

[Notice on Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing](#)

Olmsted Center for Sight

1170 Main Street
Buffalo, New York 14209
716-882-1025

<http://olmstedcenter.org/>

Language Interpretation:

AT&T Language Assistance Program

1-800-528-5888

International Institute

864 Delaware Ave
Buffalo, NY 14209
(716) 883-1900

<https://iibuffalo.org/>

Journey's End (Health Homes)

(716) 882-4963 x207 or 201

[Legal Assistance and Advocacy \(click link here\)](#)

Appendix G: Discharge Form

Check one that applies:

Client Discharge (post-Program Entry) ___

Close an Open Referral___

Participant Name:

Participant HMIS ID: _____

Discharge Location (where was client exited to):

Program Name:

Program Contact/Case Manager:

Phone Number of Above Contact:

Please **CIRCLE** all Discharge Categories that apply to this participant & circumstance

Physical Violence

Inability to maintain ADL's independently

Arson related behaviors

MIA/Disappeared

Self-Harm

Refusing Housing Opportunities

Multiple Lease Violations

Program Specific Violations

Please describe in detail the reason for program discharge:

Please share any additional information about this client that would be helpful to Outreach or CE providers in future service coordination efforts.

Appendix H: Transfer Request Form:

This form is intended to be used when a client is being referred to or housed by a housing provider and the housing provider needs to transfer such clients. Request form should be submitted to the appropriate coordinated entry lead based on program type:

Buffalo/Erie County - Jacob Hoffman, jhoffman@rsiwny.org

Niagara Falls - Amira Akpaloo, a.akpaloo@heartloveandsoul.org

The Coordinated Entry (CE) Referral Committee, a subcommittee of the CE Oversight Committee, will review all the transfer requests on a monthly basis (as needed) to make appropriate and fair transfer determinations for the COC. A letter from the Chair of the Committee will be sent to the agency requesting a transfer within a week of the meeting. In the event of an emergency transfer situation (that cannot wait until a monthly meeting) CE Leads will make such determinations based on criteria agreed upon within the CE Referral Committee.

Client transfer from a program with different program requirements (for example from a non-Chronically homeless dedicated bed to a dedicated bed) should be reviewed by HUD local CPD representative to ensure eligibility and documentation is meeting the program requirements. This can be done by the housing provider and/or CE Lead.

*If you have any additional documentation (that is not covered in this form) that would help the CE Referral Committee understand the situation, please feel free to attach them along with your request.

Appendix H: Transfer Request Form

Please do NOT use Participant Name on this form

Date:

Participant HMIS ID: _____

Program Name: _____

Program Contact/Case Manager submitting Request: _____

Phone Number of Contact submitting Request: _____

Desired Transfer Destination (if applicable): _____

Months Homeless (upon program entry): _____

Most current VI score: _____

Please CIRCLE answer that best describes participant current living situation

Homeless Shelter Bridger Permanent Housing

For how long has participant been in current living situation (while enrolled in your program)?

_____ **Years** _____ **Months**

Please briefly summarize major reasons why this participant is in need of a program transfer:

Please answer the following questions; if they do not apply, simply put N/A

1. If the cause of this request is due to the participant causing repeated harm to themselves or others, or hands-on violence, please describe the incidences.

2. In the event that a client is a threat to themselves or others and may be in need of hospitalization, have you contacted and advocated for the client with Crisis Services (or other emergency services such as 911) in order to push for an emergency intervention that would lead to stabilization? If so, please describe.

3. Have you contacted the participants' initial referral source e.g. shelter or outreach provider? If yes, what actions were taken?

4. Many times a participant can fail to thrive due to environmental circumstances (i.e. a particular building, area, or neighborhood, neighbors, etc.). Please describe how you have provided alternative accommodations (for scattered site projects)? If so, what has been the result?

5. Have you attempted to/referred the client to needed resources in the community (i.e. Care Coordination, Health Home services, ACT, APS, NLS and other behavioral health treatment)?

If yes, please describe current community based services that this participant has been referred to or is presently connected to .

6. If a client is refusing to engage in services, please explain the efforts you have made toward engagement and/or trust building.

7. Please explain how this transfer will better meet the needs of the participant.

8. How has the agency communicated with the participant about the potential transfer opportunities?

9. Is the client willing to engage in the transfer process and those opportunities? ___YES ___NO

Appendix I The NY-508 Prevention/Diversion Screening Tool for YHDP

Date of Screening Interview: _____/_____/_____

Name: _____

Birthdate: _____

Location: _____

Staff completing interview: _____

Pre-Screen Questions

1. Do you believe you will become homeless in the next 2 weeks?

Yes No

1a. Are you homeless or do you believe you will become homeless in the next 3 days?

Yes No

HUD Category 1: *living in a place not meant for human habitation, in emergency shelter (including domestic violence shelter), in transitional housing, or exiting an institution where they temporarily resided for up to 90 days and were in shelter or a place not meant for human habitation immediately prior to entering that Institution.*

HUD Category 2: *At imminent risk of homelessness within 14 days.*

Are you currently residing with, or trying to leave, an intimate partner who threatens you or makes you fearful?

Yes No

**If yes to Question 2, clients are referred to DV resources to crisis housing.*

Call 211 for DV resources. Call Erie County's 24 hour hotline at 716.862.4357 or for shelter call 716.884.6000

3. Where did you sleep last night? _____

4. Was it a safe location? Yes No

If no, ask "What made the location unsafe?" "Is there another place you can think of where you feel safe and could stay for a couple of nights?" If unsafe due to domestic violence, refer to DV services / crisis housing.

PREVENTION/DIVERSION QUESTIONS

5. Why did you have to leave the place you stayed last night?

6. Could you stay tonight at the same location? ___ Yes ___ No

If no, skip to Question 9

7. What would you need to help you stay where you stayed last night again?

Examples: (Landlord mediation, Conflict resolution, Rental assistance, Utility assistance, etc.)

8. Would it help if I contacted the person you stayed with? What is the best way to contact that person?

Name _____ Phone _____

9. Is there anyone else you (and your family) could stay with? Friends, family, co-workers?

___ Yes ___ No

If no, skip to Question 12

10. What would you need to help you stay there?

Examples: (Landlord mediation, Conflict resolution, Rental assistance, Utility assistance, etc.)

11. Would it help if I contacted that person you can stay with? What is the best way to contact that person?

Name _____ Phone _____

12. Were you able to successfully divert this person(s) via homeless prevention or other community resources, without enrollment in FET or CE assessment?

Yes No

Outcome of Screening:

Appendix J Referral Letter Template

Chronically homeless Dedicated Program Referral Letter

[DATE]

To Whom It May Concern:

HMIS ID:

VI Score:

Contact Info:

Shelter/Outreach Worker Information:

All chronically homeless individuals on the Coordinated Entry By-Name List are currently linked with housing. [ClientName] is currently homeless and based on their VI score has been approved and prioritized based on CoC Coordinated Entry Policy and Procedure.

OR This letter certifies [CLIENT NAME] is chronically homeless and has the highest vulnerability on the current chronically homeless coordinated entry list. Their homeless history is as follows:

[# months/times in shelter, other verification, general disability info. if available etc.]

[HMIS Entries/VOH/Self Report]

I am referring [ClientName] to [Receiving Program] on the date of [Date].

As per HMIS, the client has a PSH qualifying disability. The housing provider has 45 days to obtain proof of disability for the client.

If you have any further questions or require further clarification, please contact me by email at _____
Sincerely,

Coordinated Entry Systems Specialist

To Whom It May Concern:

HMIS ID:

VI Score:

Contact Info:

Shelter/Outreach Worker Information:

[**ClientName**] is currently homeless and based on their Homeless time and VISPDAT score, has been approved and prioritized based on the CoC CE Policy and Procedure to be housed next for Rapid Rehousing/Permanent Supportive Housing. Their homeless history is as follows:

[# months/times in shelter, other verification, general disability information etc.]

[HMIS Entries/VOH/Self Report]

I am referring [**ClientName**] to [**ReceivingProgram**] on the date of [**Date**].

If you have any further questions or require further clarification, please contact me by email at _____

Sincerely,

Coordinated Entry Systems Specialist