MICHIGAN BALANCE OF STATE CONTINUUM OF CARE
COORDINATED ENTRY SYSTEM POLICY

Guiding Principles

The Coordinated Entry System for the Michigan Balance of State Continuum of Care (BOS) as detailed in this manual has been established to ensure the following guiding principles are upheld by all participating members of the BOS Coordinated Entry System:

I) Ensure service accessibility

a) All people experiencing a housing crisis have fair and equal access and are quickly identified, assessed for, referred, and connected to housing and assistance based on their strengths and needs

b) All geographic areas claimed by the BOS are covered by the Coordinated Entry System

Region 1 Counties
Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Luce, Mackinac, Menominee, Keweenaw Ontonagon, Schoolcraft
Region 2 Counties
Charlevoix, Emmet, Manistee County, Missaukee, Wexford
Region 3 Counties
Alcona, Alpena, Cheboygan, Crawford, Iosco, Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle, Roscommon
Region 4 Counties
Allegan, Barry, Ionia, Lake, Mason, Mecosta, Montcalm, Newaygo, Oceana, Osceola
Region 5 Cities & Counties
Arenac, Bay City, Bay Clare Gladwin Gratiot, Isabella, Midland
Region 6 Counties
Huron, Lapeer, Sanilac, Shiawassee, St. Clair, Tuscola
Region 7/8/9 Counties
Berrien, Branch, Cass, Clinton, Hillsdale, Niles, St. Joseph, Van Buren
Region 10
N/A

c) The Coordinated Entry System has established access points that are easily accessible throughout the entirety of the geographic area served by the BOS

d) Ensure that staff conducting the assessments are trained and competent in the assessment process

e) Local Planning Bodies (LPBs) have a specific procedure put into place to guide the operation of the Coordinated Entry System to address the needs of individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking, but who are seeking shelter or services from non-victim specific providers

II) Align services to meet client need

a) Individuals and families are offered the most appropriate housing intervention based on their needs and strengths in order to end their homelessness as quickly and efficiently as possible

b) Consistent use of comprehensive and standardized assessment tools and processes throughout the BOS in order to provide initial, comprehensive assessment of individuals and families for housing and services
c) Diversion of individuals and families away from the homeless response system who are able to self-resolve and end their homelessness.

III) Prioritize services for clients with the greatest need

a) Facilitate exits from homelessness to stable housing in the most rapid manner possible given available resources
b) Prioritize people who have been homeless the longest and/or are the most vulnerable to scarce permanent supportive housing resources

IV) Build a system that works efficiently and effectively for clients, referral sources and receiving programs

a) Incorporate provider and client choice in housing and service decisions
b) Promote collaboration, communication and knowledge sharing regarding resources among providers
c) Ensure assessors have knowledge and real-time access to eligibility for all receiving programs
d) All agencies participating in the coordinated entry system comply with the equal access and nondiscrimination provisions of Federal civil rights laws

V) Ensure data collection and management is a critical function of the coordinated entry system

a) Providers limit data collection to only that which is relevant to the Coordinated Entry System
b) Providers use HMIS as part of the coordinated entry system, collecting, using, storing, sharing, and reporting participant data associated with the coordinated entry system
c) Leverage Homeless Management Information System (HMIS) data and infrastructure whenever possible for system evaluation, monitoring, and client care coordination and ensure data quality

VI) Invest in continuously evaluating and strengthening the coordinated entry system

a) Continue to make enhancements to the Coordinated Entry System in response to enhanced policy and innovative ideas as related to needs and changes in city, state or federal policy
b) Coordinated Entry providers consult with each participating project and project participants at least annually to evaluate the intake, assessment, and referral processes associated with coordinated entry. Solicitations for feedback must address the quality and effectiveness of the entire coordinated entry experience for both participating projects and households

c) Coordinated Entry providers participate in (at minimum) a monthly Coordinated Entry Continuous Quality Improvement (CQI) meeting related to improving processes and procedures for the BOS Coordinated Entry System

DEFINITIONS

Access Points – Designated areas located within the BOS where individuals or families can go to for intake and assessment of homeless prevention and housing services for which they may qualify.

Acuity – When utilizing the VI-SPDAT, VI-F SPDAT, and TAY VI-SPDAT acuity speaks to the presence of a presenting issue based on the prescreen score. Acuity refers to the severity of the presenting issues. The VI-SPDAT prescreens are evidence-informed common assessment tools that will inform acuity scores for each screened individual or family.

Assessor- Assessors are individuals who complete the common assessment tools for housing triage and enter the information into HMIS. Assessors are located at all access points and are trained on the 9 steps of diversion as well as how to complete assessment through a person-centered approach.

Chronically Homeless – An individual or family who: (i) resides in a place not meant for human habitation, a safe haven, or in an emergency shelter or institutional care facility (has been living in the institutional care facility fewer than 90 days and was living in a place not meant for human habitation, a safe haven, or in an emergency shelter immediately prior to entering the care facility) and has been homeless and residing in such a place for at least 12 months or on a least four separate occasions in the last three years where the combined occasions must total at least 12 months; and (ii) has a head of household with a diagnosable substance use disorder, serious mental illness, developmental disability (as defined in Section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002)), post-traumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical illness or disability.

In order to meet the ‘‘chronically homeless’’ definition, the individual also must have been living as described above continuously for at least 12 months, or on at least four separate occasions in the last 3 years, where the combined occasions total a length of time of at least 12 months. Each period separating the occasions must include at least 7 nights of living in a situation other than a place not meant for human habitation, in an emergency shelter, or in a safe haven.

NOTE:

- *Transitional Housing does not qualify an individual/family for chronic status; meaning that if an individual/family enters transitional housing they would not continue to add months to their chronic status, but would maintain their literally homeless status.*
- *Veterans receiving Supportive Services for Veteran Families (SSVF) or other grant per-diem programs offered by the Veterans Administration do maintain their Chronic Status;*
- *ESG Rapid Re-housing is not considered transitional housing; RRH is considered permanent housing;*
- *Institution stays of less than 90 days do not constitute a break and can be included in the time calculation as long as the individual/family were on the streets, in emergency shelter, or safe haven when they began;*
- *Stays in “housed” environments that are less than seven (7) consecutive nights do not constitute a break in*

homelessness.
• A BREAK in homelessness is defined as a stay in housing that lasts at least seven (7) consecutive nights; therefore a client must have at least four (4) separate occasions to qualify under this option.

Community Housing Prioritization Meetings (CHP) – Meetings that occur every two weeks or as needed in order to prioritize individuals and families for housing programs as well as to conduct case consultations during face to face meetings. These meetings are held locally in order to effectively meet the needs of each area within the BOS. Procedural decisions and suggestions are also made during this meeting.

Disability – (HUD Definition)
HUD defines a person with disabilities as a person who:
1. has a disability as defined in Section 223 of the Social Security Act (42 U.S.C.423), or
2. is determined by HUD regulations to have a physical, mental or emotional impairment that:
a. is expected to be of long, continued, and indefinite duration;
b. substantially impedes his or her ability to live independently; and
c. is of such a nature that such ability could be improved by more suitable housing conditions, ***or***
3. has a developmental disability as defined in the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 15002(8)), ***or***
4. has the disease acquired immunodeficiency syndrome (AIDS) or any conditions arising from the etiologic agent for acquired immunodeficiency syndrome (HIV).

Diversion – Diversion is a strategy that prevents homelessness for people seeking shelter, or other homeless assistance, by helping them identify immediate alternate housing arrangements and, if necessary, connecting them with services and financial assistance to help them return to permanent housing. Diversion programs can reduce the number of families becoming homeless, the demand for shelter beds, and the size of program wait lists.

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

Housing Assessment and Resource Agency (HARA) – The intent of the HARA is for a single agency or a collaboration of multiple agencies working together to provide housing access and referral to individuals and families who are experiencing homelessness or who are at-risk of homelessness. The HARA is also responsible for maintaining the MSHDA Housing Choice Voucher with Homeless Preference waiting list.

HMIS – Homeless Management Information System; is a local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness. Each Continuum of Care is responsible for selecting an HMIS software solution that complies with HUD's data collection, management, and reporting standards.

Homeless – (Category 1) an individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) an individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; (ii) an individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, State, or local government programs for low- income individuals); or (iii) An individual who is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution; (Category 2) An individual or family who will imminently lose their primary nighttime residence, provided that: (i) The primary nighttime residence will be lost within 14 days of the date of application for homeless assistance; (ii) No subsequent residence has been identified; and (iii) The individual or family lacks the resources or support networks, e.g., family, friends, faith-based or other social networks, needed to obtain other permanent housing; or (Category 4) Any individual or family who: (i) Is 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, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence; (ii) Has no other residence; and (iii) Lacks the resources or support networks, e.g., family, friends, and faith- based or other social networks, to obtain other permanent housing. 24 CFR 578.3.

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

Local Planning Body (LPB)— Given the large geographic area of the Michigan Balance of State CoC, Local Planning Bodies, which are geographically based committees, work on common issues based on local resources. Specific procedures to implement this CES policy are developed at the Local Planning Body level.

Permanent Supportive Housing (PSH) – Community-based housing without a designated length of stay. PSH program participant(s) must be the tenant on a lease for a term of at least one year, which is renewable for terms that are a minimum of one month long, and is terminable only for cause. Permanent supportive housing means permanent housing in which supportive services are provided to assist homeless persons with a disability to live independently. 24 CFR 578.3.

Rapid Re-Housing (RRH) –An intervention designed to help individuals and families exit homelessness as quickly as possible, return to permanent housing, and achieve stability in that housing. Rapid re-housing assistance is offered without preconditions (such as employment, income, absence of criminal record, or sobriety) and the resources and services provided are typically tailored to the unique needs of the household. The core components of a rapid rehousing program are housing identification and relocation, short-and/or medium term rental assistance and move-in (financial) assistance, and case management and housing stabilization services.

SPDAT (Service Prioritization Decision Assistance Tool)—The evidence informed assessment utilized by all trained CoC providers in either enacting more detailed determinations of acuity for housing placement and/or ongoing use in case management to ensure housing stabilization. The SPDAT (or "Full SPDAT") has an individual and family tool. Staff must be trained by OrgCode Consulting or Balance of State CoC staff on the SPDAT. The SPDAT can be completed on paper or in HMIS and attached to a client record.

Transitional Housing (TH) – Housing, where all program participants have signed a lease or occupancy agreement, the purpose of which is to facilitate the movement of individuals and families experiencing homelessness into permanent housing within 24 months. 24 CFR 578.3.`

VI SPDAT – (Vulnerability Index-Service Prioritization Decision Assistance Tool) Assessment tool developed and owned by OrgCode and Community Solutions that is utilized by projects in the BOS determine initial acuity and to recommend the level of housing supports necessary to resolve the presenting crisis of homelessness. Other forms of the VI SPDAT utilized throughout the BOS include:

- VI-F SPDAT: Vulnerability Index for Families
- TAY-VI SPDAT: Vulnerability Index for Transitional Age Youth

These assessment tools are used uniformly across every access point throughout the BOS.

System Design and Overview

The following overview describes the path a household would follow from an initial request for housing services through housing placement. The overview also lists key roles and expectations of partner organizations that play a critical role in the system. Additional information regarding job descriptions as well as system procedures can be found in the BOS procedure manual.

- Step 1: Initial Request for Housing Services/Connection to the Coordinated Entry System
  Households in need may access the Coordinated Entry System through a call center, or in person at a designated entry point (HARA walk in hours or Street Outreach).
  *If the individual or family is currently fleeing domestic violence, appropriate safety planning will be made with a direct referral to a domestic violence provider.

- Step 2: Diversion
  At the time of initial request for housing services a strategic diversion attempt is made by the assessor in order to assist the household in diverting away from the homeless system; when applicable. Diversion attempts are conducted using an evidence informed nine step process that includes conflict resolution, mediation, in-depth problem solving as well as outreach and referral from assessment staff. Outreach and referrals to other partner agencies or friends/family are made by assessors in order to more effectively assist the household with the immediate housing crisis, rather than entering the homeless system.

- Step 3: Housing Assessment
  When diversion is unsuccessful or not appropriate, a housing assessment takes place in order to assess the current vulnerability and needs of the household seeking housing assistance. The housing assessment will act as a prioritization tool in order to ensure the most appropriate housing intervention is recommended to each household as well as to give priority to those experiencing the greatest need. Assessors are available at the call center, street outreach staff as well as prisoner re-entry case managers. The common assessment tool(s) utilized throughout the BOS are designed to assess vulnerability and life areas affected by homelessness. Tools utilized include the VI

SPDAT, VI-F SPDAT, and TAY-VI SPDAT. The assessment is completed using HMIS and is then coordinated within the reporting feature of HMIS in order to begin the prioritization process and creation of the by name list for each local prioritization group. Each version of the VI SPDAT must be completed every six months.

- Step 4: Housing Referral
  Information gathered from the assessment is used to determine which housing intervention is most appropriate to end the household's homelessness (Rapid-Rehousing or Permanent Supportive Housing). Once the assessment is completed in HMIS, a score is generated and placement on the local by name list is done automatically. The housing matching process takes place at local area prioritization meetings or Client Housing Prioritization in coordination through the housing locator, housing navigator and/or housing based case managers of specified housing programs. (See procedure manual for detailed information on each housing program available within the BOS Coordinated Entry System)

- Step 5: Housing Navigation and Placement:
  Prior to or during prioritization meetings, individuals and/or families are matched with a housing navigator related to the specific housing program they were referred to by the assessor. Housing navigators then meet with individuals/families to determine housing preference and choice and most appropriate location/housing type to best meet the needs of the individual or family. Navigators walk alongside the individuals/families to help them become document ready (obtain ID and other vital documents required by program) and also work in coordination with the housing locator until a housing placement is made. Once housing has been identified and the individuals/families are set to move in, a warm transfer is made to the housing based case manager working within the identified housing program.

- Step 6: Housing Supports
  Housing based case managers then work with the individuals and families within their housing programs in order to assist them in maintaining their housing long-term. (see housing based case management in procedure manual)

Access

Coverage Area
All BOS Local Planning Bodies follow a locally developed intake model for the Coordinated Entry System where multiple coordinated locations and access points are utilized for assessment. More than one access point is necessary within the BOS Coordinated Entry System in order to ensure quick and efficient access throughout a large rural area.

Households in need may initiate a request for housing services through call centers, street outreach, or walk in services at local HARAs throughout the BOS. a 24-hour access call center housed coordinated through the HARA or they may utilize walk-in services during HARA business hours. Call centers and walk-in services are accessible for all populations and have the ability to make referrals to external services providers based on all sub-population needs.

Other access points offered through the BOS Coordinated Entry System may include Street Outreach, Shelters, Domestic Violence Shelters and other locally identified services. Any and all access points offer the same standardized process as persons who access the Coordinated Entry System through site-based or call center access points. Individuals and families who enter domestic violence shelters directly, are offered direct referral to the Coordinated Entry System through the Domestic Violence provider.

All individuals and families facing homelessness or are at risk of becoming homeless in Barry County should be referred to the Housing Assistance Resource Agency, HARA (Barry County United Way,) for initial assessment and screening for all CoC and ESG projects. BCUW is easily accessible for clients in regards to the physical location and access through online sources, phone, and email. The HARA will refer clients to any additional partner programs they may be eligible for, i.e. veteran services, domestic/intimate partner violence, etc. Clients that meet more than one of the populations will be served at all access points in which they qualify through the CE process.
The same assessment approach will be provided for all clients experiencing homelessness which includes the VI-SPDAT or VI-F-SPDAT assessment tool and full SPDAT if applicable. Clients cannot be denied services due to being a victim of domestic violence, dating violence, sexual assault, or stalking. For clients meeting one of the above circumstances the HARA will discuss domestic violence shelter options and further services to assist with their needs.
CES partner programs can be found throughout Barry County. Referrals will be made from these agencies to BCUW for clients experiencing homelessness or other housing needs.
Street outreach will be conducted through a partnership with local law enforcement, hospitals, and libraries in the Barry County geographical region. If a client is located in a place not meant for human habitation or identifies as homeless, the agency who has made contact with the client will make contact with the HARA to inform them of the situation. After this point the HARA will make contact with the client to begin the CE process. A Point in Time (PIT) count will be conducted annually using street outreach to identify those in sheltered and unsheltered situations.

Fair and Equal Access

Providers participating in the BOS Coordinated Entry System shall ensure fair and equal access to Coordinated Entry System programs and services for all clients regardless of actual or perceived race, color, religion, national origin, age, gender identity, pregnancy, citizenship, familial status, household composition, disability, Veteran status, or sexual orientation.

Households who are included in more than one of populations for which an access point is dedicated can be served at all of the access points for which they qualify as a target population.

Access points with physical locations (the HARA) are located in proximity to public transportation and is also compliant with accessibility requirements for individuals with disabilities including individuals who use wheelchairs per ADA regulations.

The BOS Coordinated Entry System provides appropriate auxiliary aids and services necessary to ensure effective communication (e.g. Braille, audio, large type, assistive listening devices and sign language interpreters) at walk-in locations as well as through the call center. Access points additionally include referral to offer Coordinated Entry process materials and participant instruction in multiple languages to meet the needs of minority, ethnic, and groups with Limited English proficiency.

BOS Coordinated Entry System ensures participants may not be denied access to the coordinated entry process on the basis that the participant is or has been a victim of domestic violence, dating violence, sexual assault or stalking.

CES participating providers shall provide necessary safety and security protections for persons fleeing or attempting to flee family violence, stalking, dating violence, or other domestic violence situations. Minimum safety planning must include a baseline assessment for presence of participant safety needs and referral to appropriate trauma-informed services if safety needs are identified.

If a program participant's self-identified gender or household composition creates challenging dynamics among residents within a facility, the host program should make every effort to accommodate the individual in order to make him/her feel safe.

Participating providers of the BOS Coordinated Entry System shall offer universal program access to all subpopulations as appropriate, including chronically homeless individuals and families, Veterans, youth, persons and households fleeing domestic violence, as well as transgendered persons.
Population-specific projects (e.g. women only, tribal nation members only, chronically homeless etc.) are permitted to maintain eligibility restrictions as currently defined and will continue to operate and receive prioritized referrals.

Marketing

The BOS will market the Coordinated Entry System through local implementation and planning efforts approved by the BOS Continuum of Care. Strategies include:

- Ensure the methods of entry into the CES are visible and posted in areas frequently accessed by those experiencing homelessness.
- Consistent messaging and promotion of the intake hotline number on participating agency social media accounts and websites.
- Target non-housing provider groups who may come into frequent contact with those experiencing homelessness by providing education on the Coordinated Entry System as well as posting critical marketing information:
    - Hospitals/Clinics
    - Law Enforcement
    - Faith Communities
    - Mental Health Service Providers
    - Drop-In Centers
    - Local social service providers

Marketed materials describing the CE process will be made available at the HARA office as well as other partner agencies in the Barry County CoC which include mental health service providers, social service agencies, faith communities, the local shelter, and many other organizations. A link to information regarding the CE process will also be made available on the Barry County United Way website for users to view.
For individuals and families with limited English proficiency, marketed materials will be made available in more than one language at the HARA's local office. Coordination will also be made with local teaching staff to assist with communication with Spanish speaking families if necessary.

Emergency Services
The Coordinated Entry System requires emergency services, drop-in service programs, and emergency shelters, including domestic violence shelters and other short-term crisis residential programs, to operate with as few barriers to entry as possible. People are able to access emergency services, such as emergency shelter, independent of the operating hours of the system's call center and intake and assessment processes. Local Planning Bodies will determine follow up procedures for after-hours shelter entry processes. During follow-up the HARA completes the housing assessment and will then make appropriate referrals to housing programs based on need identified through client choice and the assessment process.

The hours of operation for Barry County United Way is Monday through Friday, 8:00am-5:00pm. Clients in need of emergency assistance after-hours can call the HARA's office number or may call 211 to be referred to the HARA for immediate needs. After the client has called into the HARA's office phone number they will be able to make contact with the Executive Director and explain their emergency needs. Coordination has been made with the local Emergency Room and police departments who can also refer clients directly to the Executive Director for services during the HARA's hours of operation and also in after-hour instances.
If there is a need for immediate housing, the HARA may be able to provide lodging overnight at

the local motel by utilizing Emergency Shelter Program funds. Following the lodging the HARA will follow up with the client to assess other resources or services that could be implemented to resolve the housing crisis.
Coordination is made between BCUW and the local domestic violence shelter, Green Gables Haven, however a referral does not need to be made by BCUW for clients to access the shelters services. Clients are able to make contact with the shelter regardless of business hours using their local phone number. One on one services will be provided to those in shelter by the HARA during regular business hours.

Prevention Services

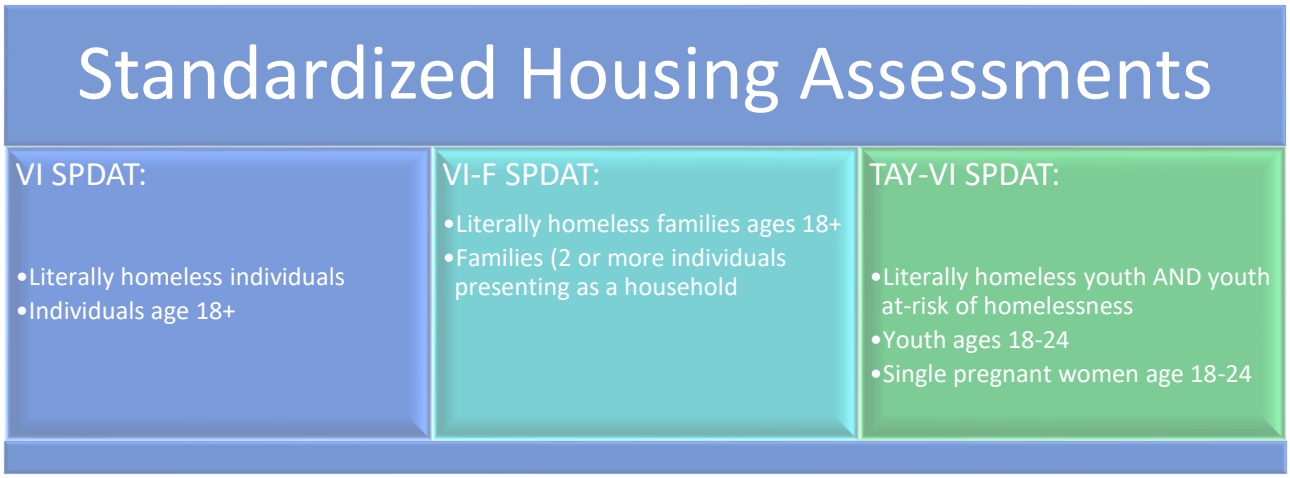
The HARA is the lead agency for Emergency Solutions Grant (ESG) funding and makes eligibility determinations for individuals and families requesting prevention related financial assistance and services and is the designated access point for ESG eligibility. Prevention services are never refused at other access points as service providers at other access points make direct referrals to the HARA for prevention assistance. HARA staff will complete an eligibility screening for ESG Prevention funding and services followed by a direct referral to other community partner agencies providing prevention assistance.

Clients experiencing a risk of becoming homeless and are in need of assistance will be assessed for the use of prevention funds through an intake process to determine their eligibility based on the ESG criteria. An initial intake can be completed in person, over the phone, or via email at which time information will be gathered such as amount owed, rental rate, state of need and court intervention (ie. demand for possession, court summons, eviction notice) and income. Using the above information it will be determined whether or not assistance can be provided through the ESG prevention funds. If assistance can be provided an in person appointment will be scheduled with the Housing Specialist to review documents, complete the Self-Sufficiency Matrix, and begin the enrollment process. The HARA may refer the client to other assistance programs in the county such as DHHS or Barry County Cares for the client to gain further financial assistance if necessary.

Assessment

Housing assessment through the BOS Coordinated Entry System is consistently applied at every access point. When diversion is unsuccessful or not appropriate, a housing assessment takes place in order to assess the current vulnerability and needs of the household seeking housing assistance. The housing assessment acts as a prioritization tool in order to ensure the most appropriate housing intervention is recommended to each household as well as to give priority to those experiencing the greatest need. Assessors are available at the call center and other LPB identified services. The common assessment tool(s) utilized throughout the BOS are designed to assess vulnerability and life areas affected by homelessness. Tools utilized include the VI SPDAT, VI-F SPDAT, and TAY-VI SPDAT. The assessment is completed using HMIS and is then coordinated within the reporting feature of HMIS in order to begin the prioritization process and creation of the by name list for each CHP meeting. Each version of the VI SPDAT must be completed every six months.

The Barry County CE process includes the utilization of the VI-SPDAT, VI-F-SPDAT, and full SPDAT assessment tools to assess the needs and priority of those experiencing homelessness. The Self-Sufficiency Matrix will be used to assess the needs and priority of those at risk of homelessness.
The VI-SPDAT, VI-F-SPDAT, full SPDAT, or Self-Sufficiency Matrix assessment tools with be utilized to create uniform decision making. Using the scoring system on the assessment tools, the priority of need will be determined and clients will be referred to corresponding projects. If the most appropriate project has a waiting list, client will be placed on the waiting list and also directed to the next corresponding project.
Clients will not be denied access to the CE process based on their income, history of substance abuse, domestic violence, resistance to receiving services, type or extent of disability-related services or supports that are needed, history of evictions or poor credit, lease violations or history of not being a leaseholder, or criminal history.



Ensuring Low Barriers to Entry
The BOS Coordinated Entry System prohibits any providers from assessors or projects from screening people out of the coordinated entry process due to perceived barriers to housing or service, including but not limited to, too little or no income, active or a history of substance abuse, domestic violence history, resistance to receiving services, the type or extent of a disability-related services or supports that are needed, history of evictions or poor credit, lease violations or history of not being a leaseholder, or criminal record.

After the appropriate version of the VI-SPDAT is administered to a literally homeless household-:

1. The HMIS System Administrator places the household on the CHP meeting prioritization list to be prioritized for referral to the identified PSH or RRH housing program.

2. As housing program openings become available, teams attending the Community

Housing Prioritization (CHP) meeting prioritize households for referral to the RRH or PSH program openings, per the prioritization process explained below.

3. Housing navigation occurs throughout this process to facilitate a timely and smooth transition into permanent housing. Housing navigation is practiced through a housing first model and strictly adheres to client choice. Throughout the BOS, the only time a client is denied a housing program is under the following circumstances:
    - Specific program eligibility not met (chronicity, acuity, verification of disability, sub-population requirements)
    - Landlord or property manager denial based on their own restrictions. For example: a site based program for households with children not having the ability to house sex offenders, OR a private market landlord denying an individual based on criminal record.
4. After housing is identified, provider staff administers ongoing assessment and case management as appropriate. Ongoing assessment is driven by the full SPDAT assessment based on client identified sub-population (households with children, youth, and individuals.) Housing based case management services are voluntary through PSH projects, and are based on the Org Code curriculum of Housing Based Case Management.

Assessor Training

The BOS Coordinated Entry System provides training opportunities at least once annually to organization and or staff persons at organization that serve as access points or administer assessments. On-going Continuous Quality Improvement (CQI) meetings will also be held at least monthly to address any on-going training issues and needs amongst providers and assessors. The HARA will update and distribute training protocols at least annually in coordination with training offered through OrgCode podcasts and training materials. The purpose of the training is to provide all staff administering assessment with access to material that clearly describe the methods by which assessments are to be conducted with fidelity to the BOS Coordinated Entry System policies and procedures. Training curricula will additionally include requirements for use of assessment information to determine prioritization, adopted variations for specific subpopulations (families, youth) as well as criteria for uniform decision making and referrals.

All assessment staff are also trained on how to conduct a trauma-informed assessment of participants. Special considerations and application of trauma-informed assessment techniques are afforded to victims of domestic violence or sexual assault to help reduce the chance of re-traumatization. Assessors receive additional training focused around culturally and linguistically competent practices and assessments.

Participant Autonomy, Privacy and Protections

Participants of the BOS Coordinated Entry System are freely allowed to decide what information they provide during the assessment process, to refuse to answer assessment questions, and to refuse housing and service options without retribution or limiting their access to other forms of assistance.

At time of referral, clients are informed of their right to request a "lesser" program and that they have the choice and the right to refuse the program. There is no limit to the number of times a client may refuse a program or referral. A household can choose not to accept a referral when it is made from the Priority List or from the program once the intake is complete, they will be placed back on the Priority List in the same position as they had been prior to referral. If a client is referred to a program, is accepted to that program, but then cannot find an apartment that will accept them within the appropriate time frame allowed by the program's requirements, they will be placed back on the priority list in the same position as they had been prior to referral.

All data collected through the Coordinated Entry process is provided through the Michigan Coalition Against Homelessness (MCAH) standardized Release of Information process utilized by all providers to input data into HMIS. Providers utilize the ROI based on a Michigan statewide adopted, HIPPA compliant release. Participants of the Coordinated Entry System are informed that the assessment process cannot require disclosure of specific disabilities or diagnosis. Specific diagnosis or disability information may only be obtained for purposes of determining program eligibility to make appropriate referrals.

Grievance Process

The following grievance policy will be followed for those utilizing the Barry County CE process. For those experiencing an event in which a grievance needs to be filed regarding the CE process or housing related violation, the information in which they are reporting needs to be written and given to the Executive Director at Barry County United Way for review. Once reviewed by the Executive Director it will be at their discretion which course of action needs to be taken.

If the client does not agree with the decision of the Executive Director or would like to appeal the decision, the client's written report of violation or concern will be presented to the Barry County CoC for review. The Barry County CoC will discuss the concern as a whole and develop a course of action to be taken.

In the event that an assessor receives a participant based complaint, the assessor should attempt to address the concern immediately; the best they can in the moment. Complaints

that should be addressed directly by the agency staff member or agency staff supervisor include complaints about how they were treated by agency staff, agency conditions, or violation of confidentiality agreements. Any other complaints should be referred to the LPB Coordinated Entry Lead Agency Provider (HARA) to be dealt with in a similar process to the one described below for providers. Any complaints filed by a client should note their name and contact information so the team can contact him/her to discuss the issues.

Filing a grievance is the responsibility of all directors, officers, and employees of providers participating in the BOS Coordinated Entry System. Anyone filing a complaint concerning a violation or suspected violation of the policies and procedures must be acting in good faith and have reasonable grounds for believing an agency is violating the Coordinated Entry System policies and procedures.

To file a grievance regarding the actions of an agency, contact a designated supervisory staff of the Coordinated Entry lead agency with a written statement describing the alleged violation of the Coordinated Entry System policies and procedures, and the steps taken to resolve the issue locally. The CES lead agency contact person will contact the agency in question to request a response to the grievance. Once the Coordinator has received the documentation he/she will decide if the grievance is valid and determine if further action needs to be taken. If the individual or agency filing the grievance, or the agency against whom the grievance is filed, is not satisfied with the determination they may file a grievance with the LPB Steering Committee. This must be done by providing a written statement regarding the original grievance, and why the complainant disagrees with the decision made by the coordinator. LPB Board/Steering Committee Chair will bring the matter to the Board/Steering Committee for discussion and a final decision. If corrective action is needed a corrective action plan will be generated by the LPB Board/Steering Committee. The LPB Board/Steering Committee will track progress on the corrective action plan beyond the resolution of the grievance.

Referrals

The BOS Coordinated Entry System operates from a uniform and coordinated referral process for beds, units, and services available at participating projects within the BOS's geographic area for referral to housing and services. Projects participating in the BOS Coordinated Entry System do not screen potential project participants out for assistance based on perceived barriers related to housing or services. Each agency participating with the BOS Coordinated Entry System must comply with the equal access and nondiscrimination provisions of Federal civil rights laws. The referral process is informed by Federal, State, and local Fair Housing Laws and regulations and ensures participants are not "steered" toward any particular housing facility or neighborhood because of race, color, national origin, relation, sex, gender identity, marital status, disability or the presence of children.

Emergency Solutions Grant (ESG) and Continuum of Care (COC) program recipients and sub recipients use the coordinated entry system established by the BOS as the only referral source from which to consider filling vacancies in housing and/or services funded by the COC and ESG programs.

All clients in need of housing and/ or housing related services in Barry County will be referred to the HARA to be assessed. Once in contact with the HARA an initial intake will be completed to assess client housing needs. For clients experiencing homelessness, a VI-SPDAT will be completed. If the clients reach a score recommending Permanent Supportive Housing the client will also complete the full SPDAT. For clients at risk of homelessness, a Self-Sufficiency Matrix will be completed. Priority will be given to those receiving a higher VI-SPDAT/SPDAT/Self-Sufficiency Matrix score and projects will be looked at for assistance. For homeless clients, a referral may be made to the local emergency shelter; however, it is not necessary to be referred by the HARA to access the shelters services.
The CE Process does not take perceived barriers related to housing or services into consideration when screening and prioritizing clients for CoC projects.
To utilize housing and/ or services funded by the CoC and ESG programs, recipients must use the CE process established by the CoC. This will ensure uniform and the equal availability of funds for all referred clients.

Referrals to Participating Projects

Access points within the BOS Coordinated Entry System maintain and are provided with an annually updated list of all resources that may be accessed through referrals from the coordinated entry system. Each ESG and COC project establishes and makes publicly available the specific eligibility criteria the project uses to make enrollment determinations.

If the highest priority household is not selected for referral to an available opening, documentation needs to occur. The Priority List Manager will document why the household that was higher in priority was not referred and why the household that was of lower priority received the referral.

Referrals from the Coordinated Entry System Assessors are made to the following service types

or projects:

HARA Call Center or Walk-In Center makes referrals to the following when locally available (not limited to): street outreach, emergency shelter, housing projects (PSH, PBV wait list, HCV wait list, RRH), information and referral agencies, Domestic Violence providers, drop-in services, mainstream benefit agencies (DHHS, Social Security), income based housing projects, the VA as well as other organizations targeting sub-populations and other housing assistance needs.

If LPBs have Street Outreach, Street Outreach staff makes referrals to the following when locally available (not limited to): all entities listed above as well as to the HARA for HCV sign up.

Emergency Shelters make referrals to the HARA for HCV sign up as well as housing assessment and shelter referral if after hours.

Referral types offered through Coordinated Entry as well as assessment score intervention types:

Information and Referral (No housing intervention recommended)

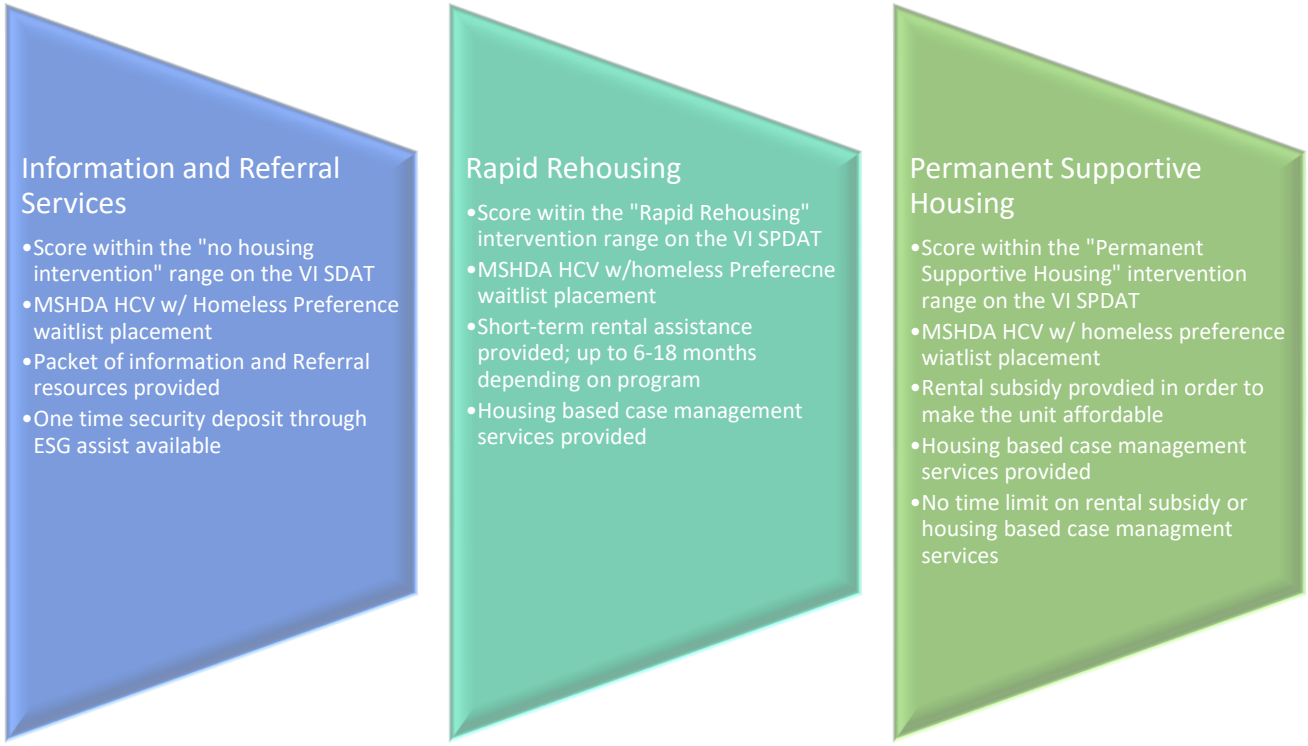
- VI (Individuals): 0-3
- VI-F: 0-3
- TAY-VI: 0-3

Rapid Rehousing

- VI (Individuals): 4-7
- VI-F: 4-8
- TAY-VI: 4-7

Permanent Supportive Housing

- VI (Individuals): 8+
- VI-F: 9+
- TAY-VI: 8+



Prioritization

The BOS Coordinated Entry System prioritizes the following projects listed below. Not included in prioritization are processes/projects to include, entry to emergency shelter and immediate crisis response. The BOS Coordinated Entry System does not use data collected for the assessment process to discriminate or prioritize households for housing and services on a protected basis, such as race, color, religion, national origin, sex, age, familial status, disability, actual or perceived sexual orientation, gender identity or marital status.

Prioritization through the Barry County CE process will be determined based on the score received from the clients VI-SPDAT, VI-F-SPDAT, SPDAT, or Self Sufficiency Matrix. For homeless clients receiving a VI-SPDAT/VI-F-SPDAT score recommending Permanent Supportive Housing, a full SPDAT will be completed. Prioritization will be given to those with the highest SPDAT score. Barry County will also follow the mandated prioritization of those who are chronically homeless following HUD's Order of Priority. The Prioritization list will be monitored and managed by the HARA using the by name feature on the Homeless Management Information System, HMIS.

CHP meetings occur every two weeks, or as needed. In addition to referring households into housing programs, the committee makes procedural decisions and conducts case consultations during face-to-face meetings. To ensure housing program referrals are not delayed between the meetings, CHP members continue referrals between meetings as openings become available via the CHP process.

A standardized ROI is utilized by all providers to input data and VI-SPDAT information into HMIS. This ROI is based on a Michigan statewide adopted, HIPPA-compliant ROI.
All assessments and VI-SPDAT information for HMIS agencies must be recorded in HMIS within 24 hours of when the information was first collected. The HMIS System Administrator updates the by name prioritization list prior to CHP meetings. The lists are used during the meetings to facilitate prioritization and housing program referrals and housing location.
HUD regulations only allow RRH and PSH programs to serve

- people who are literally homeless (Category1)
- people who are homeless because they are fleeing domestic violence (Category 4).

In addition, HUD mandates that communities prioritize literally homeless households who are chronically homeless (CH) for housing and services.

To this end, the prioritization groups first prioritize literally homeless households (who meet the household size requirements for the available permanent housing unit) based on their VI-SPDAT scores, with CH households having first priority. If there are no CH households on the housing prioritization list, households are still prioritized based on their VI-SPDAT scores. This

prioritization follows HUD's Order of Priority in CPD-14-012 which states:

First Priority: *Chronically Homeless Individuals and Families with the Longest History of Homelessness and with the Most Severe Service Needs.*

A chronically homeless individual or head of household as defined in 24 CFR 578.3 for whom both of the following are true:

i. The chronically homeless individual or head of household of a family has been homeless and living in a place not meant for human habitation, a safe haven, or in an emergency shelter for
at least 12 months either continuously or on at least four separate occasions in the last 3 years, where the cumulative total length of the four occasions equals at least 12 months; and
ii. The CoC or CoC Program recipient has identified the chronically homeless individual or head of household, who meets all of the criteria in paragraph (1) of the definition for chronically homeless, of the family as having severe service needs.

Second Priority: *Chronically Homeless Individuals and Families with the Longest History of Homelessness.*

A chronically homeless individual or head of household, as defined in 24 CFR 578.3, for which both of the following are true:

i. The chronically homeless individual or head of household of a family has been homeless and living in a place not meant for human habitation, a safe haven, or in an emergency shelter for at least 12 months either continuously or on at least four separate occasions in the last 3 years, where the cumulative total length of the four occasions equals at least 12 months; and,
ii. The CoC or CoC program recipient has not identified the chronically homeless individual or the head of household, who meets all of the criteria of the definition for chronically homeless, or the family as having severe service needs.

Third Priority: *Chronically Homeless Individuals and Families with the Most Severe Service Needs.*

A chronically homeless individual or head of household as defined in 24 CFR 578.3 for whom both of the following are true:

i. The chronically homeless individual or head of household of a family has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter on at least four separate occasions in the last 3 years, where the total length of those separate occasions equals less than one year; and

ii. The CoC or CoC program recipient has identified the chronically homeless individual or the head of household, who meets all of the criteria in paragraph (1) of the definition for chronically homeless, of the family as having severe service needs.

Fourth Priority: *All Other Chronically Homeless Individuals and Families.*

A chronically homeless individual or head of household as defined in 24 CFR 578.3 for whom both of the following are true:

i. The chronically homeless individual or head of household of a family has been homeless and living in a place not meant for human habitation, a safe haven, or in an emergency shelter for at least four separate occasions in the last 3 years, where the cumulative total length the four occasions is less than 12 months; and
ii. The CoC or CoC program recipient has not identified the chronically homeless individual or the head of household, who meets all of the criteria of the definition for chronically homeless, or the family as having severe service needs.

Data Management

The data systems management is provided to the BOS through the Michigan Coalition Against Homelessness (MCAH) who oversees HMIS for the state of Michigan. The BOS upholds a memorandum of understanding with MCAH for all data management requirements and standards and follows the state level HMIS Policies and Procedures published at www.mihomeless.org