MA-507 THREE COUNTY CONTINUUM OF CARE

Written Standards for Providing Services to Homeless and At-Risk Households accessed by a Coordinated Entry System

COMMUNITY ACTION PIONEER VALLEY

Updated July 2020

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Introduction and Background

Regulatory Mandate

The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 reauthorized the McKinney-Vento Homeless Assistance programs. Through the enactment of the HEARTH Act, the Department of Housing and Urban Development (HUD) published the new Continuum of Care (CoC) Program interim rule. The CoC Program interim rule requires that the CoC must establish and consistently follow written standards for providing CoC assistance, in consultation with recipients of the Emergency Solutions Grant program (ESG). At a minimum, these written standards must include:

- Policies and procedures for evaluating individuals' and families' eligibility for assistance in the CoC Program
- Policies and procedures for determining and prioritizing which eligible individuals and families will receive assistance for permanent supportive housing assistance, transitional housing assistance, and rapid re-housing assistance

Goals of the Written Standards

The CoC recognizes and supports HUD's goals for its local written standards and strives to meet its obligations under the HEARTH Act in a way that helps to enhance its systemic response to people. These standards hereby:

- Establish community-wide expectations on the operations of projects within the community
- Ensure that the system is transparent to users and operators
- Establish a minimum set of standards and expectations in terms of the quality expected of projects
- Make the local priorities transparent to recipients and sub-recipients of funds and all community stakeholders
- Create consistency and coordination between recipients' and sub-recipients' projects within the Three County CoC.

The Three County CoC agrees that these standards must be applied consistently across the entire Three County CoC's defined geographic area while also taking into consideration individual county-specific needs and resources. Additionally, Three County CoC recipient and sub-recipients are to administer their assistance in compliance with the CoC's written standards. Recipients and sub-recipients of CoC and local funds may develop additional standards for administering program assistance, but these additional standards cannot be in conflict with those established by the Three County CoC or the CoC Program interim rule. Other CoC providers and stakeholders are strongly encouraged to adopt the standards and practices discussed in this document.

Furthermore, these standards recognize the unique geography of the Three County CoC and accommodate the unique needs and service availability of each respective county as well as the policy of allowing individuals and families choices in where and how they receive services and housing resources.

Individual Single Adults vs. Families with Children

The Commonwealth of Massachusetts mandates providing state-funded Emergency Assistance (EA) to all eligible families, therefore any family presenting for services will be screened for EA along with other appropriate options. CoC providers will work to ensure that EA eligible families are able to access EA supported resources as part of the required assessment process. If the family is determined ineligible for state EA, then they should receive be assessed for vulnerability assessments and be included in the CoC's By-Names-List to be prioritized for CoC resources.

Guiding Principles

The Three County CoC commits to the following Guiding Principles as part of its overall approach to ending and preventing homelessness throughout the CoC. These Guiding Principles shall inform all program and policy decisions of the CoC and its funded or affiliated housing and service providers.

Housing First

Housing First is a programmatic and systems approach that centers on providing people who are homeless with housing quickly and then providing services as needed. Three County CoC hereby implements a Housing First model that provides a range of housing services to persons experiencing or at-risk of homelessness, including outreach and engagement, emergency and transitional housing, rapid re- housing, homelessness prevention and permanent supportive housing. Through these standards, the Three County CoC formally incorporates the Housing First approach as well as non-discrimination policies into the coordinated entry system and its funding priorities.

- Housing is not contingent on compliance with services.
- Participants are expected to comply with a standard lease or occupancy agreement and are provided with services and supports to help maintain housing and prevent eviction.
- Services are provided in housing to promote housing stability and well-being.
- All programs are expected to ensure low barriers to program entry for program participants.

No Wrong Door

Staff of community organizations are able to connect individuals and/or families with the appropriate service(s) in a manner that is streamlined, effective and seamless from the individual's and/or family's perspective, even if that service(s) is not offered by their organization or within their sector. This means information and referral processes become consistently more family or individual-focused, collaborative and successful.

Non-Discrimination

The Three County CoC commits to a policy of non-discrimination for all CoC projects (recipients and sub-recipients) and activities. We adhere to and comply with all non-discriminatory and equal opportunity provisions of Federal Civil Rights laws as specified in 24 CFR 5.105(a). Including, but not limited to, the following:

- Providers must have non-discrimination policies in place and assertively outreach to people least likely to engage in the homeless system. Providers must post, onsite, information that supports clients in filing discrimination complaints.
- Providers must comply with all federal statutes including the Fair Housing Act, which prohibits discrimination on the bases of race, color, religion, sex, national origin, disability, or familial status; Section 504 of the Rehabilitation Act and the Americans with Disabilities Act, which prohibit public entities- including state and local governments and private entities that provide public accommodations- from discriminating against persons with disabilities in services, programs and activities, and housing practices
- The Three County CoC is committed to Racial Equity. We recognize that there is racism and prejudicial practices in social services and housing programs. We see racial identities as a possible area to affect vulnerability status for our homeless community members, low-income populations, and program participants. We will seek out and provide opportunities for training for local providers and will take discriminatory practices seriously. We will maintain a high level of expectation of agencies funded by the CoC, to adhere to standards set forth to understand and address the experience of all minority groups in our

service area.

- The Three County Coc will not deny access to the coordinated entry process on the basis that a person is or has been a victim of domestic violence, dating violence, trafficking, assault, or stalking.
- Three County CoC is committed to abiding by the Equal Access Rule at 24 CFR 5.105(a)(2) which prohibits eligibility determinations in HUD Programs based on actual or perceived sexual orientation, gender identity, or marital status, including projects funded by CoC, ESG, or HOPWA.
  Three County CoC practices a person-centered model that strongly incorporates participant choice and inclusion of subpopulations present in Three County, including, but not limited to, homeless veterans, youth, families with children, and victims of domestic violence.
- Coordinated entry flyers, marketing materials and the assessment tool will affirmatively market services with non-discrimination language and will be viewed by populations served to ensure adherence to this expectation. Discrimination complaints specific to the Coordinated Entry process will go to the Collaborative Applicant staff to be presented to the CoC Board. Complaints related to the provider agency and not the Coordinated Entry system should go through that agencies regular complaint process.

Client Choice

Given the geography of the Three County CoC, the CoC strives to ensure that clients seeking assistance are provided choice in the types and duration of services they receive, dependent on available resources. To the degree possible based on resources and the prioritization mechanisms described in this document, and where safety is not compromised, clients are given choice in:

- The type of services they receive by whom and over what time period
- The location and type of housing they access
- The elements and goals of their housing stability plans

Affirmative Outreach and Marketing

Three County CoC providers must affirmatively market their Coordinated Entry efforts, Housing and Supportive Services projects to eligible persons who are least likely to apply in the absence of specific outreach and intentional efforts to reach marginalized communities and vulnerable populations. The Three County COC commits to using Department of Housing and Community Development Office of Program Monitoring Fair Housing and Equal Opportunity's Affirmative Housing Marketing Plan as a resource to conduct outreach to vulnerable populations and specifically engage marginalized communities.

HUD's Primary Goals of Effective Coordinated Entry

HUD's primary goals for coordinated entry processes are that assistance be allocated as effectively as possible and that it be easily accessible no matter where or how people present. Most communities lack the resources needed to meet all of the needs of people experiencing homelessness. This, combined with the lack of well-developed coordinated entry processes, can result in severe hardships for people experiencing homelessness. They often face long waiting times to receive assistance or are screened out of needed assistance. Coordinated entry processes help communities prioritize assistance 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. See 24 CFR 578.7(a)(8) for more information and current requirements.

The Following are adopted "best practices" of Effective Coordinated Entry

The Three County CoC will strive to achieve proficiency in these areas and will measure our success annually, based on these expectations.

- Prioritization. HUD has determined that an effective coordinated entry process ensures that people with the greatest needs receive priority for any type of housing and homeless assistance available in the CoC, including PSH, Rapid Rehousing (RRH), and other interventions.

- Low Barrier. The coordinated entry process does not screen people out for assistance because of perceived barriers to housing or services, including, but not limited to, lack of employment or income, drug or alcohol use, or having a criminal record. In addition, housing and homelessness programs lower their screening barriers in partnership with the coordinated entry process.

- Housing First orientation. The coordinated entry process is Housing First oriented, such that people are housed quickly without preconditions or service participation requirements.

- Person-Centered. The coordinated entry process incorporates participant choice, which may be facilitated by questions in the assessment tool or through other methods. Choice can include location and type of housing, level of services, and other options about which households can participate in decisions.

- Fair and Equal Access. All people in the CoC's geographic area have fair and equal access to the coordinated entry process, regardless of where or how they present for services. Fair and equal access means that people can easily access the coordinated entry process, whether in person, by phone, or some other method, and that the process for accessing help is well known. Marketing strategies may include direct outreach to people on the street and other service sites, informational flyers left at service sites and public locations, announcements during CoC or other coalition meetings, and educating mainstream service providers. If the entry point includes one or more physical locations, they are accessible to people with disabilities, and easily accessible by public transportation, or there is another method, e.g., toll-free or 211 phone number, by which people can easily access them. The coordinated entry process is able to serve people who speak languages commonly spoken in the community.

- Emergency services. The coordinated entry process does not delay access to emergency services such as shelter. The process includes a manner for people to access emergency services at all hours independent of the operating hours of the coordinated entry intake and assessment processes. For example, people who need emergency shelter at night are able to access shelter, to the extent that shelter is available, and then receive an assessment in the days that follow, even if the shelter is the access point to the coordinated entry process.

- Standardized Access and Assessment. All coordinated entry locations and methods (phone, in-person, online, etc.) offer the same assessment approach and referrals using uniform decision-making processes. A person presenting at a particular coordinated entry location is not steered towards any particular program or provider simply because they presented at that location.

- Inclusive. A coordinated entry process includes all subpopulations, including people experiencing chronic homelessness, Veterans, families, youth, and survivors of domestic violence. However, CoCs may have different processes for accessing coordinated entry, including different access points and assessment tools for the following different populations: (1) adults without children, (2) adults accompanied by children, (3) unaccompanied youth, or (4) households fleeing domestic violence. These are the only groups for which different access points are used.

For example, there is not a separate coordinated entry process for people with mental illness or addictions, although the systems addressing those disabilities may serve as referral sources into the process. The CoC continuously evaluates and improves the process ensuring that all subpopulations are well served.

- Referral to projects. The coordinated entry process makes referrals to all projects receiving Emergency Solutions Grants (ESG) and CoC Program funds, including emergency shelter, RRH, PSH, and transitional housing (TH), as well as other housing and homelessness projects. Projects in the community that are dedicated to serving people experiencing homelessness fill all vacancies through referrals, while other housing and services projects determine the extent to which they rely on referrals from the coordinated entry process.

- Referral protocols. Programs that participate in the CoC's coordinated entry process accept all eligible referrals unless the CoC has a documented protocol for rejecting referrals that ensures that such rejections are justified and rare and that participants are able to identify and access another suitable project.

- Outreach. The coordinated entry process is linked to street outreach efforts so that people sleeping on the streets are prioritized for assistance in the same manner as any other person assessed through the coordinated entry process.

- Ongoing planning and stakeholder consultation. The CoC engages in ongoing planning with all stakeholders participating in the coordinated entry process. This planning includes evaluating and updating the coordinated entry process at least annually. Feedback from individuals and families experiencing homelessness or recently connected to housing through the coordinated entry process is regularly gathered through surveys, focus groups, and other means and is used to improve the process.

- Informing local planning. Information gathered through the coordinated entry process is used to guide homeless assistance planning and system change efforts in the community.

- Leverage local attributes and capacity. The physical and political geography, including the capacity of partners in a community, and the opportunities unique to the community's context, inform local coordinated entry implementation.

- Safety planning. The coordinated entry process has protocols in place to ensure the safety of the individuals seeking assistance. These protocols ensure that people fleeing domestic violence have safe and confidential access to the coordinated entry process and domestic violence services, and that any data collection adheres to the Violence Against Women Act (VAWA).

- Using HMIS and other systems for coordinated entry. The CoC may use HMIS to collect and manage data associated with assessments and referrals or they may use another data system or process, particularly in instances where there is an existing system in place into which the coordinated entry process can be easily incorporated. For example, a coordinated entry process that serves households with children may use a system from a state or local department of family services to collect and analyze coordinated entry data. Communities may use CoC Program or ESG program funding for HMIS to pay for costs associated with coordinated entry to the extent that coordinated entry is integrated into the CoCs HMIS. A forthcoming paper on Coordinated Entry and HMIS will provide more information.

- Full coverage. A coordinated entry process covers the CoC's entire geographic area. In CoCs covering large geographic areas (including statewide, Balance of State, or large regional CoCs) the CoC might use several separate coordinated entry processes that each cover a portion of the CoC but in total cover the entire CoC. This might be helpful in CoCs where it is impractical for a person who is assessed in one part of the CoC to access assistance in other parts of the CoC.

Three County CoC Coordinated Entry System

HUD requires that CoC Program and ESG Program funding within the CoC area must establish, operate and use a coordinated entry (CE) process. The requirement was established in the 2012 CoC Program interim rule (24 CFR 578) and the 2011 ESG interim rule (24 CFR 576). Details of the requirement, as well as additional policy considerations, are provided there and in several documents issued by HUD since:

- HUD required new DATA Elements – Announcement and information on HUD's new data elements focusing on Coordinated Entry (2019)
- HUD Coordinated Entry Notice CPD-17-01 – Notice Establishing Additional Requirements for a Continuum of Care Centralized or Coordinated Assessment System (2017)
- HUD Prioritization Notice CPD-16-11 – Notice on Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing (2016)
- HUD Coordinated Entry Policy Brief (2015)
- CoC Program interim rule: 24 CFR 578.7(a)(8)
- ESG interim rule: 24 CFR 576.400(d)
- HUD Equal Access rule: 24 CFR 5.105(a)(2) and 5.106(b)
- HUD Changes to Coordinated Entry Prioritization to Support and Respond to COVID-19
- HUD COVID-19 Equity-Driven Changes to Coordinated Entry Prioritization

Coordinated Entry Procedure:

1) An Individual or Family experiencing homelessness is identified by phone or in person at a shelter or service provider, or is encountered by an outreach team outside.
2) With the 'no wrong door model' the person will be connected to the same procedure and services no matter where they present or who first encounters them. However, there are several scenarios:
    a. Service Provider has the staff and capability of entering client into the Coordinated Entry system. This staff person becomes case manager for that client until the housing offer is made.
    b. Service Provider does not have enough staff or appropriately trained staff to enter the client into the Coordinated Entry system, the service provider either contacts Service Net, to connect the person to the Coordinated Entry System, or contacts the CoC Coordinated Entry staff. The CoC staff will make appropriate referrals. Service-Net will become the "case manager" for that participant.
    c. The client connects directly with the Soldier On call center 1-800# and they do the assessment and enter the client in ETO Enterprise or the Green River Data Warehouse. A case manager will be matched to these clients at the weekly case conferencing meetings. Soldier On would share this information with the CoC Program Director and the Program Specialist.
3) Staff at each entry point are trained to address the client's needs for immediate shelter and safety first, do a basic HMIS intake and then within one to ten days, complete the Coordinated Entry Assessment for Vulnerability, and enter it into the ETO HMIS system or Green River Data Warehouse.
4) Some clients may self-resolve or be connected to prevention services or other support services not requiring housing and will be removed from the By Names List by their case manager through the Green River Data Warehouse or by communicating with the Three County CoC Staff.
5) The CoC Data and Evaluation Manager (A Member of the Collaborative Applicant staff) will ensure regular data

pulls from the ETO system to bring new Coordinated Entry Assessments in to the warehouse.

6) A nightly data dump from the ETO HMIS system to the Green River Data Warehouse will keep the Green River Warehouse up to date. Clients will be made active in the Coordinated Entry system and available for matching by uploading their Release of Information either to the ETO HMIS or the Green River Data Warehouse.
7) By names lists will be maintained by population through the CoC, in the warehouse.
    a. Individual
    b. Family
    c. Youth
    d. Victims of Domestic Violence
    e. Veterans
    f. Chronic
8) The CoC Program Specialist (a member of the collaborative applicant staff) will run a weekly report of new or updated assessments and create a By Names List of all clients who are active in the Coordinated Entry system and therefore have completed an assessment and are seeking permanent housing. The list will be sorted according to the numerical code which helps to determine prioritization. The list will include other necessary data fields such as county preferences, case manager contact, veteran status, disability status, etc. To protect client confidentiality in cases where even the intake agency may reveal a client's status as someone with HIV or someone fleeing domestic violence – the following protections will be in place:
    a. the client may be given a randomly generated unique identifier
    b. the agency name and case manager may be masked with a numeric code known to the Collaborative Applicant staff
    c. the clients age will be shown, not the clients date of birth
9) All CoC service providers will have access to viewing needed information from the list on an ongoing basis.
    a. The Collaborative Applicant will maintain a list of current or upcoming vacancies of all PH units on the Housing Inventory Chart and within the warehouse, for our CoC. Housing providers should update the vacancy report regularly by email. The Collaborative Applicant staff will ensure that the vacancy list is available for case conferencing and to individual providers involved in Coordinated Entry, upon request.
    b. Providers with a vacancy may make a housing offer to the client highest on the By Names List who meets their basic entry criteria.
    c. The offer will be made through the client's case manager as their point of contact.
    d. The provider with the available housing unit can only skip over the highest ranked client if their unit has a designation which makes that client ineligible and those designations must be consistent with a Housing First approach.
    e. A client stating a geographic preference may still be contacted about housing openings in other geographic areas and be given the option to decline.
    f. If two eligible clients are equally scored numerically, the client with the longest time homeless should be offered the unit first.
    g. Clients must NOT be passed over for the next on the list for any other reason, other than the CoC Project or other housing unit's basic entry eligibility, chronic status, or significant safety issues. Concerns about a client's suitability of match or predications of successful placement are not sufficient to exclude the client from the offer.
    h. The housing offer must be documented in the data system.
    i. If the housing offer does not result in a successful lease-up within ten business days due to missing documents, loss of contact with client, or eligibility issues, the housing provider may go to the next highest client on the prioritized By Names List. The housing provider may also, at their discretion, extend

this time period for the client to complete the paperwork. In other words, the housing provider may move down the list, but are not required to if they feel the client is eligible and only needs more time for to get ready to sign a lease. Housing provider must update the CoC via the Program Specialist or case conferencing team if they client has become unreachable in case other providers know the client location and can connect them quickly.

j. While the initial assessing case manager may not have control over the housing placement outcome, it is still their responsibility to keep the ETO data updated on housing offers, decline or acceptance, and successful or unsuccessful lease-up, until the client is inactive.

k. Any questions or concerns which arise during this housing offer step must be brought to the case conferencing meeting or the CoC staff in the County where the client lives.

10) Vacancies and prioritized By Names List will be on the agenda of a weekly or bi-weekly case conferencing meeting in each County. The agenda will include reviewing referrals and placements which have changed the make-up of the by-names list, addressing any concerns or questions which have arisen and case conferencing on new clients added to the list within that County. Community Action CoC staff will ensure an updated By Names List is available at each meeting.

11) Significant issues or disagreements on placements or the use of the list will be sent to the Collaborative Applicant staff to be placed on the agenda for the CE Work Group to track and analyze the program and the CoC Board meetings for guidance and/or resolution.

ACCESS

The Three County CoC is committed to ensuring that the coordinated entry process is available to all eligible persons regardless of race, color, national origin, religion, sex, age, familial status, disability, actual or perceived sexual orientation, gender identify, or marital status

The Three County CoC follows a 'no wrong door' approach that ensures that regardless of where a client appears requesting assistance, they will have fair and equal access to the coordinated entry process. If a client presents at a program but does not match the subpopulation eligibility requirements of that program, they will have the immediate opportunity to make an appointment for coordinated assessment by a trained staff person via the 1-800 #. Annual training in June or July for all CoC sub-recipients will include this procedure to ensure that all people in different populations and subpopulations in the CoC's geographic area - people experiencing chronic homelessness, veterans, families with children, youth, and survivors of domestic violence - have fair and equal access to the coordinated entry process.

CoC staff will train Community Action's Information and Referral Line staff to do on-call assessment for clients who cannot be assessed through providers. CE Assessment Training will be provided to area social service agencies, emergency shelter staff, businesses, police, fire and emergency personnel, municipal employees, as well as to local mental health providers, addictions counselors, peer support programs, detox providers, and others who regularly encounter folks who may be homeless or at risk of homelessness. Local Housing and Shelter Providers and CoC Collaborative Applicant staff may assist and supplement those agencies and providers whose staff is not trained to do the assessment as part of their regular client services, or where point of assessment creates privacy concerns, such as with an HIV or DV program provider.

Assessor Training will include:

- Progressive and phased assessment - gathering information as trust is built
- Conducting assessments within the Data Systems as well as paper format
- Using trauma-informed protocols

- Safety-planning – if the assessment uncovers safety issues (domestic violence concerns, assault, abuse or neglect of a child, stalking trafficking, mental or physical health concerns)
- Providing cultural competency or language of origin support
- Addressing the needs of persons with disabilities

Regardless of access point to coordinated entry assessment, all service providers and stakeholders will attempt to address immediate housing and safety needs of clients first. Access to emergency services, including domestic violence shelters, short-term crisis residential programs, emergency shelters and hotlines for those services, must have as few barriers to entry as possible. While recognizing the importance of coordinated entry assessment, the Three County CoC prioritizes client safety first before the coordinated entry assessment can or should be begun by a service provider.

Soldier On has established a published, toll-free 1-800 number that is used by currently homeless and at-risk of homeless individuals and families, along with the IR line at Community Action Pioneer Valley, to access CoC funded housing/service options. Where possible, the CoC encourages the participation of other service providers not funded by the Three County CoC.

Community Action Pioneer Valley will maintain a database of providers within the CoC to include admissions targeting through their "Look for Help" program to ensure that individuals and families are referred to the appropriate program via case conferencing process. Admission targets for all applicable programs will adhere to the principles, priorities and overall standards contained in this document.

Community Action will publish, through print and web materials, their **Look for Help** information database for providers and their **Information and Referral Line** that can create a direct connection to the CoC Coordinated Entry System. Through these two tools, our agency is able to provide resources to both the providers and the person in need of housing. This will streamline contact in order to access CoC funded programming and to gain information on other essential resources within the CoC. Information about Look for Help and the number for the Information and Referral Line will be distributed to agencies within the area that work with those people with the highest barriers including hospitals, jails, courts, laundromats, community bulletin boards, CoC agencies, Housing Authorities, Police Departments, mental health crisis agencies, and Community Action Pioneer Valley's Programs.

Most access points to Coordinated Entry are accessible for the mobility impaired.

In person or by phone, materials are available to communicate with clients with disabilities – Braille, large type, sign language interpreters and language translation services are available within the CoC system.
Individuals and families who are fleeing domestic violence, dating violence, sexual assault or stalking have safe and confidential access to services via the Information and Referral Line. Spanish Speaking staff are available. . Physical access points will make every effort to provide a safe and confidential location to discuss the common assessment form with clients. Unique client identifiers will be used for case conferencing for clients with safety and confidentiality issues pertaining to domestic violence or HIV status. Domestic violence situations are identified on the common assessment form as an available data point for referrals and as part of eligibility criteria for specific programs.

All street outreach staff funded under ESG and CoC programs are required to initiate the assessment process with a newly encountered client. An appointment to complete the assessment should be made as part of the client's routine, for example agreeing to meet at a meal site to complete the assessment. Or, initiating the appointment could mean providing the Information and Referral line number and explaining the benefits to the client of the coordinated assessment process. Street outreach staff may complete the assessment with the client if the conditions are conducive, but it is not required and often not possible.

COMMON ASSESSMENT

All assessments will be conducted using the CoC Coordinated Entry Client Assessment form in ETO ASIST or through the Green River Warehouse of the Three County CoC. Clients must be told by staff performing the assessment that they have the right to refuse to provide information and still receive emergency services, that they have the right to decline housing services based on their preference and still remain eligible for future offers and services, and staff must have the client complete the appropriate release of information.

The Three County CoC Assessment tool is designed to prioritize clients for housing services based on need. Need is based on vulnerability of the client in the absence of resources to move them into secure and stable housing. Detailed prioritization by subpopulation is provided below.

The assessment must NOT be used to screen clients out of services. Barriers to housing or services identified in the assessment will be used ONLY for the purposes of referral to the program or service which best matches the client need. A portion of each case conferencing meeting will be devoted to problem solving for those who remain on the list due to housing barriers. This will include both coordinating solutions for that particular client, and identifying systemic gaps in services in the three counties based on the barriers the prioritization list reveals.

The assessment tool will include information to determine risk factors and to prioritize clients. Prioritization criteria are based on the following, consistent with HUD Notice CDP:-16-11:

- Chronic homeless status including long-term homeless status and disability status
- Inclusion in a vulnerable or marginalized group, including: 1) young adult; 2) older adult (60+); 3) identify as LGBTQ; 4) fleeing domestic violence; 5) living outside/unsheltered; 6) disproportionately impacted due to being a person of color
- Veterans' status
- Household status
- Assessment score, including the functional domains of substance abuse, mental health, health care needs, legal issues, work status, independent living skills, community involvement, and survival skills

The assessment tool will also seek to identify barriers to housing. These barriers are meant to assist matching clients to eligible programs but are not factors in the prioritization score and should NOT be used to screen out otherwise eligible clients. There is an exception for site-based projects in cases where one of these barriers may prevent an eligible individual or family from residing in a site (for example, some clients who are registered sex offenders may not be able to live in a site where children are housed):

- Significant CORI issues
- History of evictions
- Sex Offender registration
- Non-service animals/pets
- Poor credit history
- Housing preference within our CoC region

CHANGES TO THE CE ASSESSMENT AND PRIORITIZATION TO RESPOND TO COVID-19

As a response to the COVID-19 pandemic, HUD released a notice strongly encouraging CoC's to make changes to their Coordinated Entry System to prioritize and protect people experiencing homelessness at high risk of development severe COVID-19 symptoms. The Three County CoC responded by quickly implementing a supplementary assessment tool designed to prioritize people at high risk for CoC PSH. The COVID-19 Assessment tool is to be used with the Common Assessment and use of the new tool is in effect until 8/31/2020, which may be extended as deemed

necessary by the Three County CoC. The COVID-19 Supplementary Assessment Tool should be completed by providers trained to conduct CE Common Assessments and submitted to the Three County CoC via a secure link provided by CoC staff.

The Three County CoC may implement use of temporary assessment and prioritization procedures, as encouraged by HUD, in the event of pandemics or similar mass crises.

PRIVACY & INFORMATION PROTECTION

Assessment questions on medical, disability and substance abuse issues are meant to assess risk factors; specific health diagnoses are not requested nor gathered. Specific diagnosis or disability information may only be obtained for purposes of determining program eligibility to make appropriate referrals. For programs where receiving services reveals information about a client's health or might put them at risk (for example, organizations which only assist those living with AIDS or HIV+), the projects will be marked as "Confidential" in the Green River Data Warehouse. Projects marked as "Confidential" will hide the enrollment information for that project.

All information and data collected in coordinated entry will be treated as confidential and subject to the same rules governing the privacy and protection of HMIS data. Prioritized By-Names Lists will protect client identity by using only first and last initial. By-Names Lists will be kept in password protected computers and private offices. No printed copies will be left in public areas or meeting rooms and will be shredded rather than discarded in the trash or recycling. The Coordinated Access System used for Coordinated Entry in the Green River Data Warehouse is password protected with user accounts and data is transmitted with 128-bit encryption. User accounts are managed by the CoC Data & Evaluation Manager (a member of the Three County CoC staff) to ensure that access is granted at the lowest level required and only for applicable programs.

DOCUMENTATION FOLLOWS ENTRY

Eligibility documentation specified by certain programs needs to be gathered prior to a housing placement, but should not be a barrier to entering the Coordinated Entry system. The Coordinated Entry system is primarily based on self-reporting with some staff input and is meant to be followed up in the following weeks with documentation to meet requirements of specific programs and services.

REFERRAL

PROVIDER DECLINE POLICY

Rapid re-housing, and permanent supportive housing providers may only decline households found eligible for their programs under limited circumstances—such as when:

- There is no actual vacancy available
- The household presents with more people or different information than referred by the coordinated entry system.
- The provider has determined, based on their individual program policies and procedures, that the household cannot be safely accommodated with the supports provided by the program.
- All denials must be reviewed by the weekly case conferencing.

Rapid re-housing providers may decline a client locating outside their service area unless another agency is able and

willing to provide support services to that client.

Providers are allowed one household denial per vacancy. Repeated denials by a given provider or project may result in de-prioritization during future funding rounds. Documentation related to all referrals and any denials will be maintained by CoC Collaborative Applicant staff.

An intake denial notification will include, at a minimum, the following details, if applicable:

- The reason the client cannot enter the program, including the reason for rejection by the client or program Instructions for appealing the decision, including the contact information for the person to whom and under what time frame the appeal should be submitted.

CLIENT DECLINE POLICY

Client choice is an important theme of the coordinated entry system in the Three County CoC. Therefore, households should only be referred to housing projects or interventions they are eligible for and have an interest in living/participating in.

Case conferencing will be used to review and resolve rejection decisions by consumers. The purpose of the case conference will be to resolve barriers to the client receiving the indicated and desired level of service. In addition, case conferencing on barriers will reveal any systemic gaps in services or procedures which are impeding successful housing placements.

PRIORITIZATION

Permanent Supportive Housing Eligibility and Prioritization

PSH Eligibility

For permanent supportive housing programs, households must meet both the HUD definition of homelessness under Category I, and have a disability. Once meeting the Category I eligibility requirements, households are then prioritized by Three County's target populations.
Programs may not establish additional eligibility requirements beyond those specified in Category I and those required by funders. Some projects may be required to serve only chronically homeless households, per the NOFA under which that project was funded.

Households qualify as Category I if they are:

- Sleeping in a place not designed for or used as a regular sleeping accommodation, including the street, a car, park, abandoned building, bus or train station, airport, camping ground etc.
- Living in a shelter designed to provide temporary living arrangements (including emergency shelter, congregate shelters, transitional housing, hotels and motels paid for by charitable organizations or by government programs)
- Exiting an institution where they resided for ≤ 90 days, and were residing in an emergency shelter or place not meant or human habitation immediately prior to entering the institution

PSH Prioritization

Of those eligible households, the populations must be prioritized in accordance with:

- The U.S. Interagency Council on Homelessness (USICH) plan, Opening Doors
- HUD's guidance on prioritization of chronically homeless households and policy brief on coordinated entry systems
- HUD's recommendations for changes to the CE assessment and prioritization procedures to respond to the COVID-19 pandemic

The Three County CoC has established the following priority populations for permanent supportive housing for individuals and families. These priorities have been established because solving homelessness for Three County CoC's most vulnerable people and highest users of resources will enhance the CoC's goal of quickly transitioning people who are homeless to permanent supportive housing, and ultimately eradicating homelessness throughout the entire geographic area. This prioritization encompasses Three County CoC's coordinated entry system:

1. *As of 6/2/20 the CoC amended this prioritization to prioritize chronically homeless individuals and families at highest risk for severe health impacts from COVID-19, per the CDC, as strongly recommended by HUD. This prioritization will be in place until further notice from the CoC.
2. Chronically homeless individuals and families with the most severe service needs
3. Chronically homeless individuals and families with the longest history of homelessness
4. All other chronically homeless individuals and families
5. Youth, meeting category 1 (literal homelessness), 2 (Imminent Risk of Homelessness), and 4 (Fleeing Domestic Violence) documented homelessness
6. Homeless individuals and families with a disability with the most severe service needs
7. Homeless individuals and families with long period of continuous or episodic homelessness
8. Homeless individuals and families coming from places not meant for human habitation (such as emergency shelters, streets, safe havens, etc.)

Anticipated vacancies must be reported to the CoC via the Collaborative Applicant staff as soon as possible, but no later than 3 business days after the client leaves the unit or program. Vacant units must be open to all providers participating in the CoC Coordinated Entry system via the weekly case conferencing. The provider with the vacant unit or housing opportunity must make every effort to move the highest scoring clients off the prioritization list into the housing unit. If, however, the unit has remained vacant for more than 31 days/rental month period, the provider with the unit may make the housing offer to a client in the next category on the list (ie from Chronic Homeless to Homeless). While we recognize the importance of housing those with highest needs first, a vacant unit is a wasted resource.

The CoC is dedicated to eradicating veteran homelessness. First priority for all categories will be chronically homeless households, followed immediately by veterans. Essentially, this means that if two households present for assistance and both fall under the same order of priority (e.g. both chronically homeless and fall under Priority 1), but one is a veteran household and the other is not, the veteran household should be prioritized first. In general, the CoC will prioritize any veteran households who are not eligible for VA housing or services by targeting those Veterans to the most appropriate CoC-funded projects.

PSH Minimum Standards

All referrals to permanent supportive housing will be made through the coordinated entry system. The following minimum standards will be applied to all permanent housing programs

- Support services must be available throughout the duration of stay in housing. However, participation in supportive services will not be a requirement of receiving CoC PSH assistance.
- Program participants must enter into a lease agreement for a term of at least one year, which is terminable for cause. The lease must be automatically renewable upon expiration for terms that are a minimum of one month long, except on prior notice by either party.
- There is no designated length of stay for program participants.
- All PSH projects will use a Housing First approach and only terminate participants from the project in the most extreme cases.
- PSH projects will not administer drugs tests, impose income requirements, require employment, or require services (case management, mental health, behavioral health) as a condition of housing. Providers are encouraged to practice Trauma Informed Practices, Motivational Interviewing, and Client-Centered Housing Stability Planning. This standard may be flexible in cases of immediate safety concerns other extreme circumstances.

Rapid Re-Housing Eligibility, Rent Policies and Prioritization

Rapid Re-Housing Eligibility

For rapid re-housing programs, households must meet the HUD's definition of homelessness under Category I, any subsequent CoC Program Notice of Funding Availability (NOFA) eligibility requirements, and any additional funder eligibility requirements. Rapid Re-Housing projects must commit to a Housing First, client-centered approach whereby any eligible household can be served regardless of severity of service needs of length of time homeless, particularly in the event that a more intensive housing intervention is not available in the CoC or the county in which the household chooses to reside.

Rapid Rehousing Prioritization

The process for prioritizing participants for rapid re-housing resources will first include that eligible participants are referred to the rapid re-housing program which they are eligible for, and then secondly be based on the following prioritization:

- Any household not otherwise eligible or able/willing to access a Permanent Supportive Housing unit
- Families and individuals whose score on the Common Assessment Tool indicate a moderate to high vulnerability.
- Households eligible and prioritized for Permanent Supportive or Transitional Housing where either a) that housing type is not immediately available with the client's preferred geography, or b) the client chooses RRH over PSH
- Households with the longest history of homelessness
- Households expected to sustain housing once they have addressed housing barriers through case management

Rapid Re-Housing Minimum Service Standards

All referrals to rapid re-housing will be made through the coordinated entry system. The following minimum standards will be applied to all rapid re-housing programs

- Maximum participation in a rapid re-housing program cannot exceed 24 months
- Support services must be provided throughout the duration of stay in housing. Supportive services must be provided at least monthly.
- Program participants must enter into a lease agreement with the landlord/owner for a term of at least one year, which is terminable for cause. The lease must be automatically renewable upon expiration for terms that are a minimum of one month long, except on prior notice by either party.

- RRH projects will not administer drugs tests, impose income requirements or require services (case management, mental health, and behavioral health) as a condition of housing, except where required by funders. Providers are encouraged to practice Trauma Informed Practices, Motivational Interviewing, and Client-Centered Housing Stability Planning. This standard may be flexible in cases of immediate safety concerns other extreme circumstances.

Rapid Re-Housing Rent Guidelines

Rental assistance will be tailored to the individual needs of each household and delivered in a progressive manner, beginning with the least assistance necessary to house the household and continuing thereafter on an as needed basis. Each RRH provider will submit its rent guidelines and justification for these guidelines to the CoC Board for review, and if necessary, the Board will respond with recommended changes. Providers are encouraged NOT to impose "one size fits all" assistance packages and instead work within the flexibility allowed by the funder to deliver effective, individualized rental assistance and supportive services to meet unique client needs. Providers are also strongly encouraged to ensure participants fully understand the limitations of RRH funding and ensure responsible, transparent client rent sharing as part of their service delivery. The CoC recognizes that some households may only need a single financial assistance payment and short term services, while other households (particularly those with the highest barriers who cannot otherwise immediately access PSH) may need the full range of rental assistance and services allowed under the funder's program requirements.

Transitional Housing Eligibility and Prioritization

Transitional Housing Eligibility

For transitional housing programs in the Three County CoC, households must meet both the HUD definition of homelessness, under Categories I or IV. Once meeting the following eligibility requirements, households are then prioritized by Three County's target populations based on the unique criteria for the CoC's transitional housing programs.

Transitional Housing programs will specifically target households experiencing literal homelessness (Category 1), households actively fleeing domestic violence (Category IV), and households where the head of household is an unaccompanied youth or single guardian with dependents.

Households qualify as Category I if they are:

- Sleeping in a place not designed for or used as a regular sleeping accommodation, including the street, a car, park, abandoned building, bus or train station, airport, camping ground etc.
- living in a shelter designed to provide temporary living arrangements (including emergency shelter, congregate shelters, transitional housing, hotels and motels paid for by charitable organizations or by government programs)
- Exiting an institution where they resided for ≤ 90 days, and were residing in an emergency shelter or place not meant or human habitation immediately prior to entering the institution

Households qualify as Category IV if they meet the following requirements:

- They are fleeing, or attempting to flee domestic violence
- No subsequent residence has been identified
- They have no resources or support networks to obtain permanent housing

Prioritization for Transitional Housing

The process for prioritizing households for transitional housing first includes eligible households based on HUD's

homeless definition, and then secondly based on the below prioritization. Transitional Housing facilitates the movement of homeless households to permanent housing within 24 months of entering transitional housing.

In the Three County CoC, each transitional housing program has its own eligibility criteria. At entry, this may be based on the sub-population served—such as age, gender, family composition, severity of behavioral health issues, etc. If multiple households meet the transitional housing programs individualized eligibility criteria, then prioritization will take place in the following order:

Households with the highest service needs will be prioritized first

1. Eligible households who, after being presented with any permanent housing options available to them, choose to instead pursue a Transitional Housing environment.
2. Length of time homeless
3. Falling under one of the target populations for transitional housing:
    a. Single guardian with dependents
    b. Family with head of household between the ages of 18-24 years old
    c. Households fleeing domestic violence
    d. Households with severe service needs that threaten their immediate health or safety and who cannot safely live in an independent living environment but for whom institutional recovery or treatment services are not desired or available.

Transitional Housing Minimum Service Standards

The following minimum standards will be applied to all transitional housing programs:

- Maximum length of stay cannot exceed 24 months.
- Assistance in transitioning to permanent housing must be provided. Permanent housing plans are established immediately upon intake to the Transitional Housing program, even if those plans anticipate a prolonged length of stay in TH prior to moving to PH.
- Support services must be provided throughout the duration of stay in transitional housing.
- Program participants in transitional housing must enter into a lease, sublease or occupancy agreement for a term of at least one month. The lease, sublease or occupancy agreement must be automatically renewable upon expiration, except on prior notice by either party, up to a maximum term of 24 months.

Ineligible Participants

A project that is following a housing first approach may request information related to a potential program participant's sex offender status, criminal history, or other information which was either informed during Coordinated Entry Assessment, or as general practice for that program's intake process. Information obtained at any point during assessment or identified during intake screenings should be used to determine the most appropriate housing placement and not to screen out an otherwise eligible individual or family.

The only exception to this policy is for site-based projects. In these instances, it is possible that an individual or family may be screened out of the site-based project based on a background check (e.g., if an individual is a registered sex offender and cannot live near children and the site has a household with children residing in it); however, HUD encourages the recipient or sub-recipient of that project to work with the individual or family presenting for assistance and the coordinated entry system, to identify another appropriate housing placement.

Individual Projects may have specific eligibility criteria based on expectations from funding sources, but COC funded projects should make every effort to house through the Coordinated Entry process.

*Individuals and families should never be removed from the CE list due to histories that are thought to increase difficulty to house.

Homelessness Prevention, Eligibility and Prioritization

Individuals and families who are currently housed, but at risk of losing that housing, should be referred to regional or sub-regional providers (agencies) for homelessness prevention programming, which may include ESG supported services. These households should be provided with referrals to agencies that are the most geographically accessible. Upon referral, households will be screened and assessed by appropriate regional and sub-regional agencies to determine the following: what programming and resources a household is eligible to receive, which may include a screening for ESG supported interventions and resources; what resources are currently available; and what are the most appropriate interventions for a household. Because most of these at-risk households currently have housing – even if it is insecure in the near term – they would not score highly in terms of vulnerability, and the 'right-size' resource for them will typically include one or a combination of the following: financial support, legal counseling, housing counseling, case management, housing search, and/or community based or court connected mediation to keep them in their current home or divert them from homelessness. The Coordinated Entry Assessment does not need to be completed for these at-risk households until they have become literally homeless, at which time the referral to an agency providing more than prevention will be their entry point in the system.

The policy will continue to be developed to ensure consistency with DHCD's anticipated prescribed policy regarding homeless prevention and coordinated entry.

Program Evaluation

The Coordinated Entry program will be evaluated annually using a participatory evaluation model and a mixed methods approach.

The evaluation will be overseen by the CoC staff at Community Action Pioneer Valley and will occur each spring, starting in 2020, reporting to the CoC Board by June 1st of each year on the quality and effectiveness of the coordinated entry experience of both the participating projects and clients via surveys, focus groups and key informant interviews. The evaluation will also measure the Coordinated Entry process's adherence to HUD's expectations and guidance for effectiveness. Those participating in the evaluation process will be representative of the diversity of participating households and individuals in the CoC region.

Client surveys may be incorporated into Exit Interviews from Shelter or TH into PH, and will also include a survey link for responses from current project participants. The survey will reflect a representative sample of clients as noted above, is voluntary, and intended only for the purposes of improving the CE system.
Improvements to the process will be made after the conclusion of the annual evaluation period, based on the strengths and limitations of the process emerging from the evaluation.

HUD, CE, and Housing Definitions

Affordable Housing: In general, housing for which the occupant(s) is/are paying no more than 30 percent of his or her income for housing costs, including utilities. Some jurisdictions may define affordable housing based on other, locally determined criteria.

Case Manager: one who assists in the planning, coordination, monitoring, and evaluation of services for a participant with emphasis on quality of care, continuity of services, and proper administration of their goals and programming.

Case Conference: A meeting held between Coordinated Entry providers to discuss client details for the purpose of coordinating care. In the Three County CoC these meetings are held weekly in each of the three counties.

Chronic Homelessness (CH): An unaccompanied homeless individual with a disability who has either been continuously homeless for a year or more OR has had at least four episodes of homelessness in the past three years.

Homeless in this definition means that the individual is living either in a place not meant for human habitation (in their car, in a tent in winter, in an abandoned building, etc.), a safe haven (program for people who have severe mental illness and are homeless), or in an emergency shelter, or in an institutional care facility (in a hospital, substance program, etc.) but they were homeless prior to entering the facility.

Collaborative Applicant: the eligible applicant designated by the CoC to collect and submit the CoC Registration, CoC Consolidated Application (which includes the CoC Application and CoC Priority Listing), and apply for CoC planning funds on behalf of the CoC during the CoC Program Competition.

Consolidated Application: The CoC **Consolidated Application** is made up of two parts: the CoC Application and the CoC Priority Listing, with all of the CoC's project applications either approved and ranked, or rejected. The Collaborative Applicant is responsible for submitting both the CoC Application and the CoC Priority Listing in order for the CoC Consolidated Application to be considered complete.

Continuum of Care (CoC): A collaborative funding and planning approach that helps communities plan for and provide, as necessary, a full range of emergency, transitional, and permanent housing and other service resources to address the various needs of homeless persons. HUD also refers to the group of service providers involved in the decision making processes as the "Continuum of Care." The Program is designed to promote communitywide commitment to the goal of ending homelessness; provide funding for efforts by nonprofit providers, and State and local governments to quickly rehouse homeless individuals and families while minimizing the trauma and dislocation caused to homeless individuals, families, and communities by homelessness; promote access to and effect utilization of mainstream programs by homeless individuals and families; and optimize self-sufficiency.

Coordinated Entry (CE): a standardized access, assessment, and referral process for housing and other services across agencies within a CoC to assist individuals and families seeking housing and services.

CE Partner: Coordinated Entry Partners are organizations/agencies which participate in the Three County Continuum of Care Coordinated Entry System in any way. This could refer to local emergency services, libraries, or other public services which assess visitors interested in participating in CE, CoC Funded and Unfunded Projects, emergency housing programs and case workers.

Data Warehouse: Information system storing program and operational data. In our CoC, Green River is a **data warehouse** that is used to consolidate data from a number of sources, including HMIS and other systems.

Emergency Shelter (ES): is any facility whose primary purpose is to provide temporary or transitional shelter for the homeless in general or for specific populations of the homeless. In Massachusetts we have a large ES program run by the State specifically for families.

Emergency Solutions Grant (ESG): (new with Hearth) **Emergency Shelter Grant** (previous program name)

Emergency Solutions Grant Program: A federal program designed to help improve the quality of existing emergency shelters, to make additional shelters available, to meet the costs of operating shelters, and to provide essential social services to homeless individuals. ESG also provides short-term homeless prevention assistance to persons at imminent risk of losing their own housing due to eviction, foreclosure, or utility shutoffs.

Geographic Preference: The area, within the Continuum, that an Individual or family wants to reside and therefore may choose housing opportunities only available in that area.

HEARTH Act: The Homeless Emergency Assistance and Rapid Transition to Housing (**HEARTH**) Act of 2009 amends and reauthorizes the McKinney-Vento Homeless Assistance Act with substantial changes, including:

- A consolidation of HUD's competitive grant programs
- The creation of a Rural Housing Stability Assistance Program
- A change in HUD's definition of homelessness and chronic homelessness
- A simplified match requirement
- An increase in prevention resources
- An increase in emphasis on performance

Homelessness Management Information System (HMIS): is a computerized data collection system designed to capture client-level information over time on the characteristics and service needs of men, women, and children experiencing homelessness, while also protecting client confidentiality. It is designed to aggregate client-level data to generate an unduplicated count of clients served within a community's system of homeless services. An HMIS may also cover a statewide or regional area, and include several CoCs. The HMIS can provide data on client characteristics and service utilization.

U.S. Department of Housing and Urban Development (HUD): Established in 1965, HUD is a cabinet-level agency that oversees federal programs designed to help Americans with their housing needs. HUD's mission is to increase homeownership, support community development, and increase access to affordable housing free from discrimination. The agency enforces federal housing laws, operates mortgage-supportive initiatives and distributes millions of dollars in federal grants.

Housing First (HF): 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.

Housing Opportunities for Persons with AIDS (HOPWA): Provides housing assistance and supportive services to low-income people with HIV/AIDS and their families. HOPWA funds may also be used for health care and mental health services, chemical dependency treatment, nutritional services, case management, assistance with daily living, and other supportive services.

No Wrong Door: a model of integrated and coordinated service delivery based on the premise that every door in the

service system should be the right door. It represents a philosophy whereby service providers are committed to actively engaging people to ensure they receive appropriate and adequate support for their needs regardless of their initial entry point.

NOFA: The **Notice of Funding Availability** is a notice published each year on Grants.gov for HUD's Discretionary Funding Programs. This notice describes the type of funding available on a competitive basis. The deadline for submission is typically 60 to 90 days from the date of NOFA publication.

Participatory Evaluation Model: Participatory evaluation is an approach that involves the stakeholders of a program or policy in the evaluation process. This involvement can occur at any stage of the evaluation process, from the evaluation design to the data collection and analysis and the reporting of the study.

Point of Contact: The specific staff person at an organization or agency responsible for all contact with a particular client. In most scenarios in this CoC the **Point of Contact** will be the client's case manager.

Project (CoC): A Program that is funded as the sub-recipient for HUD funds, that has applied for and been approved by the Continuum, to provide Housing and Supportive Services to a priority population.

Permanent Supportive Housing (PSH): is permanent housing with indefinite leasing or rental assistance paired with supportive services to assist homeless persons with a disability or families with an adult or child member with a disability achieve housing stability.

Recipient: The Agency or Organization Awarded the CoC HUD funds. In this Continuum, that is the Collaborative Applicant.

Rapid Re-Housing (RRH): **RRH** rapidly connects families and individuals experiencing homelessness to permanent housing through a tailored package of assistance that may include the use of time-limited financial assistance and targeted supportive services.

Subsidized Housing: housing for low or very low-income households where the rent is capped at a percent of the occupant's income (often 30-40%). Public housing is a type of subsidized housing, as is a Housing Choice Voucher (Section 8).

Sub-Recipient: The "Project" within an Agency or Organization that enters in to a contract with the Recipient or Collaborative Applicant for funding and resources which follow the programs expectations within the guidelines and Interim Rule.

Supportive Services Only (SSO): This program provides services to homeless individuals and families living in the community. SSO recipients may use the funds to conduct outreach to sheltered and unsheltered homeless persons and families, link clients with housing or other necessary services, and provide ongoing support.

Trauma Informed: Approaches delivered with an understanding of the vulnerabilities and experiences of trauma survivors, including the prevalence and, physical, social, and emotional impact of trauma. This approach recognizes signs of trauma in staff, clients, and others and addresses this by integrating knowledge about trauma into policies or procedures and practices. Trauma informed practices place priority on restoring survivor's feelings of safety, choice and control. Programs, services, organizations & communities can be trauma-informed.

Transitional housing (TH): provides temporary housing for the certain segments of the homeless population, including working homeless making insufficient wages or homeless individuals with mental or physical disabilities who have trouble affording long-term housing, and is set up to transition their residents into permanent, affordable housing within a reasonable amount of time (usually 24 months).

Victim-centered: Placing the victim's priorities, needs, and interests at the center of the work with the victim. Providing Non-judgmental assistance, with an emphasis on client self-determination, where appropriate, and assisting victims in making informed choices; ensuring that restoring victims feelings of safety and security are a priority and safeguarding against policies and practices that could inadvertently re-traumatize victims; ensuring that victim's rights, voices, and perspectives are incorporated when developing and implementing system and community based efforts that impact crime victims.