ACCESS POINT
OPERATING
PROCEDURES

February 2023
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In consultation with recipients of Emergency Solutions Grants program funds within the geographic area, establish and operate either a centralized or coordinated assessment system that provides an initial, comprehensive assessment of the needs of individuals and families for housing and services. The Continuum must develop a specific policy to guide the operation of the centralized or coordinated assessment system on how its system will 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 service providers. This system must comply with any requirements established by HUD by Notice.

Introduction

Provisions in the Continuum of Care (CoC) Program Interim Rule at 24 CFR 578.7(a)(8) require that CoC’s establish a “Centralized or Coordinated Assessment System.” The U.S. Department of Housing and Urban Development (HUD) views an effective coordinated entry process as a critical component of each community’s efforts to meet the goals of Opening Doors: Federal Strategic Plan to Prevent and End Homelessness. Idaho’s Balance of State CoC has adopted this same philosophy. The primary goals for any coordinated entry process are to deliver assistance and allocate resources as effectively as possible and that it be easily accessible no matter where or how homeless persons or those at risk of homelessness present for assistance.

Recognizing that homeless response systems lack adequate resources needed to meet all of the needs of people experiencing homelessness, coordinated entry systems have been developed to assist communities with prioritizing assistance based on the length of time homeless, vulnerability, and severity of service needs to ensure that those with the greatest need receive assistance, and do so in a timely manner.

COORDINATED ENTRY POLICY BRIEF

An effective coordinated entry process is a critical component to any community’s efforts to meet the goals of Opening Doors: Federal Strategic Plan to Prevent and End Homelessness. This policy brief describes HUD’s views of the characteristics of an effective coordinated entry process. This brief does not establish requirements for Continuums of Care (CoCs), but rather is meant to inform local efforts to further develop CoCs’ coordinated entry processes.

Provisions in the CoC Program interim rule at 24 CFR 578.7(a)(8) require that CoCs establish a Centralized or Coordinated Assessment System. In this document, HUD uses the terms coordinated entry and coordinated entry process instead of centralized or coordinated assessment system to help avoid the implication that CoCs must centralize the assessment process, and to emphasize that the process is easy for people to access, that it identifies and assesses their needs, and makes prioritization decisions based upon needs. However, HUD considers these terms to mean the same thing. See 24 CFR 578.7(a)(8) for information on current requirements.

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.

HUD has previously provided guidance regarding prioritization for permanent supportive housing (PSH) in Notice CPD-014-12 Notice on Prioritizing Persons Experiencing Chronic Homelessness in Permanent Supportive Housing and Recordkeeping Requirements for Documenting Chronic Homeless Status. This brief builds upon that Notice and provides guidance for using coordinated entry to prioritize beyond permanent supportive housing (PSH).

Qualities of Effective Coordinated Entry
An effective coordinated entry process has the following qualities:

- **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.

The remainder of this brief clarifies a few aspects of the coordinated entry process that deserve further explanation and emphasis, including how communities prioritize people in their coordinated entry process, how communities think about and address waiting lists, and considerations for the assessment tools and processes that communities implement. This document also clarifies some of the considerations to be made at the local level as communities further develop their process.

**Prioritizing people who are most vulnerable or have the most severe service needs**

One of the main purposes of coordinated entry is to ensure that people with the most severe service needs and levels of vulnerability are prioritized for housing and homeless assistance. HUD’s policy is that people experiencing chronic homelessness should be prioritized for permanent supportive housing. In some cases PSH projects are required to serve people experiencing chronic homelessness and in other cases, HUD provides incentives for projects to do so. HUD is strongly encouraging communities to fully implement the prioritization process included in Notice CPD-014-12.
In addition to prioritizing people experiencing chronic homelessness, the coordinated entry process prioritizes people who are more likely to need some form of assistance to end their homelessness or who are more vulnerable to the effects of homelessness. When considering how to prioritize people for housing and homelessness assistance, communities can use the following:

- Significant health or behavioral health challenges or functional impairments which require a significant level of support in order to maintain permanent housing;
- High utilization of crisis or emergency services, including emergency rooms, jails, and psychiatric facilities, to meet basic needs
- The extent to which people, especially youth and children, are unsheltered
- Vulnerability to illness or death
- Risk of continued homelessness
- Vulnerability to victimization, including physical assault or engaging in trafficking or sex work

Communities should decide what factors are most important and, to the greatest extent possible, use all available data and research to inform their prioritization decisions. The coordinated entry process is meant to orient the community to one or two central prioritizing principles by which the community can make decisions about how to utilize its resources most effectively. This prioritization ensures that across subpopulations and people with different types of disabilities, those most vulnerable or with the most severe service needs will be prioritized for assistance. The prioritization may not target a category of people with a particular disability. However, individual programs, including CoC funded projects, may restrict access to people with a particular disability or characteristic. In these cases, the coordinated entry process should ensure that people are only referred to projects for which they are eligible. At the same time, providers should ensure that eligibility criteria are limited to those required by Federal or local statute or by funding sources.

Communities should take care to ensure that their prioritization process does not allow people who are more vulnerable or who have more severe service needs to languish in shelters or on the streets because more intensive types of assistance are not available. Evidence indicates that one of the most important factors to successfully ending an episode of homelessness is the speed with which the intervention is made available to the person (see discussion of assessment tools below and HUD’s February 2015 report on assessment tools). This means that if a person is assessed as being highly vulnerable, that person may be prioritized for PSH, but if PSH is not available or the PSH has a long waiting list, that person should be prioritized for other types of assistance such as RRH or TH. CoCs should not assume that because a person is prioritized for one type of assistance, they could not be served well by another type of assistance. However, CoCs should be aware that placing a household in transitional housing can affect their eligibility for other programs. For example, people coming from transitional housing are not eligible for most rapid re-housing funded under the ESG and CoC Programs and placement in transitional housing can affect a person’s chronic homelessness status.

**Addressing waiting times through coordinated entry**

Long wait times make homeless assistance less effective and reduce the overall performance of a community’s homeless assistance system. When a community faces a scarcity of needed resources, they should use the coordinated entry process to prioritize which people will receive housing assistance rather than continuing to add people to a long waiting list. For example, if a community has enough permanent supportive housing to serve 10 new households per month, but 30 households are assessed as needing PSH every month, the coordinated entry process should be adjusted to prioritize approximately 10 households for PSH each month. The other 20 households should be prioritized for other resources available in the community, such as RRH, TH (taking care to consider the impact of placement in TH on an individual’s chronically homeless status or future eligibility in other programs), housing subsidies, or other mainstream resources. Short waiting times of a few days or weeks might be necessary to properly manage utilization, but waiting times for homeless assistance of several months or years should be eliminated whenever possible. Although PSH is almost always the most effective resource for people with high levels of vulnerability and high service needs, including those experiencing...
chronic homelessness, the lack of available PSH should not result in people languishing in shelters or on the streets without further assistance.

Most communities face a gap between need and availability based on limited resources. Communities should be proactively taking steps to close these gaps that are identified through the coordinated entry process. For example, if there is insufficient PSH available in the community, the CoC should be working with PHAs, other affordable housing providers, and Medicaid-funded agencies to increase the supply of PSH. To the maximum extent possible, existing PSH should be targeted to chronically homeless people based on the severity of their service needs (as described in Notice CPD-014-12). Where there are individuals in PSH who no longer need a high level of services, the CoC should pursue “move up” strategies that help those individuals shift to another form of housing assistance, freeing up the PSH assistance for another prioritized household.

**Implementing effective assessment tools and processes**

HUD does not endorse any specific assessment tool or approach, but there are universal qualities that any tool or criteria used by a CoC for their coordinated entry process should include. HUD outlined some of these qualities in the Notice CPD-014-12 and is building on those qualities in this brief. HUD recognizes the need for guidance as both the process and the tools continue to evolve, so some of the qualities have remained the same, while others have had changes and additions that reflect HUD’s evolving understanding of the assessment process and what is most effective. Please refer to HUD’s February 2015 report on assessment tools for further information.

At its core, the assessment process is not a one-time event to gather as much information about a person as possible. Instead, assessments are performed only when needed and only assess for information necessary to help an individual or family at that moment. Initial assessments happen as quickly as possible regardless of where households are residing—streets or in shelter, and the assessment process uses tools as a guide to start the conversation, not as a final decision-maker. Following are several principles that communities can use to ensure an effective assessment process:

- **Phased assessment.** The assessment tools are employed as a series of situational assessments that allow the assessment process to occur over time and only as necessary. For example, an assessment process may have separate tools that assess for each of the following:
  - Screening for diversion or prevention
  - Assessing shelter and other emergency needs
  - Identifying housing resources and barriers
  - Evaluating vulnerability to prioritize for assistance
  - Screening for program eligibility
  - Facilitating connections to mainstream resources

  These assessments will likely occur over a period of days or weeks, as needed, depending on the progress a homeless household is making. The different assessments build on each other so a participant does not have to repeat their story. There will also be instances where a participant should be reassessed or reprioritized, particularly if they remain homeless for a long period of time.

- **Necessary information.** The assessment process only seeks information necessary to determine the severity of need and eligibility for housing and services and is based on evidence of the risk of becoming or remaining homeless. For example, a coordinated assessment process would only assess for a particular disability to determine if that household could be referred to a program that requires a particular disability as part of its eligibility criteria.

- **Participant autonomy.** The protocol for filling out assessment tools provides the opportunity for people receiving the assessment to freely refuse to answer questions without retribution or limiting their access to assistance.
Person-centered. The assessment process provides options and recommendations that guide and inform client choices, as opposed to rigid decisions about what individuals or families need. The process also incorporates participants’ strengths, goals, and protective factors to recommend options that best meet the needs and goals of the people being assessed.

Cultural competence. Staff administering assessments use culturally competent practices, and tools contain culturally competent questions. For example, questions are worded to reflect an understanding of LGBTQ issues and needs, and staff administering assessments are trained to ask appropriately worded questions and offer options and recommendations that reflect this population’s specific needs.

User-friendly. Tools are brief, easily administered by non-clinical staff including outreach workers, minimize the time required to utilize, and easy for those being assessed to understand.

Privacy protections. Privacy protections are in place to ensure proper consent and use of client information.

Meaningful recommendations. Tools are designed to collect the information necessary to make meaningful recommendations and referrals to available housing and services. Participants being assessed should know exactly what program they are being referred, what will be expected of them, and what they should expect from the program. The coordinated entry process should avoid placing people on long waiting lists.

Written standards and policies and procedures. The CoC has written standards describing who is prioritized for assistance and how much assistance they might receive, and the policies and procedures governing the coordinated assessment process are approved by the CoC and easily accessible to stakeholders in the community.

Sensitive to lived experiences. Providers recognize that assessment, both the kinds of questions asked and the context in which the assessment is administered, can cause harm and risk to individuals or families, especially if they require people to relive difficult experiences. The tool’s questions are worded and asked in a manner that is sensitive to the lived and sometimes traumatic experiences of people experiencing homelessness. The tool minimizes risk and harm, and provides individuals or families with the option to refuse to answer questions. Agencies administering the assessment have and follow protocols to address any psychological impacts caused by the assessment and administer the assessment in a private space, preferably a room with a door, or, if outside, away from others’ earshot. Those administering the tool are trained to recognize signs of trauma or anxiety.

Integrating youth into the coordinated entry process

CoCs with a network of youth serving programs should consider whether they would better serve youth by creating coordinated entry access points dedicated to underage and transition aged youth. These access points can be located in areas where homeless youth feel comfortable and safe. They can be staffed with people who specialize in working with youth. CoCs should take care to ensure that if they use separate coordinated entry points for youth, that those youth can still access assistance from other parts of the homeless assistance system and that youth who access other coordinated entry points can access assistance from youth serving programs.

Regardless of whether a CoC uses youth dedicated access points, the coordinated entry process must ensure that youth are treated respectfully and with attention to their developmental needs.

Serving people fleeing domestic violence

CoCs must work with domestic violence programs in their communities to ensure that the coordinated entry process addresses the safety needs of people fleeing domestic violence. This includes providing a safe location or process for conducting assessments, a process for providing confidential referrals, and a data collection process consistent with the Violence Against Women Act. If the CoC’s coordinated entry process uses separate access points for people fleeing domestic violence, CoCs should take care to ensure that people who use the DV coordinated entry process can access homeless assistance resources available from the non-DV portion of the coordinated entry process and vice versa. Many people experiencing homelessness have a history of domestic violence, and should be able to access appropriate DV services even if they are not accessing it through a DV coordinated entry point. Similarly, people fleeing domestic violence
often have housing and homeless assistance needs that should not be limited by their decision to access a DV coordinated entry access point.

**Defining coordinated entry roles in the homeless assistance system**

Diverse stakeholders have different roles in a coordinated entry process. In some cases, these roles are clearly defined. Often, the roles are challenging to define and can change over time.

**Homeless assistance organizations**

All homeless assistance organizations should be involved in the coordinated entry process by helping people access the system and receiving referrals. Homeless assistance organizations may also provide assessments or provide space for assessments to be conducted. Emergency shelter, transitional housing, rapid re-housing, and permanent supportive housing programs should only receive referrals through the coordinated entry process.

**Mainstream housing and services**

Affordable housing and mainstream services are crucial tools for ending homelessness and should be involved in the coordinated entry process. As a CoC’s coordinated entry process is developed, mainstream providers can act as a source or receiver of referrals. For instance, sources of referrals could include mental health service providers, substance abuse service providers, Department of Veterans Affairs (VA) Medical Centers, jails, or emergency rooms. Receiving agencies could include public housing authorities, multifamily properties (like Section 8 PBRA, 811, and 202), mental health service providers, and substance abuse providers. Organizations acting as receiving agencies will determine the extent to which they will rely on referrals from the coordinated entry process. In some instances, certain services could be co-located with a physical access point, or a virtual access point, like a telephone service such as 2-1-1. The more mainstream programs and resources that are connected to your coordinated entry process through the coordination of referral, application, and eligibility determination processes, the more effectively your community can consistently connect homeless individuals with housing resources and the community-based supports that they need to maintain that housing. How a provider or program is integrated into the coordinated entry process will depend on a number of factors including the makeup of the local homeless population, the patterns of service use in the community, and whether the coordinated entry process has been folded into an existing mainstream service system or if it stands alone. These decisions evolve as communities build their processes, and communities might decide to incorporate certain mainstream services over time—as a referral source, a receiving agency, or both.

**Prevention and Diversion**

There are many more people who qualify for homelessness prevention assistance than homeless assistance. In developing coordinated entry processes, CoCs should consider how much capacity they have to manage prevention assistance. At a minimum, ESG funded prevention assistance should be incorporated into the coordinated entry process. Communities should decide to what extent they include additional non-prevention programs and how they are incorporated.

**A Note on Future Guidance**

As more communities implement coordinated entry and more research on the topic is conducted, HUD is learning more about what makes an effective coordinated entry process, and the Department will continually modify its guidance and recommendations to communities. This is challenging for communities, who have to adjust their processes to stay up to date. Nonetheless, HUD believes it is important to act on the best available evidence known at the time, while also recognizing that communities need time and resources to keep up with new guidance.

In the coming months, HUD anticipates releasing the following materials related to coordinated entry:

- Summer 2015: Notice on the requirements for development and implementation of a CoC’s coordinated entry process. This notice will establish requirements for coordinated entry and timelines for implementation.
- Ongoing: Technical Assistance products
o Meeting HUD expectations and requirements
o Special considerations for youth
o Special considerations for people fleeing domestic violence
o Compliance and monitoring
o Options for funding coordinated entry
o Advanced approaches for coordinated entry processes and systems
o Deciding on community-specific assessment tools
o Planning and implementation o Data sharing
o CoC written standards
o Using progressive engagement

Additionally, HUD intends to release the Emergency Solutions Grant (ESG) and CoC Program interim rules for public comment in 2015. During this time, HUD encourages CoCs, ESG recipients and subrecipients, and CoC Program recipients to submit comments on the requirements contained in the interim rules related to coordinated entry.
**Section 1: Definitions**

**At Risk of Homelessness:** A person is at risk of homelessness if they are at risk of losing their housing accommodation. A person may be at risk of homelessness if they are experiencing one or more of a range of factors or triggers that can contribute to homelessness.

**Case Conference:** Regularly planned, formal and structured meetings to provide coordinated and integrated discussions among Access Point service providers regarding individual housing placement action plans for those included on the queue and not receiving housing referrals.

**Case Manager:** Service provider and/or other agency staff trained to assist clients in identifying their housing goals, needs, and resources, and helps facilitate their connection to services.

**Chronically Homeless:** HUD defines a chronically homeless person as a homeless individual or family with a disabling condition who has either been continuously homeless for a year or more, or has had at least four episodes of homelessness in the last 3 years, where the combined occasions total a length of time of at least 12 months. To be considered chronically homeless, persons must have been sleeping in a place not meant for human habitation (e.g., living on the streets) and/or in an emergency homeless shelter during that time.

**Collaborative Applicant:** Idaho Housing and Finance Association is the designated Collaborative Applicant. The Collaborative Applicant is responsible for staffing the system administrator position to oversee the day-to-day administration of Access Point.

**Consumer:** An individual or household utilizing housing or services provided as part of the CoC.

**Diversion:** A strategy that prevents homelessness by helping clients identify immediate alternate housing arrangements and, if necessary, connecting them with services and financial assistance to help them return to permanent housing.

**Access Point:** Designated agency/agencies selected to serve as the single point of entry for Access Point. The designated access points are the only locations within each region where people experiencing homelessness are assessed and referred to homelessness assistance services.

**Access Point System Administrator:** Responsible for the day-to-day management and administration of Access Point.

**Homeless Management Information System (HMIS):** A Homeless Management Information System (HMIS) is a database used to record and track client-level information on the characteristics and service needs of homeless persons.

**Homelessness Prevention:** Activities and programs intended to prevent the incidence of homelessness such as short-term housing subsidies, utility subsidies, and other financial assistance activities designed to prevent homelessness.

**Homelessness Prevention Assessment:** Standard assessment tool used to identify issues or conditions that may impact a person’s ability to maintain stable housing.

**Housing Navigator:** Refers to the Idaho Department of Health and Welfare’s Navigators who assist consumers in identifying housing resources and will participate in Access Point by conducting pre-screening, providing and accepting housing referrals, and participating in case conferencing.

**Literally Homeless:** HUD defines this as an individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning the individual or family’s nighttime residence is a public or private place not meant for human habitation, or who’s residence is a publicly or privately operated shelter.

**Pairing:** Associating an individual or family with a particular type of housing intervention based on the outcome of an assessment.
**Pre-screen:** An assessment process designed to assist in identifying individuals and families that are homeless or at risk of homelessness who may be eligible for federal, state or locally-funded assistance and resources.

**Prioritization:** Prioritization indicates a preference. These standards establish a preference for people with known disabilities or other key vulnerabilities. The IHCC has adopted HUD’s Orders of Priority for prioritizing PSH in accordance with HUD Notice CPD-16-11 (See Appendix).

**Program:** Refers to a federal funding source, such as HUD CoC funding.

**Project:** Refers to a distinct unit of an organization that provides services and/or lodging and is identified by the CoC as part of its service system.

**Queue:** List of potentially eligible consumers prioritized by greatest need. Housing units will be offered as they become available to the highest priority consumer.

**Receiving Project:** Project or program identified as offering the level of service that most closely aligns with the consumer’s needs and to which the consumer has been referred through Housing Connect.

**Regional Coalitions:** Providers and organizations among the IHCC Balance of State COC that collaborate to respond to issues and coordinate resources and services to address homelessness. There are six regional coalitions within the Idaho Balance of State COC.

**Screening:** A follow-up to the pre-Screening Assessment which asks additional questions designed to determine a client’s need for homelessness prevention or homelessness housing services.

**Youth:** Meet the definition of homeless and under age 25.

**Attachment**
- Exhibit 1: Balance of State CoC Acronyms
Section 2: System Overview

Purpose

The goal of the Idaho Homeless Coordinating Committee (IHCC) Access Point is to, in collaboration with the Collaborative Applicant, HMIS Lead Agency and the Boise City/Ada County Continuum of Care (including BC/AC COC’s Coordinated Entry System), prevent and end homelessness within the CoC’s geographic area. Access Point was developed in accordance with HUD rules, which defines this effort as “a centralized or coordinated process designed to coordinate program participant intake, assessment, and provision of referrals across a geographic area. The system covers the geographic area, is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool” (24 CFR Section 578.3). It is the responsibility of each CoC to implement Access Point in their geographic area.

Access Point creates a front door to Idaho’s many providers working to end homelessness for single adults, youth, and families. The system encompasses four participant-centered components: 1) Access: ensure that all people experiencing a housing crisis have fair and equal access; 2) Assess: providers quickly identify and assess persons seeking assistance using a standardized, communitywide tool; 3) Assign: those with the longest history of homelessness and most severe service needs are prioritized, while all are connected to housing and homelessness assistance based on their strengths and needs as quickly as possible; and 4) Accountability: all providers support and align with common goals and a shared framework.

The IHCC uses consistent and uniform assessment and referral processes to determine and secure the most appropriate response to each individual’s or family’s immediate and long-term housing and service needs.

Goals and Guiding Principles

The establishment and continued governance of a uniform and collaborative system must be founded upon consistent and universal goals and principles. The Continuum has adopted goals and guiding principles to focus the efforts and activities of the Coordinated Entry System.

Goals

The goals established for the Access Point are:

- Provide ease of access to community resources for those in need.
- “Right-size” resource allocations to reflect the needs of persons experiencing homelessness and those at risk of homelessness.
- Increase system uniformity while remaining considerate of community and regional needs.
- Align all Federal programs and other services for the homeless to maximize resources and meet Opening Doors strategic goals.
- Reduce first time homelessness, length of time homeless and returns to homelessness by providing the most needed and appropriate services to each community and individual seeking assistance.
Guiding Principles

The guiding principles established for Access Point are:

- **Transparency**: Process is visible and community driven. Everyone is accountable and responsible to the system; the system is accountable to those it serves.

- **Evidence-based & Data-driven**: Decisions are based on data, evidence, accountability, and assessment, and used to determine the type and extent of needs of the individual.

- **Trauma-informed & Participant-centered**: System processes are dignified, empathetic, responsive, and support self-determination, with a focus on offering services that fit specific needs.

- **Equitable Resource Allocation**: Allocation of resources is strategy-oriented, intentional and determined by performance outcomes and population location, size and needs.

- **Streamlined Processes**: System is as easy to navigate as possible.

- **Low-barrier, Housing First Approach**: To the extent possible, housing placements are based on need, not on program eligibility. Housing placement is offered as quickly as possible.

- **Ongoing Evaluation of Resources & Data**: Ensure that data quality and resource allocation for the system is functional and meet state led performance measures.

- **Prioritization**: Those with the longest history of homelessness and of the greatest service need receive housing resources first.

System Flow

**Stage 1- Accessing the System**: To ensure accessibility to households in need, Access Point provides access to services from multiple, convenient physical locations. The statewide 2-1-1 Careline refers callers who are homeless to the local Access Point. Consumers in need may initiate a request for services in person or by calling any of the designated Access Points or 2-1-1.

Accessible information about how to obtain services through Access Point is also available through a broad range of community-based service providers.

**Stage 2- Pre-screen**: Referral agencies performing outreach or otherwise interacting with homeless or at risk consumers and access points who are assisting consumers with accessing the system will conduct pre-screening. Pre-screening questions help identify other systems of care that may be able to assist the consumer more immediately or in a more specialized and complete manner. Other systems of care include those for survivors of domestic violence and those for youth, among others. Consumers who are not eligible for homelessness assistance programs and cannot be served by other homeless resources will be referred to other non-Access Point participating resources.

**Stage 3- Screening/Diversion**: Once a consumer is determined to be potentially eligible for Homeless Connect resources additional screening takes place at an Access Point. The purpose of the screening is to determine the most appropriate path one might take through the system. Screening may be performed in person or via telephone. Every effort will be made to divert potential consumers when appropriate and agreed by the persons seeking assistance. Diversion tactics will be used to assist the household in remaining housed without utilizing homelessness assistance resources. This may include family, friend, or landlord mitigation and/or other types of counsel. For those who are successfully diverted, their interaction with the Access Point ends here. Those who may be appropriately served by homelessness prevention based on screening results will move to Stage 4. Those who may be appropriately served by another homelessness assistance intervention offered within an access point will be prioritized, placed in the Queue, and move to Stage 5.
Stage 4- Homelessness Prevention: Consumers at risk of homelessness will have the Homelessness Prevention Assessment administered by an access point. Once HP assistance is offered, interaction with Homeless Connect ends here.

Stage 5- Housing Assessment: A QOL is administered during the Housing Needs Assessment Consumers are presented with their housing intervention options and assessment results are used to assist consumers in making informed decisions on their housing and service options.

Stage 6- Housing Referral: Housing providers will notify the Access Point upon the opening or expected opening of a project unit. The Access Point will review the Queue and the list will be sorted based on the orders of priority established herein and then filtered based on eligibility factors. The consumer at the top of the list will be reserved for the project’s opening. The Access Point will contact the potential consumer to assess their interest in participating in the project. Upon confirmation from the household, the Access Point will notify the receiving project to begin the intake process and documenting eligibility. The consumer will have choice in location, provider, and in some cases, housing type; however, declining housing offerings may delay being housed due to limited housing unit availability.

Stage 7- Housing Navigation: The receiving project and Navigators or PATH Peer Specialists may assist consumers with locating a rental unit if one is not already secured by the receiving project. When necessary, the Navigators, receiving project, or PATH Peer Specialists may assist the consumer with obtaining an identification card, social security card, homelessness documentation, security deposit assistance, application fees, transportation and other assistance that would secure housing and shorten the time a consumers remains un-housed. For RRH and PSH projects, consumers would be entered into their projects at the point they are reasonably sure the consumer would qualify but before documentation is required.

Stage 8- Housing Intervention: Housing assistance is provided while the consumer is offered a range of appropriate services and supports. The consumer is not required to participate in services, but is regularly engaged through case management to encourage participation in appropriate services.

Stage 9- Performance Measurement: CoC committees and the Access Point Administrator will be responsible for ensuring the system’s success and effectiveness is monitored. Data and reporting analysis activities will feed into system measurements. System performance and outcome measurements will be evaluated to create and propose system improvement recommendations to the IHCC for approval. This process will also ensure a system outflow strategy exists and is producing intended results.

The Access Point system flow is portrayed visually in the Idaho Balance of State Access Point System Workflow (Exhibit 2).

Attachment
- Exhibit 2: Idaho Balance of State Access Point System Workflow
Section 3: System Governance

A system of governance has been established within Idaho’s Balance of State CoC to ensure the goals and guiding principles detailed herein, along with HUD’s coordinated entry system guidance, are adhered to and are in compliance with fair housing laws.

Policy

Governance of the Access Point will be comprised of multiple stakeholders, including The Idaho Homelessness Coordinating Committee (IHCC) and its subcommittees, the Collaborative Applicant, the System Administrator, Regional Coalitions, access points, referring agencies, partnering systems, other participating agencies, and consumers. Each will be granted varying degrees of authority, assume specific roles, and be assigned responsibilities consistent with their level of participation.

The Idaho Balance of State COC Organizational Structure (Exhibit 3) identifies each party’s roles and responsibilities, as well as the party to which each is accountable.

The Access point Organizational Structure (Exhibit 4) offers a visual representation of the line of authority established to govern the system. All roles, authority, and responsibilities described in these Operating Procedures are granted upon the affirmative majority vote by the IHCC. These Operating Procedures may be updated occasionally to reflect necessary system improvements and change. The IHCC should re-affirm the policy and authority granted by these Operating Procedures at least bi-annually.

Process

The IHCC will meet on a quarterly basis under the convening of the board Chair, IHFA’s Vice President of Housing Support Programs. IHFA’s Homeless Programs Coordinator will be responsible for scheduling board meetings, creating and distributing agendas and associated materials, and recording meeting minutes. Should policy discussions need to occur, they will be initiated and presented by a sub-committee with support from IHFA and the system administrator.

The system administrator will be responsible for the day-to-day management and administration of the Access Point, including the following activities:

- Serving as point person and lead to all Regional Coordinated Entry Work Groups
- Providing training to participating agencies
- Communicating to user agencies and outreach coordinators
- Serving as a liaison with HMIS Lead Agencies
- Working with the HMIS Lead to administer Access Point client records
- Report generation
- Responding to requests for consumer deletion
- Responding to email generated questions
- Monitoring system performance
- Creating and widely disseminating materials regarding services available through the Access Point and how to access those services;
- Designing and delivering training at least annually to all key stakeholder organizations, including but not limited to the required training for Access Points;
- Ensuring that pertinent information is entered into HMIS for monitoring and tracking the process of referrals including vacancy reporting and completion of assessments;
- Participating in regional case conferences
- Facilitating the review and resolution of rejection decisions by receiving programs and refusals by clients to engage in a housing plan in compliance with receiving program guidelines;
- Managing an eligibility determination appeals process in compliance with the protocols described in this manual;
- Managing manual processes as necessary to enable participation in the Access Point by providers not participating in HMIS;
• Designing and executing ongoing quality control activities to ensure clarity, transparency, and consistency in order to remain accountable to consumers, referral sources, and homeless service providers throughout the coordinated access process;
• Periodically evaluating efforts to ensure that the system is functioning as intended;
• Making periodic adjustments to the system as determined necessary;
• Ensuring that evaluation and adjustment processes are informed by a broad and representative group of stakeholders; and
• Updating policies and procedures.

The HMIS Lead will be responsible for the management of consumer HMIS records, including the following activities:
• Executing Service Provider Contracts
• Providing HMIS training for the access point designated users
• Creating and updating Access Point reports
• Monitoring data quality and release of information
• Conducting annual security monitoring of access point users
• Reviewing and updating data standards and data entry forms
• Participating in IHCC sub-committees

The Access Point Committee will meet according to IHCC committee meeting requirements. The system administrator will act as the Committee Chair in the absence of members willing to fill this role. The system administrator will act as coordinator and scribe for meeting minutes. The Committee will solicit feedback from various stakeholders on a regular basis. Process efficiency, system success, and recommended improvements will be communicated to the Committee from case conferences through the system administrator. The Committee will respond by providing process instructions or clarifications or by drafting policy change recommendation. The system administrator will support this work. The Committee will present policy change proposals accompanied by a background summary, change recommendation, and impact statement to the IHCC. The Committee will instruct the HMIS Lead in the creation of quarterly performance and outcome reports based on the criteria outlined in Section 8: Accountability, and present them to the IHCC at each board meeting. The system administrator may assist in generating Access Point performance measurement reports. Given the purpose of the Data Collection, Reporting, and Evaluation (DCR&E) Committee, DCR&E may be asked to assist in the monitoring of system outcomes. The Committee, system administrator, or Collaborative Applicant will carry out any directives issued by the Board in response to system-related discussions. Access Point policies, procedures, and performance reports will be distributed to service providers and made available online to ensure transparency and public availability. Regional Coalitions will be held at least quarterly while case conferences will occur at least every other month. Coalitions will be coordinated and facilitated by local membership. Case conferences will be coordinated and facilitated by the regional Access Point. The system administrator will be available to support meeting functions. Contact information (Exhibit 5) for all parties involved in the governance structure is included as an attachment.

**Attachments**
- Exhibit 3: The Idaho Balance of State COC Organizational Structure
- Exhibit 4: Access Point System Structure
- Exhibit 5: COC Contact List
Section 4: Target Populations and Prioritization

The Idaho Balance of State CoC is comprised of six regions throughout the state. One additional region, Region 7, is served by the Boise City/Ada County CoC. The Idaho Balance of State CoC Access Point system is intended to serve people within the CoC that are experiencing homelessness and those at imminent risk of homelessness. Homelessness and at risk of homelessness is defined in accordance with HUD’s definition of homelessness. Chronic homelessness is defined by HUD as:

1. A “homeless individual with a disability,” as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:
   
   i. Lives in a place not mean for human habitation, a safe haven, or in an emergency shelter; and
   
   ii. Has been homeless and living as described continuously for at least 12 months or on a least 4 separate occasions in the last 3 years as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described. Stays in institutional care facilities for fewer than 90 days will not constitute a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility;

2. An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility for fewer than 90 days and met all of the criteria in paragraph 1 of this definition, before entering that facility; or

3. A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Additional effort is made to first house those identified as priority populations in Opening Doors: Federal Strategic Plan to Prevent and End Homelessness, and other special populations, including Veterans, the chronically homeless, survivors of domestic violence, and youth.

As further detailed later in this document, prioritization will be based on length of time homeless. Section 6: Assess includes specific details on the order of priority.
Section 5: Access

The Access Point will utilize a multi-site, centralized access model that will provide the opportunity for remote access, physical or walk-in access, and a range of flexibility to allow for local preference and need. Through broad marketing and outreach activities, those who would be eligible for homelessness resources but are not yet receiving assistance will be identified and encouraged to access the system.

The remote access will occur through direct call-in to physical access sites as well as by referral through Idaho’s 2-1-1 Careline. The IHCC, Regional Coalitions, and other stakeholders will promote the use of these call-in lines throughout the community to ensure that those persons who are homeless or at risk of homelessness or those who interact with homeless persons can make successful connections to the system.

The Access Point institutes a phased approach to all activities carried out by outreach teams, referral sources, access points, and other participating partners, but most notably within data collection, screening, and assessment processes.

Marketing

To be successful in the identification of homeless persons, the Access Point must be extremely visible throughout all communities across the CoC’s geographic area.

Policy

7.11 Advertising and public awareness activities will be accomplished through filtering 2-1-1 Careline calls; educational and promotional materials with local access point contact information. Regional resources will be distributed by Regional Coalitions. Multiple effective means of outreach and linkage to the system include public reports, press releases, coordination with statewide and local emergency response systems, and other stakeholders who frequently interact with homeless persons. Access Points will provide appropriate auxiliary aids and services necessary to ensure effective communication such as Braille, audio, large type assistive listening devices, and sign language interpreters.

Process

All participating providers, as well as community stakeholders, will be provided promotional outreach material that will describe the purpose of the Access Point and how to connect with Access Point resources. This material will be distributed through a variety of methods to educate community partners and service providers on Access Point and how to access resources. Access Point information and public awareness materials will also be made available in accessible formats when requested. Participating agencies should seek out and utilize any and all opportunities possible to promote the system. Regular discussion should be held in Regional Coalition meetings, Behavioral Health Board meetings, and service provider meetings. Those presenting and distributing this information should report the audiences’ reaction and any feedback to the Regional Coalition who will inform the Access Point Committee. The Access Point Committee will respond accordingly and in a manner that aligns with Access Point goals and guiding principles.

Outreach and Referral

Performing outreach in places homeless persons commonly frequent, whether frequented by the general population or not, is intended to increase linkage to Access Point and other homelessness assistance programs for those who have not previously or do not usually participate in such programs. Increasing access to programs promotes an environment of stability and self-sufficiency. Homeless persons connecting to the system through these outreach activities will participate in the same standardized assessment process.

Policy

All participating agencies with the means to perform outreach to homeless persons should do so with the intent of connecting those identified to the Access Point. Both CoC and ESG funds may be used to support outreach activities. Emergency response systems will also be encouraged to perform outreach activities in areas where homeless persons may reside that may be unsafe for providers or volunteers to access. As homeless persons are identified and express a desire
to be connected to homelessness assistance resources, trained outreach workers should assist with 7.14 conducting the access point assessments

Process

7.14 Coordinated Entry-Trained street outreach workers will take paper copies of the assessment tool with them out into the field to administer assessments to those on the streets who wish to connect with Access Point. The regional access point will add client data into HMIS and placed on the queue. All stakeholders willing and able to act in a referring capacity to assist homeless or at risk persons in connecting with the system are encouraged to do so. Marketing and informational material will be provided to a variety of locations, programs, providers, and other stakeholders who frequently interact with homeless or at risk persons. Referring parties may ask pre-screening questions with each homeless or at risk person. The answers will help indicate whether the consumer is potentially eligible for Access Point resources and if they are in need of specialized resources. The consumer should be given the access point’s location, hours of operation, and contact information if they are potentially eligible for homelessness services.

If unable to ask pre-screening questions, agencies should refer the homeless or at risk persons directly to the local access point or direct them to the 2-1-1 Careline. The access point or Careline will then ask pre-screening questions.

When access points are closed outside of normal business hours, a voicemail message should be activated to instruct those seeking services to return during operating hours. The message should also instruct consumers on where to go to obtain emergency shelter until Access Point is able to refer them to a housing intervention.

Access Points

Access points must be established to provide a physical point of access for consumers wishing to participate in homelessness assistance programs. Access points will have specific roles and responsibilities that guide the Access and Assess phases of the Access Point.

Policy

Access point selection considerations should include the proximity to population centers, accessibility, and capacity of participating agencies, among other barriers or accessibility factors. Sites selected as physical access points must commit to the following criteria or responsibilities:

- Participate in Access Point training when required by the IHCC or the system administrator;
- Employ Housing First practices in the organization’s housing practices;
- Participate in IHCC meetings and planning activities;
- Participate in regularly scheduled case conferencing meetings to review proper referral and placement of applicants;
- Participate in HMIS (or comparable database for agencies whose primary mission is to serve survivors of domestic violence) and adhere to HMIS policies, procedures, and standards required by the HMIS Lead, HUD, and the IHCC;
- Demonstrate staffing capacity to perform assessments and participate in diversion and prevention activities;
- Utilize CoC-established diversion strategies to assist households in avoiding homelessness whenever possible;
- Conduct an assessment process utilizing standardized, CoC-approved assessment tools and prioritization criteria.
• Make appropriate referrals for prevention services if the household could not be diverted from Homeless Connect;

• Make referrals for appropriate, and consumer-preferred, housing interventions and complete necessary data collection and entry to add the household to the centralized Queue;

• Ensure appropriate linkages to emergency shelter services for households that cannot immediately access a recommended housing intervention due to lack of availability; and

• Ensure appropriate linkages to mainstream resources and other services in the community (vocational, behavioral health, substance abuse, healthcare services, etc.).

• Abide by the HMIS Policy and Procedures

In addition to general access points, Access Point may include access sites with programs explicitly for youth and victims of domestic violence (DV) due to the delivery of specialized services at these sites, narrow eligibility criteria, HUD guidance, safety measures, and privacy considerations. These sites must meet each of the criterions listed above. DV and youth access sites must be available to assist any consumer with being assessed and included in the centralized Queue.

All access points sites must offer the same assessment approach and referrals using uniform decision-making processes. A person presenting at a particular access site must not be steered toward any particular program or project due to its connection to the access site or simply because the individual presented at that location.

All access points and supporting staff will be provided with training necessary to carry out the system operating procedures in a complete, accurate, and effective manner. Training will focus on system policies and procedures, HMIS use and data entry, system workflow, administering assessments, and other main elements and steps of Access Point. A current list of access points is attached (Exhibit 6).

In the event an access point is not established within a region, the responsibilities of an access point, as outlined and referenced above, will become the function of all HUD-funded homelessness assistance providers in that region.

Process

The system administrator, in consultation with the CoC’s Access Point Committee, may identify and secure agencies willing and able to service as a regional access point. Regional representatives participating on the Access Point Committee may make their respective local Regional Coalition aware of the proposed access site. The Coalition may express support or opposition to the proposed access site based on the proposed agency’s ability to adhere to the requirements of access points listed herein, as well as Access Point goals and guiding principles. Agencies who wish to participate in Access Point as an additional regional site should make their interest known by submitting a letter of interest to the Access Point Committee for consideration following the process as outlined above. The Access Point Committee may approve or deny a proposed access point agency.

Special Populations

Veterans

When a consumer is homeless or at-risk of homelessness and identified as a veteran, the veteran will be given the option of being referred to the VA and/or Supportive Services for Veteran Families (SSVF) providers for homeless assistance services. If the veteran chooses that option, he/she should be referred immediately. If a veteran’s agency determines that the consumer seeking veteran-specific services is not eligible for VA or other veterans services, the consumer will be reconnected with the regional access point. Although the VA and SSVF grantees are not required to participate in Access Point, they may participate at the capacity they choose. If the VA chooses to participate they may complete the standard, CoC-approved Access Point assessment process and may enter the data in HMIS to instantly add the consumer to the Queue to avoid the additional time it would take to be added through another alternative access site. Should the VA not
participate in access point, they may refer veterans not eligible for VA services to the system through a physical access site or call-in hotline.

**Victims of Domestic Violence**

Victim and non-victim Access Point-participating agencies prioritize safety and equitable access to housing and services for households who are fleeing or attempting to flee domestic violence, dating violence, sexual assault or stalking, while ensuring participant choice is upheld.

While victim service providers operate specialized housing and services targeted to consumers who are experiencing domestic violence, Access Point participants should have access to the full range of housing and services available within the CoC, including projects that are not dedicated to serving victims of domestic violence. Assistance to these consumers can be approached differently, depending on where the consumer presents for service:

When presenting at a DV-specific project:

Should the consumer experiencing DV desire to participate in other special needs housing projects rather than a DV-specific project, the victim service provider will administer the standard, CoC-approved assessment process and contact the regional access site to provide a client identification number and assessment score to establish the consumer’s placement on the Queue. The DV project will maintain a paper copy of the assessment and prioritization tools and will not enter any assessment data into HMIS or CMIS.

When presenting at an access site:

Consumers who present at an access site and indicate they are a survivor of domestic violence, dating violence, sexual assault, or stalking may be immediately referred to a domestic violence provider for a safety assessment if they desire to do so. If the consumer wants the option to participate in the full range of housing and services available within the CoC, the access site may also administer the assessment with the consumer’s consent.

The access site will maintain the assessment outcomes for all DV households for the purpose of managing a centralized DV Queue, outside of the HMIS (the system chosen by the CoC to manage the CES), in order to prioritize for placement. DV providers will contact the access site upon the expected availability of a slot in their project to receive a referral to fill the opening.

**Youth**

All referrals for young adults, age 18 – 24, must be screened and assessed.

Young adults who present through Access Point, or at emergency shelters, will be referred to a access site to receive an assessment. The access site and other Access Point-participating agencies may consult with expert providers of this population when conducting intake to properly match consumers and providers, and reduce the risk of flight for this highly vulnerable population.

If the assessment results in the consumer not being referred to services provided by specialized young adult agencies, the access site will proceed with prioritization and placement in the Queue.

**Attachment**

- Exhibit 6: CoC Access Sites
Section 6: Assess

The purpose of the Assess phase is to confirm that those seeking homelessness assistance services are potentially eligible for such services, resources are maximized and used as efficiently as possible, homeless persons are provided with a recommendation on housing types that meet their needs, and enough information is collected to properly prioritize consumers according to the orders of priority adopted by the CoC. The Assess phase consists of pre-screening, diversion, screening and housing assistance, homelessness prevention and the World Health Organization’s (WHO) Quality of Life scale. Each assessment will collect only as much information as is necessary for its purpose and the stage each consumer is navigating.

Pre-Screening

The pre-screening process is meant to assist in identifying consumers that are homeless or at risk of homelessness, and may potentially be eligible for homelessness assistance program resources. This process will also attempt to maximize HUD-funded homelessness assistance by leveraging the services available by other Federal, state, and local programs and funding sources. These mainly include funding for veterans, youth, and survivors of domestic violence.

Policy

Pre-Screening Assessments may be administered by any agency, volunteer, or stakeholder, including access points. Those who are found to be potentially eligible to participate in a homelessness assistance project will be referred to the access point for a screening and assessment. Those who would not be eligible for homelessness assistance resources should be directed to other service or housing resources (e.g., affordable or subsidized housing projects). Those who are potentially eligible for homelessness assistance through Access Point or other partnering programs should be connected to the appropriate site through a warm hand-off from the referring agency. Specialized consumers (DV, youth, veteran) may be connected to a specialized agency; however, consumers are not required to be routed through another source prior to an access point performing the intake process.

Process

The Collaborative Applicant will create and make available outreach materials, including brief pre-screening questions (Exhibit 7), system process information, and housing options. Materials will be distributed through the regional Access Point Committee representative or access point staff to the Regional Coalitions. Coalition members will be asked to distribute Access Point information and materials to community stakeholders - agencies, offices, projects, and systems that frequently serve homeless persons or those at risk of homelessness. Pre-screening questions can be used by stakeholder agencies to help direct consumers to emergency shelters and the local access point if they intend to connect with the access point in person. If they intend to connect remotely, the referring agency should assist the consumer in connecting with an access point remotely and relay the assessments responses to access point staff.

The access point staff will be engaging consumers in person or by phone, and either through referral from elsewhere in the community (with pre-Screening Assessment) or as the first point of contact to address their homeless circumstance. The Intake Specialist will provide a quick overview of the Access Point with each consumer and explain what data will be requested, how it will be shared, with whom it will be shared, and what the consumer’s rights are regarding the use of the consumer’s data. The Intake Specialist will be responsible for ensuring consumers are informed of their data confidentiality rights. Prior to collecting any information the Intake Specialist must review and explain the Access Point Privacy Notice and Release of Information (Exhibit 8). This must be reviewed and completed prior to data collection and entry by access point staff. If the consumer visited the access site in person, the Privacy Notice and Release of Information will be signed. If the consumer is connecting with the access site via telephone, a data information statement will be read and verbal acknowledgment will be indicated in HMIS. The Access Point intake staff will then move onto the screening and diversion phase.

Access point operating hours will be publicly posted to inform the applicant and referring agency of the most appropriate time to connect with the access point.
**Screening and Diversion**

Diversion occurs during the second phase of assessment, following pre-screening. Once consumers are determined to be potentially eligible for services through the pre-screening process, it is necessary to evaluate each consumer’s type and extent of need. Screening is performed through an assessment *(Exhibit 9)* that includes diversion tactics. Diversion is intended to divert consumers from homelessness assistance if at all possible by assisting them in avoiding shelter stays without providing financial assistance. Examples of diversion include budget/financial counseling, staying with friends or family, and mediating strained landlord-tenant relationships, among other efforts. This strategy should occur at all stages of interaction and engagement with potential consumers to avoid the traumatic event of entering the homelessness services system or to locate interim housing options until permanency and/or stability can be achieved by the consumer without financial assistance. Pre-screening that will occur with some referral agencies is considered a form of diversion, in the sense that valuable staff time can be preserved and maximized by reducing the number of inappropriate contacts fielded. Updated resource lists will be managed and distributed to assist in this effort. The additional, deeper layer of diversion will occur at access sites where consumer data collection will be initiated. If diversion is not possible, the screening will assess whether a consumer is in need of homelessness prevention services or other housing services.

In a broad sense, the diversion strategy deployed by Access Point assumes the philosophy that any safe, decent, and sanitary housing situation outside of the homelessness response system is a better placement than temporary housing offered by the system. This strategy prevents homelessness and avoids other traumatizing circumstances associated with the loss of housing.

**Policy**

Administering the Screening Assessment is only done by access sites; however, an attempt to divert will be made in all circumstances and based on alternative housing support options not on vulnerability, length of time homeless, or service need. Staff administering the assessment and counseling persons seeking assistance should be trained in diversion strategies and methods. Access point staff will encourage those who are precariously housed and at risk of homelessness to mitigate and resolve relationship disputes and seek assistance from friends and family. Diversion may occur as many times as is possible and appropriate. Diversion practices will not supersede a consumer’s right to enter Access Point or participate in a project should they desire to do so.

No one who has indicated they are unsafe or in danger should be encouraged to remain in place. Those who have indicated they are in danger should be referred to a victim service provider.

If diversion is not successful, desired, or appropriate, access point staff will complete the screening process. The remaining portion of the assessment will determine the type of assistance needed by the household, those options being homelessness prevention or housing assistance. Consumers deemed appropriate and potentially eligible for homelessness prevention will have the Homelessness Prevention Assessment administered *(Exhibit 10)*. Consumers deemed appropriate and potentially eligible for medium to long-term homelessness housing services will complete the Housing Assistance Assessment and have the WHO Quality of Life administered to them. *(Exhibit 11)*.

Access Point staff to train on administering and scoring these tools, as well as the order in which they should be administered.

**Process**

Consumers will present to the Access Point by phone or in person and assessed with the Crisis Needs Assessment (Pre-assessment). If the consumer is potentially eligible for services, they will go on to the Screening component of the Homeless Assistance assessment. This process will include an attempt at diverting the consumer from participating in homelessness assistance services if possible and appropriate. Standard, universally-used diversion practices will be adopted to determine if the consumer can resolve their circumstances without participating in a program that provides financial assistance. This strategy and questioning is built into the Screening component. Should diversion be effective, the consumer’s resolution will be recorded and no further assistance will be necessary. Depending on the referring
agency’s level of participation in Access Point, diversion may be carried out prior to connecting the consumer to an access site. If the consumer cannot be, or does not desire diversion, the whole Screening Assessment component will be completed. The Screening component will evaluate the consumers housing history and will continue on the Housing Assistance assessment. If a client is found to need Prevention services, then they would complete the Homelessness Prevention Assessment.

Data and information collected from the Screening component/Housing Assistance assessment, Homelessness Prevention Assessment, and Vulnerability and Service Needs Assessment must be collected and entered into HMIS, with the exception of victim service providers who are required to use a comparable database. Separate guides and instructions on HMIS use, consumer privacy, and release of information consent will be referenced in Section 10: HMIS and Data Sharing.

Homelessness Prevention

Many people who are at risk of homelessness may still have an opportunity to remain in their current housing situation or may need to transition to a new housing setting without experiencing homelessness. In light of this, the incorporation of homelessness prevention strategies (the offering of a financial resource that prevents an at risk household from becoming homeless, whether by remaining in place or moving directly into other housing) is a key component of the fight to prevent and end homelessness. As required by funding source, this type of assistance is reserved for consumers at imminent risk of homelessness. Those who meet this eligibility criterion will undergo an assessment.

Homelessness prevention provides housing retention or placement opportunities to consumers that are at risk of homelessness. This is done through financial services and supports, and may require participation in a program at times. Examples of homelessness prevention include Idaho Department of Health and Welfare Navigator funds, PATH financial assistance, and Emergency Solutions Grant funds with this specific purpose. This strategy will occur after diversion strategies have been attempted but prove unsuccessful or not appropriate. Because no one demographic or condition, nor any combination thereof, has yet been shown to correlate with a reliable probability of becoming literally homeless, homelessness prevention assistance should be used in a strategic and targeted manner. Prior to receiving homelessness prevention assistance, consumers will be assessed to determine their service needs. The assessment to be used is the Homelessness Prevention Assessment.

Policy

Those who are recommended for homelessness prevention due to their at risk status, after attempting diversion, will be assessed to determine 1.) If they have an eviction notice requiring them to leave their home in 14 days of less, or 2.) they have a shut off notice requiring them to vacate in 14 days or less, and 3.) the household falls below the 30% AMI threshold.

While access point staff will attempt to administer the Homelessness Prevention Assessment to all those seeking this type of assistance, answering the questions is not required in order to receive assistance. A consumer may decline to answer assessment questions; however, priority for assistance will be based on assessment outcomes. Case conferencing will be used to account for missing information to determine one’s placement in the Queue for homelessness prevention.

In order to manage the prevention services grant the funding administrator may wish to limit the number of people they can serve each month. If homelessness prevention funds are not expensed at a rate consistent with budgeted projections, the funding administrator may choose to remove the monthly limit of household prevention assistance. This would be done in an effort to ensure full expenditure of funds by program yearend. If the monthly limit is temporarily removed then the order for offering assistance to consumers will be based on date and time accessing Access Point.

Resources for homelessness prevention are designed to support consumers with few barriers and the means to be stably housed going forward. In an effort to disburse program funds in an equitable and consistent manner, homelessness prevention providers may limit the number of monthly referrals received from Access Point.

Process

Access point staff begins this process already having engaged with consumers through the Crisis Needs assessment (pre-screen) and the screening component of the Housing Assistance Assessment. Once homelessness prevention is identified
as the necessary intervention and the consumer is deemed potentially eligible, access point staff administers the Homelessness Prevention Assessment. Data and information collected may be entered into HMIS real-time or at a later date. Staff will know immediately whether the consumer has met the minimum threshold score.

**Homelessness Housing Services**

This path of Access Point incorporates the remaining variety of homelessness housing programs and component types, including, at a minimum, Continuum of Care, Emergency Solutions Grant, and Low Income Housing Tax Credit, which offer rapid re-housing and permanent supportive housing. The recommendation and offering of housing will be based on the length of time homeless and the orders of priority adopted by the CoC in these Operating Procedures. The World Health Organization’s Quality of Life (QOL) Assessment tool will be administered to evaluate the severity of service needs. The assessment results will be used to assist consumers in making an informed decision on the housing and service options that align with their needs and in which programs they may wish to participate. The QOL result will be used to assist in informing the prioritization of consumers on the Queue.

**Policy**

Only access point staff and the system administrator will be allowed to administer the QOL tool to consumers seeking assistance. All access point staff must complete training prior to administering the assessment. The system administrator will be responsible for tracking the completion of training of all access point staff members tasked with administering housing assessments. While access point staff will attempt to administer assessments on all those seeking this type of assistance, answering the questions is not required to receive assistance. A consumer may decline to answer assessment questions; however, completing the assessment will assist in connecting the consumer to services to meet their needs. The results of the QOL assessment will be used in part to prioritize consumers on the Queue.

**Process**

Access point staff begins this process already having engaged with consumers through the pre-screening process. Consumers, who are potentially eligible for homelessness housing services, are not diverted, and who do not participate in prevention services will undergo a QOL to evaluate their severity of service need. The assessment will be administered by access point staff. The assessment asks a broad range of questions about health, wellness, and service needs; and is helpful in evaluating the type of housing assistance that may be most appropriate. Data and information collected may be entered into HMIS real-time or at a later date.

Prioritization will be based on the QOL, a number of vulnerability-related questions, and consumer’s length of time homeless. A Housing Assessment will be conducted to gather additional information from the client before placing them on the housing queue.

**Real-Time Data Entry**

Regions that make a collective commitment to real-time consumer data entry and/or real-time housing inventory must enter information on a regular and frequent basis. Real-time data entry must be completed within 48 hours of the information being collected. Real-time housing inventory tracking must be updated at the end of each business day. In the absence of a commitment to real-time entry, data entry must comply with the CoC’s weekly entry requirement.
Section 7: Assign

Once consumers have been connected with the system, found to be potentially eligible for Access Point-participating programs, and participated in various types of assessments through the Access and Assess stages, the Assign phase is carried out. The purpose of this phase of the system is to identify a housing intervention that offers housing and services consistent with the consumer’s needs and offer available housing first to those with the greatest need. This process is accomplished through:

1) Creating a Queue, or list, of potentially eligible consumers;

2) Ordering the Queue in such a way that prioritizes homeless persons based on greatest need;

3) Offering housing units, as they become available, to the highest priority consumer;

4) Housing consumers in housing interventions that appropriately meet their needs while allowing choice and flexibility in their participation; and

5) Convening case conferences at a regional or community level to address the needs of those not receiving a housing offering by coordinating with broader community resources.

February 2023
Subject: Notice on Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing

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Purpose

This Notice supersedes Notice CPD-14-012 and provides guidance to Continuums of Care (CoC) and recipients of Continuum of Care (CoC) Program (24 CFR part 578) funding for permanent supportive housing (PSH) regarding the order in which eligible households should be served in all CoC Program-funded PSH. This Notice reflects the new definition of chronically homeless as defined in CoC Program interim rule as amended by the Final Rule on Defining “Chronically Homeless” (herein referred to as the Definition of Chronically Homeless final rule) and updates the orders of priority that were established under the prior Notice. CoCs that previously adopted the orders of priority established in Notice CPD-
In June 2010, the Obama Administration released Opening Doors: Federal Strategic Plan to Prevent and End Homelessness (Opening Doors), in which HUD and its federal partners set goals to end Veteran and chronic homelessness by 2015, and end family and youth homelessness by 2020. Although progress has been made there is still a long way to go. In 2015, the United States Interagency Council on Homelessness extended the goal timeline for achieving the goal of ending chronic homelessness nationally from 2015 to 2017. In 2015, there were still 83,170 individuals and 13,105 persons in families with children that were identified as chronically homeless in the United States. To end chronic homelessness, it is critical that CoCs ensure that limited resources awarded through the CoC Program Competition are being used in the most effective manner and that households that are most in need of assistance are being prioritized.

Since 2005, HUD has encouraged CoCs to create new PSH dedicated for use by persons experiencing chronic homelessness (herein referred to as dedicated PSH). As a result, the number of dedicated PSH beds funded through the CoC Program for persons experiencing chronic homelessness has increased from 24,760 in 2007 to 59,329 in 2015. This increase has contributed to a 30.6 percent decrease in the number of chronically homeless persons reported in the Point-in-Time Count between 2007 and 2015. Despite the overall increase in the number of dedicated PSH beds, this only represents 31.6 percent of all CoC Program funded PSH beds.

To ensure that all PSH beds funded through the CoC Program are used as strategically and effectively as possible, PSH needs to be targeted to serve persons with the highest needs and greatest barriers towards obtaining and maintaining housing on their own—persons experiencing chronic homelessness. HUD's experience has shown that many communities and recipients of CoC Program-funded PSH continue to serve persons on a “first-come, first-serve” basis or based on tenant selection processes that screen-in those who are most likely to succeed while screening out those with the highest level of need. These approaches to tenant selection have not been effective in reducing chronic homelessness, despite the increase in the number of PSH beds nationally.

The overarching goal of this Notice is to ensure that those individuals and families who have spent the longest time in places not meant for human habitation, in emergency shelters, or in safe havens and who have the most severe service needs within a community are prioritized for PSH. By ensuring that persons with the longest histories of homelessness and most severe service needs are prioritized for PSH, progress towards the Obama Administration's goal of ending chronic homelessness will increase. In order to guide CoCs in ensuring that all CoC Program funded PSH beds are used most effectively, this Notice revises the orders of priority related to how persons should be selected for PSH as previously established in Notice CPD-14-012 to reflect the changes to the definition of chronically homeless as defined in the Definition of Chronically Homeless final rule. CoCs are strongly encouraged to adopt and incorporate them into the CoC’s written standards and coordinated entry process.

HUD seeks to achieve two goals through this Notice:

1. Establish a recommended order of priority for dedicated and prioritized PSH which CoCs are encouraged to adopt in order to ensure that those persons with the longest histories residing in places not meant for human habitation, in emergency shelters, and in safe havens and with the most severe service needs are given first priority.

2. Establish a recommended order of priority for PSH that is not dedicated or prioritized for chronic homelessness in order to ensure that those persons who do not yet meet the definition of chronic homelessness but have the longest histories of homelessness and the most severe service needs, and are therefore the most at risk of becoming chronically homeless, are prioritized.
C. Applicability

The guidance in this Notice is provided to all CoCs and all recipients and subrecipients of CoC Program funds—the latter two groups referred to collectively as recipients of CoC Program-funded PSH. CoCs are strongly encouraged to incorporate the order of priority described in this Notice into their written standards, which CoCs are required to develop per 24 CFR 578.7(a)(9), for their CoC Program-funded PSH. Recipients of CoC Program funds are required to follow the written standards for prioritizing assistance established by the CoC (see 24 CFR 578.23(c)(10)); therefore, if the CoC adopts these recommended orders of priority for their PSH, all recipients of CoC Program-funded PSH will be required to follow them as required by their grant agreement. CoCs that adopted the orders of priority established in Notice CPD-14-012, which this Notice supersedes, and who received points for having done so in the most recent CoC Program Competition are strongly encouraged to update their written standards to reflect the updates to the orders of priority as established in this Notice. Lastly, where a CoC has chosen to not adopt HUD’s recommended orders of priority into their written standards, recipients of CoC Program-funded PSH are encouraged to follow these standards for selecting participants into their programs as long as it is not inconsistent with the CoC’s written standards.

D. Key Terms

1. Housing First. A model of housing assistance that prioritizes rapid placement and stabilization in permanent housing that does not have service participation requirements or preconditions for entry (such as sobriety or a minimum income threshold). HUD encourages all recipients of CoC Program-funded PSH to follow a Housing First approach to the maximum extent practicable.

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

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

   i. lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

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

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

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

3. Severity of Service Needs. This Notice refers to persons who have been identified as having the most severe service needs.

   (a) For the purposes of this Notice, this means an individual for whom at least one of the following is true:

   i. History of high utilization of crisis services, which include but are not limited to, emergency rooms, jails, and psychiatric facilities; and/or

   ii. Significant health or behavioral health challenges, substance use disorders, or functional impairments which require a significant level of support in order to maintain permanent housing.
iii. For youth and victims of domestic violence, high risk of continued trauma or high risk of harm or exposure to very dangerous living situations.

iv. When applicable CoCs and recipients of CoC Program-funded PSH may use an alternate criteria used by Medicaid departments to identify high need, high cost beneficiaries.

(b) Severe service needs as defined in paragraphs i.-iv. above should be identified and verified through data-driven methods such as an administrative data match or through the use of a standardized assessment tool and process and should be documented in a program participant’s case file. The determination must not be based on a specific diagnosis or disability type, but only on the severity of needs of the individual. The determination cannot be made based on any factors that would result in a violation of any nondiscrimination and equal opportunity requirements, see 24 C.F.R. § 5.105(a).

II. Dedication and Prioritization of Permanent Supportive Housing Strategies to Increase Number of PSH Beds Available for Chronically Homeless Persons

A. Increase the number of CoC Program-funded PSH beds that are dedicated to persons experiencing chronic homelessness. Dedicated PSH beds are those which are required through the project’s grant agreement to only be used to house persons experiencing chronic homelessness unless there are no persons within the CoC that meet that criteria. If there are no persons within the CoC’s geographic area that meet the definition of chronically homeless at a point in which a dedicated PSH bed is vacant, the recipient may then follow the order of priority for non-dedicated PSH established in this Notice, if it has been adopted into the CoC’s written standards. The bed will continue to be a dedicated bed, however, so when that bed becomes vacant again it must be used to house a chronically homeless person unless there are still no persons who meet that criterion within the CoC’s geographic area at that time. These PSH beds are also reported as “CH Beds” on a CoC’s Housing Inventory Count (HIC).

B. Prioritize non-dedicated PSH beds for use by persons experiencing chronic homelessness. Prioritization means implementing an admissions preference for chronically homeless persons for CoC Program-funded PSH beds. During the CoC Program competition project applicants for CoC Program-funded PSH indicate the number of non-dedicated beds that will be prioritized for use by persons experiencing chronic homelessness during the operating year of that grant, when awarded. These projects are then required to prioritize chronically homeless persons in their non-dedicated CoC Program-funded PSH beds for the applicable operating year as the project application is incorporated into the 7 grant agreement. All recipients of non-dedicated CoC Program-funded PSH are encouraged to change the designation of their PSH to dedicated, however, at a minimum are encouraged to prioritize the chronically homeless as beds become vacant to the maximum extent practicable, until there are no persons within the CoC’s geographic area who meet that criteria. Projects located in CoCs where a sub-CoC approach to housing and service delivery has been implemented, which may also be reflected in a sub-CoC coordinated entry process, need only to prioritize assistance within its specified area. For example, if a Balance of State CoC has chosen to divide the CoC into six distinct regions for purposes of planning and housing and service delivery, each region would only be expected to prioritize assistance within its specified geographic area. 1 The number of non-dedicated beds designated as being prioritized for the chronically homeless may be increased at any time during the operating year and may occur without an amendment to the grant agreement. III. Order of Priority in CoC Program-funded Permanent Supportive Housing The definition of chronically homeless included in the final rule on “Defining Chronically Homeless”, which was published on December 4, 2015 and went into effect on January 15, 2016, requires an individual or head of household to have a disability and to have been living in a place not meant for human habitation, in an emergency shelter, or in a safe haven for at least 12 months either continuously or cumulatively over a period of at least 4 occasions in the last 3 years. HUD encourages all CoCs adopt into their written standards the following orders of priority for all CoC Program-funded PSH. CoCs that adopted the orders of priority established in Notice CPD-14-012, which this Notice supersedes, and who received points for having done so in the most recent CoC Program Competition are strongly encouraged to update their written standards to reflect the updates to the orders of priority as established in this Notice. Where a CoC has chosen to not incorporate HUD’s recommended orders of priority into their written standards, recipients of CoC Program funded PSH are encouraged to follow these standards for selecting participants into their programs as long as it is not inconsistent with the CoC’s written standards. As a reminder, recipients of CoC Program-funded PSH are required to prioritize otherwise eligible households in a nondiscriminatory manner. Program implementation, including any prioritization policies, must be implemented consistent with the
nondiscrimination provisions of the Federal civil rights laws, including, but not limited to the Fair Housing Act, Section 504 of the Rehabilitation Act, Title VI of the Civil Rights Act, and Title II or III of the Americans with Disabilities Act, as applicable. For example, while it is acceptable to prioritize based on level of need for the type of assistance being offered, prioritizing based on specific disabilities would not be consistent with fair housing requirements or program regulations. 1 For the State of Louisiana grant originally awarded pursuant to “Department of Housing and Urban Development—Permanent Supportive Housing” in chapter 6 of title III of the Supplemental Appropriations Act, 2008 (Public Law 110–252; 122 Stat. 2351), projects located within the geographic area of a CoC that is not the CoC through which the State is awarded the grant may prioritize assistance within that geographic area instead of within the geographic area of the CoC through which the State is awarded the grant.

A. Prioritizing Chronically Homeless Persons in CoC Program-funded Permanent Supportive Housing Beds Dedicated or Prioritized for Occupancy by Persons Experiencing Chronic Homelessness

1. CoCs are strongly encouraged to revise their written standards to include an order of priority, determined by the CoC, for CoC Program-funded PSH that is dedicated or prioritized for persons experiencing chronic homelessness that is based on the length of time in which an individual or family has resided in a place not meant for human habitation, a safe haven, or an emergency shelter and the severity of the individual’s or family’s service needs. Recipients of CoC Program-funded PSH that is dedicated or prioritized for persons experiencing chronic homelessness would be required to follow that order of priority when selecting participants for housing, in a manner consistent with their current grant agreement.

2. Where there are no chronically homeless individuals and families within the CoC’s geographic area, CoCs and recipients of CoC Program-funded PSH are encouraged to follow the order of priority in Section III.B. of this Notice. For projects located in CoC’s where a sub-CoC approach to housing and service delivery has been implemented, which may also be reflected in a sub-CoC coordinated entry process, need only to prioritize assistance within their specified sub-CoC area.

3. Recipients of CoC Program-funded PSH should follow the order of priority above while also considering the goals and any identified target populations served by the project. For example, a CoC Program-funded PSH project that is permitted to target homeless persons with a serious mental illness should follow the order of priority under Section III.A.1. of this Notice to the extent in which persons with serious mental illness meet the criteria. In this example, if there were no persons with a serious mental illness that also met the criteria of chronically homeless within the CoC’s geographic area, the recipient should follow the order of priority under Section III.B for persons with a serious mental illness.

4. Recipients must exercise due diligence when conducting outreach and assessment to ensure that chronically homeless individuals and families are prioritized for assistance based on their total length of time homeless and/or the severity of their needs. HUD recognizes that some persons—particularly those living on the streets or in places not meant for human habitation—might require significant engagement and contacts prior to their entering housing and recipients of CoC Program-funded PSH are not required to allow units to remain vacant indefinitely while waiting for an identified chronically homeless person to accept an offer of PSH. CoC Program-funded PSH providers are encouraged to follow a Housing First approach to the maximum extent practicable. Therefore, a person experiencing chronic homelessness should not be forced to refuse an offer of PSH if they do not want to participate in the project’s services, nor should a PSH 2 For the State of Louisiana grant originally awarded pursuant to “Department of Housing and Urban Development—Permanent Supportive Housing” in chapter 6 of title III of the Supplemental Appropriations Act, 2008 (Public Law 110–252; 122 Stat. 2351), projects located within the geographic area of a CoC that is not the CoC through which the State is awarded the grant may prioritize assistance within that geographic area instead of within the geographic area of the CoC through which the State is awarded the grant. 9 project have eligibility criteria or preconditions to entry that systematically exclude those with severe service needs. Street outreach providers should continue to make attempts to engage those persons that have been resistant to accepting an offer of PSH and where the CoC has adopted these orders of priority into their written standards, these chronically homeless persons must continue to be prioritized for PSH until they are housed.
B. Prioritizing Chronically Homeless Persons in CoC Program-funded Permanent Supportive Housing Beds Not Dedicated or Not Prioritized for Occupancy by Persons Experiencing Chronic Homelessness

1. CoCs are strongly encouraged to revise their written standards to include the following order of priority for non-dedicated and non-prioritized PSH beds. If adopted into the CoCs written standards, recipients of CoC Program-funded PSH that is not dedicated or prioritized for the chronically homeless would be required to follow this order of priority when selecting participants for housing, in a manner consistent with their current grant agreement.

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

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

(b) Second Priority—Homeless Individuals and Families with a Disability with Severe Service Needs.

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

(c) Third Priority—Homeless Individuals and Families with a Disability Coming from Places Not Meant for Human Habitation, Safe Haven, or Emergency Shelter Without Severe Service Needs.

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

(d) Fourth Priority—Homeless Individuals and Families with a Disability Coming from Transitional Housing.

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

2. Recipients of CoC Program-funded PSH should follow the order of priority above, as adopted by the CoC, while also considering the goals and any identified target populations served by the project. For example, non-dedicated or non-prioritized CoC Program-funded PSH that is permitted to target youth experiencing homelessness should follow the order of priority under Section III.B.1. of this Notice, as adopted by the CoC, to the extent in which youth meet the stated criteria.

3. Recipients must exercise due diligence when conducting outreach and assessment to ensure that persons are prioritized for assistance based on their length of time homeless and the severity of their needs following the order of priority described in this Notice, and as adopted by the CoC. HUD recognizes that some persons—particularly those living on the streets or in places not meant for human habitation—might require significant engagement and contacts prior to their entering housing and recipients are not required to keep units vacant indefinitely while waiting for an identified eligible individual or family to accept an offer of PSH (see FAQ 1895). Recipients of CoC Program-funded PSH are encouraged to follow a Housing First approach to the maximum extent practicable. Street outreach providers should continue to make attempts to engage those persons that have been resistant to accepting an offer of PSH and where the CoC has adopted these orders of priority into their written standards, these individuals and families must continue to be prioritized until they are housed.
IV. Using Coordinated Entry and a Standardized Assessment Process to Determine Eligibility and Establish a Prioritized Waiting List

A. Coordinated Entry Requirement

Provisions at 24 CFR 578.7(a)(8) requires that each CoC, in consultation with recipients of Emergency Solutions Grants (ESG) program funds within the CoC’s geographic area, establish and operate either a centralized or coordinated assessment system (referred to in this Notice as coordinated entry or coordinated entry process) that provides an initial, comprehensive assessment of the needs of individuals and families for housing and services. CoCs that adopt the order of priority in Section III of this Notice into the CoC’s written standards are strongly encouraged to use a coordinated entry process to ensure that there is a single prioritized list for all CoC Program-funded PSH within the CoC. The Coordinated Entry Policy Brief, provides recommended criteria for a quality coordinated entry process and standardized assessment tool and process. Under no circumstances shall the order of priority be based upon diagnosis or disability type, but instead on the length of time an individual or family has been experiencing homelessness and the severity of needs of an individual or family.

B. Written Standards for Creation of a Single Prioritized List for PSH

CoCs are also encouraged to include in their policies and procedures governing their coordinated entry system a requirement that all CoC Program-funded PSH accept referrals only through a single prioritized list that is created through the CoCs coordinated entry process, which should also be informed by the CoCs street outreach. Adopting this into the CoC’s policies and procedures for coordinated entry would further ensure that CoC Program-funded PSH is being used most effectively, which is one of the goals in this Notice. The single prioritized list should be updated frequently to reflect the most up-to-date and real-time data as possible.

C. Standardized Assessment Tool Requirement

CoCs must utilize a standardized assessment tool, in accordance with 24 CFR 578.3, or process. The Coordinated Entry Policy Brief, provides recommended criteria for a quality coordinated entry process and standardized assessment tool.

D. Nondiscrimination Requirements

CoCs and recipients of CoC Program-funded PSH must continue to comply with the nondiscrimination provisions of Federal civil rights laws, including, but not limited to, the Fair Housing Act, Section 504 of the Rehabilitation Act, Title VI of the Civil Rights Act, and Titles II or III of the Americans with Disabilities Act, as applicable. See 24 C.F.R. § 5.105(a).

V. Recordkeeping Recommendations for CoCs that have Adopted the Orders of Priority in this Notice

24 CFR 578.103(a)(4) outlines documentation requirements for all recipients of dedicated and non-dedicated CoC Program-funded PSH associated with determining whether or not an individual or family is chronically homeless for the purposes of eligibility. In addition to those requirements, HUD expects that where CoCs have adopted the orders of priority in Section III. of this Notice into their written standards. The CoC, as well as recipients of CoC Program-funded PSH, will maintain evidence of implementing these priorities. Evidence of following these orders of priority may be demonstrated by:

A. Evidence of Severe Service Needs. Evidence of severe service needs is that by which the recipient is able to determine the severity of needs as defined in Section I.D.3. of this Notice using data-driven methods such as an administrative data match or through the use of a standardized assessment. The documentation should include any information pertinent to how the determination was made, such as notes associated with case conferencing decisions.

B. Evidence that the Recipient is Following the CoC’s Written Standards for Prioritizing Assistance. Recipients must follow the CoC’s written standards for prioritizing assistance, as adopted by the CoC. In accordance with the CoC’s adoption of 12 written standards for prioritizing assistance, recipients must in turn
document that the CoC’s revised written standards have been incorporated into the recipient’s intake procedures and that the recipient is following its intake procedures when accepting new program participants into the project.

C. Evidence that there are no Households Meeting Higher Order of Priority within CoC’s Geographic Area.

(a) When dedicated and prioritized, PSH is used to serve non-chronically homeless households, the recipient of CoC Program-funded PSH should document how it was determined that there were no chronically homeless households identified for assistance within the CoC’s geographic area. Or for those CoCs that implement a sub-CoC 3 planning and housing and service delivery approach, the smaller defined geographic area within the CoC’s geographic area – at the point in which a vacancy became available. This documentation should include evidence of the outreach efforts that had been undertaken to locate eligible chronically homeless households within the defined geographic area and, where chronically homeless households have been identified but have not yet accepted assistance, the documentation should specify the number of persons that are chronically homeless that meet this condition and the attempts that have been made to engage the individual or family. Where a CoC is using a single prioritized list, the recipient of PSH may refer to that list as evidence.

(b) When non-dedicated and non-prioritized PSH is used to serve an eligible individual or family that meets a lower order of priority, the recipient of CoC Program-funded PSH should document how the determination was made that there were no eligible individuals or families within the CoC’s geographic area - or for those CoCs that implement a sub-CoC planning and housing and service delivery approach, the smaller defined geographic area within the CoC’s geographic area - that met a higher priority. Where a CoC is using a single prioritized list, the recipient of PSH may refer to that list as evidence that there were no households identified within the CoC’s geographic area that meet a higher order of priority.

Prioritization

In accordance with HUD Notice CPD-16-11, HUD funding priorities, and homelessness assistance program strategies, offered through Access Point will be prioritized. The adoption of a prioritization method is a strategic approach to move closer to preventing and ending homelessness. Those who are most vulnerable and have the most severe service needs are the most likely to consume the most public costs and experience continued homelessness or re-entry into homelessness. Housing these persons first, particularly in permanent supportive housing, will alleviate the resource burden elsewhere thereby making shorter-term resources available to those who can be permanently re-housed with little utilization of resources. Homelessness assistance programs are the last result prior to entering homelessness or one of very few options available to help become housed.

Orders of Priority

To assure consistent identification and placement of the most vulnerable persons, the orders of priority presented below have been adopted by the IHCC. The order will be based on vulnerability, with three different components to determine scoring The Homelessness Prevention Assessment will determine the extent of need for homelessness prevention.

Consumers seeking services through Access Point are served and scored in a non-discriminatory manner. Program and system implementation and operations are carried out in a manner consistent with nondiscrimination provisions of the Federal civil rights laws, including, but not limited to the Fair Housing Act, Section 504 of the Rehabilitation Act, Title V of the Civil Rights Act, and Title II or III of the Americans with Disabilities Act, as applicable.

Access Point uses the following criteria and score from the Housing Assistance assessment to appropriately identify consumers with the greatest need and aid them in quickly accessing the most appropriate housing intervention for them:

Four vulnerability questions:
- Is anyone in the household pregnant?/Are there children in the household? Two points for being pregnant or two points for children under the age of six or one point for a child aged 6-17.
- Anyone in the household over the age of 62? One point
- Accessed emergency services: accessed five or more times in the last six months
Police Contact: three or more arrests or run-ins with the police in a six-month period

Length of Time:
- Looking back over the client’s lifetime, how many months have they been homeless?
- For every month they have been homeless, up to 12 months, they receive one point. If they have been homeless for more than a year, they receive a single point for each year homeless.

World Health Organization’s (WHO) Quality of Life survey:
- 25 questions
- Intake staff will ask the question of the client and mark the answers
- The amount of deviation away from the median score will be captured in report

Should these orders of priority sort the Queue in such a manner that multiple individuals and/or families are similarly located at the top of the list, the date when the Head of Household first entered the system will be used to determine who will receive the referral.

Emergency Shelter

Individuals and families may enter emergency shelter settings without the requirement to be referred through an access site, nor will shelter be required to prioritize persons seeking shelter; however, whenever possible and appropriate, shelter providers should attempt diversion strategies for all consumers seeking shelter services. Shelter staff should assist consumers in connecting with a local access site to either begin or continue the assessment process.

Wait List Integration

HUD-funded homelessness service providers with consumers on a waiting list for housing upon implementation of Access Point on January 22, 2018 may maintain their waiting list and continue to place consumers from the list into their housing projects through March 23, 2018. After March 23, 2018, open units may only be filled through referrals from the Access Point system.

Service providers with consumers on a wait list for housing should notify those consumers of a change in the process to obtain housing assistance. Consumers should be advised that available units will be filled from the agency’s current wait list until March 23, 2018. Providers should encourage consumers on the wait list to contact the Access Point in their region to complete the assessment process to ensure the consumer’s placement in the prioritized Queue.

Program Eligibility

The orders of priority provide only an initial layer of participation selection. However, this does not guarantee eligibility for the project that has an opening when the consumer reaches the top of the Queue, nor does it guarantee an offering of placement into housing. Additional eligibility screening must occur to ensure the consumer meets each funder’s eligibility requirements prior to participating in a program.

Policy

Eligibility will be driven by each funding stream’s regulations, including the IHCC’s Written Standards. Each funding stream has its own definition of homelessness and other eligibility requirements. Participating agencies must submit all eligibility criteria to the system administrator prior to participating in Access Point. Any changes to a program’s eligibility criteria or target population must be sent to the system administrator immediately to make sure the referral protocol is updated accordingly. Consumers will be screened for only the most basic eligibility criteria (e.g., homeless status, income, special population type, etc.). Projects may enact policy that restricts participation of consumers who have posed an extreme threat to the health or safety of the project’s staff or other project participants.

Process
When a project participating in Access Point expects or experiences a unit opening, they will contact the access site to inform them of the opening. At this point the Queue will be updated and sorted to apply the order of priority. At this time the eligibility sorting must occur to ensure referrals are made to appropriate projects where the consumer will be potentially eligible. After the referral has been made, the consumer will undergo more in depth eligibility screening with the housing or service provider. More information on this process is outlined under the Housing Offering heading.

**Housing Referral**

Up to this point, the consumer has connected with an access point, experienced a phased assessment process, has been presented with a summary of housing interventions, received a recommendation for housing placement, and has been placed in the Queue. The consumer is now selected to be offered a housing referral based on the orders of priority and certain eligibility criteria upon the opening of a housing unit. The Housing Referral process informs the consumer of the housing opening and determines the consumer’s desire to participate in the identified project. If the consumer is agreeable, they are referred out to the project. **It is prohibited for any HUD homelessness assistance program funded project to accept clients through any means other than through referral from Access Point, with emergency shelters being the sole exception.** Other participating agencies and programs are encouraged to fully participate in Access Point and utilize the system’s Queue to fill program openings.

This policy and process applies to both the Homelessness Prevention and Homeless Housing Services.

**Policy**

Projects aware of a current or upcoming unit opening will contact the local access point. Prior to making a referral, the access site staff will make contact with the consumer to reaffirm their desire to participate in a homelessness housing project and to receive approval for their information to be shared with the receiving project. If permission is granted, a referral will be executed by the access point and it will then be the project’s responsibility to make contact with the consumer to execute the eligibility intake process.

**Process**

A participating project will contact the local access site staff to notify them of a vacant or soon to be vacant unit. The access site then contacts the consumer using the contact information listed in HMIS. The access site should contact the consumer within one business day of being made aware of the unit opening. If the consumer cannot be reached and they provided an alternative contact and release, the access site may contact the alternative representative (e.g., family, shelter, services programs, etc.). The access site will make at least 3 attempts over the following 3 business days to contact the consumer or an authorized representative. If the access site is unsuccessful in contacting the consumer or an authorized representative, the consumer will remain in the Queue; however, the access site may proceed in contacting the next highest priority consumer in the Queue.

Once contact has been made with the consumer, the access site will make them aware of the availability of a housing unit. The Intake Specialist will check to see if the consumer has previously declined a housing referral offer. If they have, the consumer needs to be notified that this is the final opportunity to accept prior to having to re-enter Access Point. Participation in the project cannot be promised as that responsibility lies with the receiving project. The consumer is simply being made aware of the referral about to occur and is being asked for consent to share the consumer’s information with the receiving project.

Should the consumer decline the sharing of their HMIS profile with the receiving project, the consumer will remain on the list until they are prioritized for a future unit. The consumer should be made aware that the offering of housing at this time does not guarantee that they are first in line for the next available unit. Housing offerings are made to the consumer at the top of the Queue at the time the access site becomes aware of the unit opening.

Should the consumer accept the housing referral and has provided written consent to having their information shared with the receiving project, they will be made aware that the receiving project will contact them within 3 business days. The receiving project must make at least 3 attempts to contact the consumer over at least 3 business days. If the receiving project is not successful in contacting the consumer, they will ask the access site to assist. If timing is appropriate, the
receiving project may also decide to conference the inability to contact the consumer at the next case conference session. The housing referral process will be recorded in HMIS.

**Declined Referral**

Access Point offers consumer choice. This allows a consumer to decline the offering of a housing referral. Regardless of the reason, the consumer may choose to remain in the Queue rather than be referred to a receiving project.

**Policy**

To reduce administrative burden and to create more opportunity for those with a desire to participate in a housing project, a consumer may only decline an offering of a housing referral once. If the second referral offering is declined the consumer will be removed from the Queue. If removed, the consumer may choose to pursue participation in Access Point at any time in the future without limitation. An exception to this policy may be made when a consumer declines a housing referral that is outside their geographic area. Consumers may have a lack of transportation resources and difficulty traveling and, therefore, are not required to accept a housing referral when the available unit is outside their geographic area.

**Process**

The Intake Specialist at the access site will offer a housing referral to the consumer at the top of the Queue when a unit is available or becoming available. This denial is one-time decision specific to the offer being made and does not apply to future unit openings. Should a future offer of a housing referral be made, the Intake Specialist must remind the consumer that this is the last offering prior to having to re-enter Access Point to access housing in the future.

Should the consumer elect not to accept the housing referral offer, the Intake Specialist will notify the consumer of their removal from the Queue. The client record must be notated with the consumer decision and resulting action.

Consumers may at times receive a referral to an available unit which is located outside their geographic region. Should the consumer elect to decline a housing referral outside their area, they shall retain their position on the Queue and their client record shall be maintained in the HMIS project list.

Should a consumer request to relocate outside the region, the Intake Specialist at the access site should notify the system administrator who will then notify the receiving access site.

**Post-Referral**

Following the housing referral, the receiving project will perform an eligibility screening process. Upon the collection of necessary documentation, or the lack thereof, the receiving project will make an eligibility determination.

**Policy**

Remaining consistent with the IHCC’s Written Standards and housing first principles, receiving project access criteria should be considered low-barrier. Eligibility should entail just the most basic program requirements. Receiving projects may deny entry due to a consumer’s failure to meet basic program eligibility requirements. Each receiving project rejecting a referral must record the reason for denial within the client’s HMIS records. The written denial must identify the reason for denial and provide an opportunity to appeal, along with the process to request an appeal of the decision to deny admittance.

**Process**

The receiving project will contact the consumer prioritized for the available unit. The consumer will be informed of all eligibility requirements. For PSH and RRH, if the consumer indicates they are eligible and the project reasonably believes them to be, the consumer will be entered into the project in HMIS. Documentation is not required at this time; however, the project should begin working with the consumer to obtain any required documentation. Once all available documentation and certifications have been submitted to the receiving project, they will assess whether the consumer is eligible to participate.
If the consumer is eligible, the receiving project will accept the referral. For PSH and RRH, once the consumer has found housing, a move-in date should be recorded and the Intake Specialist will exit the consumer from the Access Point Queue and the Access Point Housing Assessment Project. For TH, a project entry is not initiated until the consumer has moved into a residence. Once the consumer has moved into housing, the Intake Specialist will exit the consumer from the Access Point Queue and the Access Point Housing Assessment Project.

If the consumer is not eligible, the receiving project must issue a written denial. The receiving project will provide the consumer with the opportunity to appeal. If an appeal is requested, the project will initiate the appeal process. If the appeal is overturned, the consumer will be admitted to the project. Once the Intake Specialist sees that the referral has been accepted and the consumer was admitted to the receiving project, they will exit the consumer from the CES Queue.

Rejected Referrals and Grievance Procedures

The rejection of housing referrals is a process that must be monitored closely and regularly. All consumers have a right to housing and deserve the opportunity to exercise that right. An unmonitored system would be unable to enforce the housing first principles adopted in the IHCC's Written Standards, which emphasizes one’s right to housing. Furthermore, consumers should be afforded the opportunity for review to ensure activities are carried out in accordance with these Operating Procedures.

Policy

The rejection may be the result of an improper referral from Access Point or due to a determination by the receiving agency to deny the consumer’s admittance to the project. If the rejection is in response to a denial of eligibility determination, the receiving project must inform the consumer of the determination in writing. The written notice must detail that an opportunity for appeal exists, the process to pursue such an appeal, clear deadlines for action the consumer is required to take, and the agency’s point of contact for this process. Each agency must have their own grievance procedures that adhere to HUD grievance process requirements. The receiving project may not request another Access Point referral from the access site until the grievance process has concluded.

The system administrator will be responsible for monitoring referral rejections. The reasons for rejections will be discussed within the IHCC’s Access Point Committee. Committee members will work to resolve procedural inadequacies that may cause an inappropriate referral. Further, should it be determined that receiving projects are making eligibility determinations not in accordance with the Written Standards, the system administrator will inform the program administrator of the failure to abide by the Written Standards. The system administrator will act appropriately within their administrative authority to address the non-compliance.

Participating agencies will have an opportunity to submit grievances to the system administrator. The system administrator will have the authority to make universal administrative decisions if a policy does not currently exist to address the circumstance at hand. If the grievance requires the enactment of a new policy or adjustment to a current policy, the system administrator will include the grievance in Committee discussion. When necessary, the Committee will respond through policy recommendations that will be reviewed annually by the IHCC Board prior to adoption into these Operating Procedures.

All customer service complaints should be directed to the immediate supervisor within the agency of the staff member for which the complaint is about. The agency employing the staff member will be responsible for addressing the complaint.

Process

The access site sends the highest priority consumer to the receiving project who has indicated a unit opening exists or will exist. If during the intake process the receiving project identifies that information used by Access Point to pre-screen eligibility was inaccurate, the consumer information should be updated and the referral rejected. The receiving project will call the access site and make them aware of the rejection. The access site will generate the Queue listing, identify the next prioritized potentially eligible households, and send a referral to the receiving project. This process is carried out only if the incorrect information would alter the Screening score such that another household would have been prioritized.
higher or the correct circumstances do not meet basic eligibility requirements (gender, disability, income, etc.)- not to include criminal history.

If, during the intake process, the receiving project makes a determination to deny admittance due to screening criteria or circumstances outlined in the Housing First section of the Written Standards, the receiving project will issue a written notice to the consumer. The project will wait until the grievance response period has expired, or if a grievance is submitted, the grievance process has concluded, prior to rejecting the referral. If the determination stands and a rejection is processed, the receiving project will contact the access site to request a new referral. The system administrator will collect all rejections on a case by case basis and present them to the program administrator. The Access Point Committee will also be notified. The Committee will determine whether disciplinary action in addition to that taken by the program administrator is required. If so, a recommendation for action will be submitted by the Committee to the IHCC Board. The Board will review the recommendation at the next regularly scheduled Board meeting.

Circumstances where the receiving agency denial is the result of one of the following, the receiving agency will follow the process for rejecting a referral based on inaccurate information:

1. The request for referral was based on the anticipation of a unit opening that is no longer anticipated.

2. The household presents with more members than referred by Access Point and the project doesn’t have space for all of the participants in the household. In this situation, the consumer household should be offered the option of having a portion of their household participate in the receiving project. This would require the remaining household members to initiate a new household profile in the CES.

Queue Management

As an outgrowth of an IHCC goal, Access Point is intended to reduce the length of time Idahoans remain homeless. Thus, the Queues must not remain static for an extended period of time. In an effort to accomplish this goal, and considering the fact that the QOL is utilized as a point-in-time assessment tool, assessment information of each individual and family who remain in the Queue should be updated regularly.

Policy

Queue updates will take place quarterly, and the system administrator will make every effort to have the regional access points perform this activity quarterly (every 90 days). The updating of information is not required and is the decision of the consumer; however, participating agencies are required to attempt to contact consumers to obtain updated information, or confirm information listed is still accurate. The system administrator- the party responsible for updating assessment information- will make at least two (2) attempts to contact the consumer household by phone.

Consumers who remain on the list whose contact information becomes outdated and cannot be reached will no longer remain active in the Queue. Being removed from the list in no way prohibits a consumer from accessing Access Point again to be placed in the Queue.

Process

To perform the Queue update, the regional access points will, on a monthly basis, generate a report from HMIS listing all consumer households in the Queue. All consumers whose profile and assessment information have not been updated in the past 90 days will be included in the update. The regional access point will attempt calling each consumer. If the attempt to contact is successful, the access point will review profile and assessment information to confirm it is up to date. The consumer will remain in the Queue, and the access point staff will move on to the next households to be contacted.

If the attempt to contact is not successful, the system administrator will make one additional attempt within 5 business days. Upon no response, the consumer will be officially removed from the Queue. If the consumer responds after the deadline, they will be required to begin the process again and participate in a new assessment for placement on the Queue.
Attachment

- Exhibit 14: Sample CES Queue Removal Letter
Section 8: Accountability

This phase of Access Point is necessary to monitor operational efficiencies, adherence to IHCC policy and strategic goals, and the systematic improvements in preventing and ending homelessness. The main components of the Accountability phase are monitoring, case conferences, and regular data reporting and analysis. Monitoring will exist as a multi-faceted oversight function of Access Point. The system administrator, access sites, and participating agencies will experience some form of monitoring. A host of stakeholders will be involved in carrying out these activities, including the program administrator, the system administrator, the Access Point Committee, the IHCC Board, and local case conference members.

Coordinated Entry System Goals and Guiding Principles

Access Point goals and guiding principles are restated here to promote their inclusion in the Accountability phase.

Goals

1. Provide ease of access to community resources to those in need.
2. “Right-size” resource allocations to reflect the needs of persons experiencing homelessness and those at risk of homelessness.
3. Increase system uniformity while remaining considerate of community and regional needs.
4. Align all Federal programs and other services for the homeless to maximize resources and meet Opening Doors strategic goals.
5. Reduce first time homelessness, length of time homeless and returns to homelessness by providing the most needed and appropriate services to each community and individual seeking assistance.

Guiding Principles

1. Transparency: Process is visible and community driven. Everyone is accountable and responsible to the system; the system is accountable to those it serves.
2. Evidence-based & Data-driven: Decisions are based on data, evidence, accountability, and assessment, and used to determine the type and extent of needs of the individual.
3. Trauma-informed & Participant-centered: Access Point processes are dignified, empathetic, responsive, and support self-determination, with a focus on offering services that fit specific needs.
4. Promote Equitable Allocation of Resources: Allocation of resources is strategy-oriented, intentional and determined by performance outcomes.
5. Streamlined Processes: System is as easy to navigate as possible.
6. Low-barrier, Housing First Approach: To the extent possible, housing placements are based on need, not on program eligibility. Housing placement is offered as quickly as possible.
7. Ongoing Evaluation of Resources & Data: Ensure that data quality and resource allocation for the system is functional and meet state led performance measures.
8. Prioritization: Those with the longest history of homelessness and of the greatest need receive housing resources first.
Monitoring

Access Point monitoring activities will be carried out by the system administrator and IHFA’s Compliance Department. The administrator will be responsible for ensuring access site and participating agency adherence to these Operating Procedures. Other monitoring activities will exist within the routine activities of the IHCC Committees with assignments related to the operations and outcomes of Access Point.

Policy

The system administrator will be granted the authority by the IHCC to routinely (at least annually) monitor each access site’s and participating project’s compliance with Access Point policy and procedures. This monitoring may occur remotely or on-site depending on capacity to do so and HMIS functionality. Furthermore, the agency employing the system administrator may choose to contract out all or some of this monitoring responsibility. Each participating agency being monitored must comply with the full process, including making necessary information and documents available, responding to monitor findings, and making appropriate corrections to workflow, document, or other operational activities.

Additionally, other oversight activities will occur on a more regular basis (monthly or quarterly) to promote more immediate improvements to system efficiency, client access to Access Point and housing, and the collaboration among participating providers. Annually, Coordinated Entry will conduct a survey of clients, providers, and stakeholders as well as administer a self-assessment among the six Access Point staffs. Information gained through participation in these activities will be used to adjust and improve Coordinated Entry services.

Process

Whether monitoring occurs on-site or remotely, annually or more frequently, the following will be evaluated:

1. Access Sites
   a. Full provision of coverage occurs across the access sites region
   b. Evidence of ADA accessibility and LEP compliance
   c. Adequate staffing capacity
   d. Appropriate expenditure of CoC grant funds
   e. Accurate assessment of consumer households
   f. Adherence to Access Point policies, procedures, and HMIS workflow
   g. Participation in case conferences
   h. HMIS data quality and completeness
   i. Quality of customer service
   j. Complying with all information and data security and confidentiality protocols
   k. Other areas deemed appropriate and/or necessary by the system administrator or Access Point Committee

2. Receiving Projects
   a. Adopting housing first practices as outlined in the Written Standards
   b. Adherence to HMIS workflow and Access Point policy and procedures
   c. Rapidly re-housing consumers referred to the project

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d. Only accepting Access Point consumer referrals into the project.

e. Participating in case conferences

f. Other areas deemed appropriate and/or necessary by the system administrator

If on-site monitoring is to occur, or if the participating agencies will be required to supply documents for review, the system administrator will provide written notice of at least 30 days. If necessary, a finding letter will be issued. In such instances when a findings letter has been issued, providers will be required to respond within 30 days of the receipt of issuance of the letter.

The collaborative applicant, with input from the Access Point Committee, will monitor the activities and performance of the system administrator to ensure compliance with Federal guidelines, adherence to program policies and procedures, and the execution of the duties and responsibilities of the position.

**Case Conferences**

The main objective of case conferencing is to create housing placement action plans for consumers who have remained on the Queue without a housing offering within the past 60 days; assess and report on operations and efficiency improvements; investigate reasons for any referral denials that have occurred; execute cross-regional offerings of housing; and announce changes to Access Point.

**Policy**

To respond to this need, Case Conferences will be conducted in each region on a regular basis. Regions may choose to further segment this effort by forming multiple Case Conference groups to account for the large geographic area of each region, or the variety in populations or project types. Each Case Conference group may determine the regularity in which they meet; however, conferences will occur no less than every other month. The regional access site will coordinate and facilitate these conferences. Participants may include, access site staff, participating Access Point agencies, PATH Peer Specialists, Navigators, referring agencies, community stakeholders, housing and service providers, and other closely associated resource administrators. The system administrator will also participate in all regional Case Conferences. Local participants of the Case Conference may choose to assume the coordination and facilitation responsibility, if desired.

Those involved in Case Conferences will provide the facilitator with information relating to difficulties in finding suitable housing for those searching, the impact non-existent or limited resources have on successfully housing individuals, and policy-level changes believed to improve the crisis response system developed for our CoC’s most vulnerable citizens. The system administrator will share the concerns and recommendations discussed during Case Conferences with the Access Point Committee.

Despite the efforts to prioritize those being offered a placement into a housing project using the orders of priority established in these Operating Procedures, the system will allow for some flexibility and establishment of precedence in nuanced and unique circumstances not addressed in these procedures.

The system administrator or access site Intake Specialist will attend the Case Conference prepared to discuss consumers in the Queue who are close to being referred out and are in need of assistance to prepare for an intake process, those who have been denied housing by receiving projects, and others who have remained in the Queue for more than 60 days. Case Conference members will discuss ways to provide the consumer with other community supports and resources to end or alleviate the current housing crisis. Due to limited time and resource availability, the Case Conference group may want to establish a limit on the number of consumers in the region in the TH, RRH, and PSH Queues to be discussed in each conference.

Case Conferences may also be an environment in which housing providers can discuss consumers who are at risk of being terminated from participating in a program. Such pre-emptive activities will help those at risk of homelessness from becoming homeless and entering Access Point for the first time or even re-entering the system.

All discussion and work will be carried out with a Housing First approach and philosophy.
Process

The access site Intake Specialist will secure a location for the Case Conference to take place. The facilitator (access site Intake Specialist) will prepare the reports and agenda necessary to accomplish the goals of the Case Conferences, including referral rejections, consumers in the Queue, and grievances or comments concerning Access Point workflow. Participating agencies will prepare to discuss consumers who may potentially be terminated from their housing program and their assessment of the Access Point processes. The Case Conference will take place. The Intake Specialist will ensure all changes needing to be made in the HMIS are completed.

If the referral rejection list or Case Conference process reveals that an agency may have unnecessary barriers to entry that are not bound to local law or strict funders’ requirements, such policies may be reviewed by the Access Point Committee. In the spirit of affirmatively furthering fair housing, if the Access Point Committee has a concern that a program’s requirements may be contributing to “screening out” or excluding consumers from needed services, the Committee may request to meet with the provider to discuss their criteria. The Access Point Committee will provide information about the results of this conversation to the IHCC Board to incorporate into the CoC application process and program administrator with a recommendation to alter the criteria.

Data Reporting, Analysis and System Planning

Regular system reporting and analysis must occur to promote continued policy and process improvement and action in response to system outcomes. The majority of this work will be carried out by the system administrator with analysis and recommendation support from IHCC Committees and stakeholders.

Policy

The system administrator will, on a regular basis (no less than quarterly), monitor system outcomes, including, but not limited to:

1. Wait times for initial contact
2. The extent to which the established timelines are met
3. Number/percentage of referrals that are accepted by receiving programs
4. Rate of missed appointments for scheduled assessments
5. Number/percentage of persons declined more than once
6. Number/percentage of eligibility denial appeals- enforced, overturned
7. Completeness and quality of data at assessment and intake
8. Number of persons in the Queue
9. Number/percentage of returns to homelessness
10. Permanency of diversion
11. Permanency of homelessness prevention
12. Number of consumers reaching each stage of Access Point

Process

The system administrator will pull aforementioned reports on a regular basis. The report will be made available to the Access Point Committee and program administrator to evaluate. Other Committees, such as Strategic Planning and DCR&E may be asked to analyze the data as well. The Committee will discuss areas in need of improvement or that are not
producing intended results. Based on the data analysis, the Committee may develop policy revision recommendations, which will then be placed before the Board for a vote.

In addition, the system administrator will conduct an annual system performance and planning workshop with Access Point Committee members and community stakeholders, including homelessness service providers and at least one individual or family who has been, or is currently, engaged in Access Point. The system data and planning session input will be used to evaluate system performance and the need for process and/or policy modifications to improve outcomes.
Section 9: Fair Housing

Access Point adheres to the ideals of affirmatively furthering fair housing. Consumers are provided choice in their housing offerings and placements.

All participating agencies are required to comply with applicable civil rights and fair housing laws and requirements. Moreover, all participating agencies must comply with nondiscrimination and equal opportunity provisions of Federal civil rights laws, including:

1. The Fair Housing Act which prohibits discriminatory housing practices based on race, color, religion, sex, national origin, disability, or familial status;

2. Section 504 of the Rehabilitation Act which prohibits discrimination on the basis of disability under any program or activity receiving Federal financial assistance;

3. Title VI of the Civil Rights which prohibits discrimination on the basis of race, color, or national origin under any program or activity receiving Federal financial assistance;

4. Title II of the American with Disabilities Act which prohibits public entities, which include State and local governments, and special purpose districts, from discriminating against individuals with disabilities in all their services, programs and activities, which include housing and housing-related services such as housing search and referral assistance; and

5. Title III of the Americans with Disabilities Act which prohibits private entities that own, lease, and operate places of public accommodation, which include shelters, social service establishments, and other public accommodations providing housing, from discriminating on the basis of disability.

Access Point does not use data collected from the assessment process to discriminate or prioritize consumers 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.

The Access Point referral process is informed by Federal, State, and local Fair Housing laws and regulations, and ensures consumers are not steered toward any particular housing facility or neighborhood because of race, color, national origin, religion, sex, disability, or the presence of children.

All Access Point participating agencies must use the system in a transparent manner that is consistent with fair housing law and the statutes and regulations that govern their housing programs. The system administrator will request a tenant selection plan from each receiving project, in addition to any funding contract that requires or allows a specific subpopulation of persons to be served. It is further understood that the Fair Housing Act recognizes that a housing provider may seek to fulfill its “business necessity” by narrowing focus on a subpopulation within the homeless population. The system may allow filtered searches for subpopulations while preventing discrimination against protected classes. Not allowing such a filter would force receiving projects to operate outside of their mission.

Access Point adheres to all other nondiscrimination regulations included in 24 CFR 5.105(a), 24 CFR 578.93, 24 CFR 576.407(a) and (b), and 24 CFR 576.603, for the respective programs.

Reasonable Accommodation

Consumers have the right to request a reasonable accommodation as an exception to a policy or practice. A reasonable accommodation is a change, exception, or adjustment to a rule, policy, practice, or service. Such accommodation is not perceived as special treatment, but rather, providing equal opportunity in the use and enjoyment of Homeless Connect that would otherwise not be possible without said accommodation.
Policy

To be approved for a reasonable accommodation, the consumer must be a person with a disability and must demonstrate that a nexus between the disability and the request exists. To grant a reasonable accommodation, administrative processes may be instituted to confirm the consumer meets the disability threshold and a disability-related need for the accommodation exists. Accommodation requests may be made verbally or in writing. Should a request be made verbally, the participating agency staff will document the request in writing to ensure future clarity and consistency in responding to the request. Reasonable accommodations will be evaluated on a case by case basis considering whether the consumer requesting the accommodation is a person with a disability, whether there is a disability-related need for the accommodation, whether the request poses an undue financial burden on Homeless Connect, and whether it would fundamentally alter the nature of Access Point operations.

Process

Any participating agency may be asked to initiate the reasonable accommodation process. They will determine whether the request is in regard to the Access Point system or the receiving Access Point project or agency. If a request is made verbally, the staff member will document the request in writing. If the consumer is requesting an exception to the Access Point policy or process, the participating agency staff will forward the reasonable accommodation request to the system administrator, accompanying the request with contact information and any relevant supporting documentation. The system administrator will work to verify disability and the need for the accommodation. Based on the factors listed above and through the counsel of the Collaborative Applicant, the system administrator will render a decision on the accommodation. A written determination will be issued and the participating agency staff will be provided instruction on how to proceed. The consumer’s HMIS file will be documented and the accommodation documentation will be retained by the system administrator.

Consumers may appeal the decision.

Nondiscrimination Complaint

Any consumer who believes discriminatory actions have taken place against them may file a nondiscrimination complaint to the access site. The access site will inform the system administrator of such complaint. The two parties will work together, with the support and input from the Access Point Committee if needed, to investigate the complaint and ensure the consumer is treated fairly and equally.

Policy

Consumers must be made aware that they have the ability to file a nondiscrimination complaint. Consumers may submit a complaint verbally or in writing at any time to any participating agency. Complaints regarding participating agency staff should be addressed by the managing official at the participating agency. The system administrator will, however, be made aware of all discrimination complaints. The Access Point Committee will be made aware of any discrimination complaint that may exist. If the complainant is a member of the Committee, they may not participate in the Committee discussion regarding the complaint except to provide a personal account of the situation to be considered in the review. The Collaborative Applicant and Access Point Committee will work with the participating agency to address the complaint.

Process

Once a complaint is received it will be directed to the attention of the manager of the person for which the complaint is concerning, the system administrator, and the Collaborative Applicant. The system administrator will share the complaint with appropriate Access Point Committee members. The complaint is to be reviewed by the agency the complaint concerns as well as the Committee and Collaborative Applicant. All parties will work to address the complaint in a respectful, compliant, and expeditious manner. The consumer will be issued a response from either the participating agency or the system administrator on behalf of the Committee, Collaborative Applicant, or both within 30 days. Section 10: HMIS and Data Sharing.

The Homeless Management Information System (HMIS) is a locally-administered information system used to record and analyze consumer, service and housing data for individuals and families who are homeless or at risk of homelessness. The
Idaho HMIS is administered by Idaho Housing and Finance Association (IHFA), an Idaho independent body corporate and politic, in partnership with the Idaho Balance of State Continuum of Care (CoC), to operate as the HMIS Lead agency. The Idaho HMIS requires all agencies who participate in HMIS to enter into a HMIS Service Provider Contract (Exhibit 15) that outlines the terms and conditions of participation in HMIS. Such agencies are referred to as Affiliated Service Providers.

Access Point will operate within the CoC’s HMIS to store consumer’s demographic data and assessment information so that they do not have to endure duplicative assessments by providers. HMIS will be used to record assessments, manage the Queue, and generate reports. All Access Point access points must be HMIS Affiliated Service Providers. As expressed in Section 5: Assess, these agencies may administer assessments and the outcomes of the assessments will be entered into HMIS. The data will be used to carry out a prioritization process which will in turn be used to inform program placements.

The CoC recognizes the benefits of an open, shared database while clearly respecting and protecting the privacy of consumer level data. Access Point will abide by and comply with the Terms and Conditions as set forth in the HMIS Service Provider Contract. As System Administrator of the HMIS and custodian of data, IHFA shall have access to all Access Point project and consumer information.

Access Point will have a system administrator, access site intake staff, and designated users as authorized by the IHFA as the Collaborative Applicant through the authority designated by the IHCC. The system administrator and designated Access Point users will have full access to the client-level data entered in HMIS for the purposes of the Access Point system. Access to some data in HMIS may be further restricted according to the needs and requirements of the system. Information entered into HMIS for Access Point will only be shared with Affiliated Service Providers by permission from the consumer or the consumer’s guardian/representative in the form of a signed HMIS Privacy Notice and Release of Information (ROI).

The following data sharing policy will guide the handling and sharing of sensitive information collected by participating Access Point agencies and entered into HMIS.

**Access Point Client Consent**

- IHFA’s HMIS Lead has an unlocked by default policy for client files in the HMIS system.
- There is a Privacy Notice that must be given to consumers to read or the Access Point staff can read the privacy notice to the client.
- Verbal denial must be given by consumers in order to keep their information private.
- Consumers may not be denied services for which they are otherwise eligible based on their privacy choice and request not to share their information in HMIS with other Affiliated Service Providers. However, this does not restrict the ability of the provider serving the consumer to collect and enter data in the HMIS (while restricting sharing access) with informed consent to meet program reporting requirements.
- Consumers may change their mind and opt to not have their file open.
- Unless needed for project eligibility, information concerning physical or mental health problems will not be shared with any other Affiliated Service Provider other than the HMIS Lead, the system administrator, the Access Point Access Point agency, unless authorized by the consumer.

**Access Point System Administrator**

- System Administrator will be appointed by IHFA through authority granted by the IHCC to the Collaborative Applicant.
- System Administrator will be required to attend training in the use of HMIS and Access Point system activities prior to system access.
- System Administrator will operate within the guidelines of the HMIS Service Provider Contract and the HMIS Policy & Procedures.
- System Administrator will abide by all federal, state and local confidentiality and privacy regulations and laws that protect client records accessed or entered into the HMIS.
- System Administrator shall ensure that all Access Point staff, volunteers and other persons accessing HMIS data...
for the Access Point system receive confidentiality training on the use of HMIS and applicable confidentiality laws.

**Access Point Agency**

- Access Point agencies must sign a Memorandum of Understanding with the HMIS lead agency that dictates how consumer level data is managed within the system.
- Access Point agencies must operate within the guidelines of the HMIS Service Provider Contract and the HMIS Policy and Procedures.
- Access Point agencies must have a current signed HMIS Service Provider Contract with the HMIS Lead. The Access Point agency agrees to comply with all of the terms and conditions incorporated as part of the contract.
- Access Point agencies’ HMIS users will be appointed by the Access Point agency.
- Access Point agencies shall limit HMIS user access based upon need. Need exists only for program staff working directly with consumers or with the system administrator, administering the assessment tools, and data entry or data-related responsibilities.
- Access Point agencies’ HMIS users will be required to attend training in the use of HMIS and system activities prior to coordinated entry implementation.
- The consumer-level information at the Access Point agencies must be kept separate in HMIS from any other project that the agencies administer unless authorized by the client.
- Access Point agencies are responsible for providing a verbal explanation of the HMIS Privacy Notice and Release of Information to the consumer or consumer’s guardian and must keep the signed ROI form on file for a period of 6 (six) years.
- Access Point agencies shall not transfer any rights or obligations to another entity without the written consent of the Collaborative Applicant and HMIS Lead.
- Access Point agencies shall enter information into the HMIS database within the entry timeframe established by the region, but not longer than one week from collection. The recommended entry time is within 48 hours. All data entry must be completed for the month no later than the 5th day of the following month.

**Access Point Client Assessment**

Data will be collected on everyone that is assessed through the Access Point system as outlined in the Access Point HMIS Work Flow (Exhibit 16). In order to identify potentially eligible consumers with the greatest need and highest priority, multiple assessment tools are used, including a Screening Assessment, Homelessness Prevention Assessment, and the Vulnerability and Service Needs Assessment. Additional consumer-level information and assessments will be collected and entered into HMIS as deemed necessary by the system administrator, Access Point Committee, IHCC, Collaborative Applicant, Federal partners, and/or the HMIS Lead. Such information shall be limited to the data needed to fully administer the Access Point project; report on system improvements, outcomes, efficiency; and for research or reporting as required by Federal partners.

Consumer responses to the Vulnerability and Service Needs Assessment tool will be entered into HMIS but will not be shared without express written permission of the client.

Access Point agencies’ HMIS Users will be required to attend training on administering the assessment tools prior to entry into HMIS.

**Access Point Client Information**

Consumer information may be collected and entered in phases as the consumer progresses through the Access Point process. All data entered into HMIS will conform to Universal Data Elements (UDEs) included in the HUD HMIS Data Standards Data Manual and additional data as may be necessary for coordinated entry. This consumer information may include, but is not limited to:

- Name
- SS#
- Veteran Status
Consumer information may be shared only with written consent from the consumer.

Please note:

- Every consumer served in Access Point will be entered into HMIS, except those seeking domestic violence specific services.
- All consumers will sign an Authorization to Share Information Between Agencies (Exhibit 17), which allows agencies to coordinate services. This is different from the HMIS Privacy Notice and Release of Information.
- Consumers who decline to sign either of these consent forms will be placed on the Access Point Queue using a unique identifier number, but will not be prioritized.
- If the Consumer refuses to sign the release forms, it should be noted on the form that the privacy notice was explained but the consumer refused to sign.

Attachments

- Exhibit 15: HMIS Service Provider Contract
- Exhibit 16: Access Point HMIS Workflow
- Exhibit 17: Authorization to Share Information Between Agencies
Section 11: Training

One of the key elements of Access Point is consistency of practices so that all consumers attempting to access the system and resources across the state have the same experience regardless of the access site or location. This can only be accomplished through standardized and on-going training available to all participating agencies and staff. Access Point will make regular training available to participating agencies or those potentially interested in participating.

Training Plan

The system administrator will host an annual training. The delivery method used may be in-person or virtual. The training must be attended by at least one participating agency representative. This training will be recorded and made available for broader use throughout the state. Training will occur prior to participation in Access Point and regularly thereafter.

The system administrator and HMIS Lead will work with each access point to provide HMIS training. It is recommended that the training occurs at the same time as the regional Access Point training.

Initial Training

Training will include, at a minimum:

1. Access Point Goals and Guiding Principles
2. Access Point Overview
3. Access Point Process
4. Participation Requirements
5. Screening & Assessment Process
6. DV, Youth and Other Special Populations
7. Orders of Priority
8. Referrals
9. Confidentiality and Fair Housing Laws
10. Reasonable Accommodation
11. Using the HMIS to carry out Access Point activities
12. Case Conferences
13. Other Pertinent Information

On-going Training

New users will be provided a hard copy of the Access Point Operating Procedures and all exhibits. Agencies may wish to use these materials to conduct supplemental training for new and/or existing staff as necessary and appropriate. The system administrator may record a training webinar for new staff, which can be sent to agencies as needed. If/when on-going trainings are held, training registration information will be emailed to all agencies participating in Access Point. Training materials will be available online.

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