MINNESOTA COORDINATED ENTRY SYSTEM

STATEWIDE STRATEGY

January 2016

(as approved by Coordinated Entry IDG on 1/8/2016)

Table of Contents

Coordinated Entry –What is it? Why is it important?

Coordinated Entry (CE) represents a CoC-wide process for facilitating access to CoC resources, identifying and assessing the needs of persons experiencing a housing crisis, and referring clients to the most appropriate service strategy or housing intervention. The most effective coordinated entry systems prioritize available resources based on an intentional strategy for achieving CoC goals while respecting clients' needs and preferences. Coordinated Entry represents a fundamental systems change for many CoCs – one in which individual homeless projects no longer make enrollment determinations independent of a CoC-wide strategy for allocating homeless assistance in the most effective manner possible. For many CoCs this means prioritizing all available homeless and housing assistance to persons with the greatest need who have historically experienced difficulty in accessing CoC projects. Provisions in HUD's CoC Program and Emergency Solutions Grant (ESG) interim rules require that CoCs establish Coordinated Entry Systems. Minnesota funders of homeless and housing assistance have also adopted the coordinated entry requirement for their grantees.

Statewide Strategy

Although each individual CoC in Minnesota must design and implement a coordinated entry system, CoC stakeholders and State homeless assistance funders recognize great benefit in establishing CE design principles that are consistently adopted and followed by all CoCs. While local factors such as client needs, provider capacity, resource availability, and geographic characteristics might require some amount of local, community-specific accommodation and customization, the State's CE Strategic Plan establishes guidelines for CE systems across the State that adhere to a common set of design principles and operating guidelines. This statewide strategy will ensure that clients experience consistency in the manner in which CoC resources are accessed, clients' needs are documented, and referrals are coordinated. In addition, a statewide approach to CE design and implementation enables the State to more consistently and accurately document needs across multiple CoC jurisdictions, allocate scares resources according to defined needs, and evaluate the effectiveness of Minnesota's crisis response systems.

Guiding Principles

1. **Adopt statewide standards** but allow flexibility for local customization beyond baseline standard.
2. **Promote client-centered practices** – Every person experiencing homelessness should be treated with dignity, offered at least minimal assistance, and participate in their own housing plan. CoCs will provide ongoing opportunities for client participation in the development, oversight, and evaluation of coordinated assessment. Participants should be offered choice whenever possible.
3. **Prioritize most vulnerable participants as the primary factor among many considerations** – Limited resources should be direct first to persons and families who are most vulnerable*. Less vulnerable persons and families will be assisted as resources allow.
   *Vulnerability will be defined locally.
4. **Eliminate barriers to housing placement** – Identify system practices and individual project eligibility criteria which may contribute to excluding participants from services and work to eliminate those barriers. Barriers could include conditions such as income or sobriety as eligibility requirements for enrollment.
5. **Transparency** – Make thoughtful decisions and communicate directives openly and clearly.

6. **Exercise continuous quality improvement efforts** – Continually strive for effectiveness and efficiency and agree to make changes when those objectives are not achieved.
7. Promote **collaborative and inclusive** planning and decision making practices.
8. **Diversity** – Acknowledge and honor tribal sovereignty; respect cultural, regional, programmatic, linguistic, and philosophical differences.
9. State and local communities will **use CE data to analyze local and statewide housing needs** and create a diversity of housing options.

CES Statement of Shared Governance

The State of Minnesota will establish a process for governance decisions in relation to CES design, implementation, management, and evaluation. Ongoing and longer-term governance will need to be defined as CES oversight structures mature, the HMIS project transitions to a State-managed leadership model, and CoCs develop greater experience with day-to-day management of CES operations. Future CES governance considerations will need to be addressed in subsequent CE planning discussions. Questions for consideration in those future discussions should include the following: which elements of CES decision making should be assigned to a new governing process (as yet undefined); how should joint, cross-CoC decisions be considered, made and communicated; who makes those decisions; and, how will accountability for joint decision making be monitored for adherence to CE guiding principles?

The state has established an interim decision making group to help shape and direct the planning and design work associated with CES up to the time of implementation, planned for October of 2015. A CES Interim Decision Group (IDG) shall be comprised of **16** representatives: one from each participating CoC, **1** representative from Tribal Nations, and **5** representatives from the State of Minnesota. The role of the IDG is to make decisions based on input from established committees regarding the implementation of CES, including system design; implementation planning and coordination; protocols and policies; performance and data; and CES system governance and statewide decision making.

Coordinated Entry System Definitions & Basic Requirements

Minnesota adopts the definition of ***coordinated entry system*** from the CoC Program interim rule:

> *CES means a centralized or coordinated process designed to coordinate program participant intake assessment and provision of referrals. A coordinated entry 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.*

The State of Minnesota's design of CES, building on the HUD/CoC definition, clarifies that CES refers to a State-adopted and CoC-approved process designed to simplify and coordinate program participant intake, assessment, and provision of referrals. The state will establish baseline requirements for CES design and operations and each CoC may adopt locally-specific practices as long as those approaches comport to the state approach. Each CoC must maintain written policies and procedures for the coordinated entry process that cover all of the following requirements:

Coverage

Each CoC must define the geographic area in which the CES operates. If the geography includes negotiated partnerships and/or collaborations with neighboring geographies or CoCs for purposes of expanding referral options, improving service coordination, and/or defining data sharing options, the nature of those relationships with other geographies/CoCs must be explicitly

identified and defined in the written policies and procedures.

Fair and Equal Access

Each CoC must ensure that all persons experiencing homelessness in the CoC's CES geographic area have fair and equal access to the coordinated assessment process. To ensure easy access by individuals with disabilities, physical and communication accessibility barriers must be addressed. Coordinated entry must be easy for a potential participant to access crisis response services, whether in person, by phone, or some other method. Coordinated Entry locations must be accessible to people with disabilities. If individuals must be present to receive screening and/or assessment services, the location must be easily accessible by public transportation, or there must be another method by which individuals can easily access it.

The location or method that a person uses to access crisis response services must not negatively impact the services offered to that person or the referral made by the CES provider.

The coordinated entry process must be linked to existing CoC funded outreach efforts, if applicable, so that people served by an outreach worker are prioritized for assistance in the same manner as any other person assessed through coordinated assessment.

A coordinated entry process must include all subpopulations: persons experiencing chronic homelessness, Veterans, families, single adults, youth, survivors of domestic violence, members of Tribal Nations, and GLBT persons. However, CoCs may only have different processes for accessing assessment, including different locations, for the following different populations:

- adults without children
- adults accompanied by children
- unaccompanied youth
- households fleeing domestic violence

Standardized Assessment Processes

The assessment process must be standardized, with uniform decision-making across all assessment locations and staff. If access points or assessment processes are conducted or managed by providers who do not receive HUD, State of Minnesota, or local county funds, those providers must still abide by assessment standards and protocols defined by the CoC.

All assessment tools and processes will incorporate the following elements:

- The assessment tool and process defined by the CoC must incorporate participant choice which may be facilitated by questions in the assessment tool or through other methods. Assessments shall include the person's housing and service preferences such as scattered-site or site-based housing, level of desired programming/structure (e.g. meals, activities, and groups), neighborhood and location, security preferences, sobriety preferences, and accessible housing for persons with disabilities.
- CoCs must include basic screening for non-CoC resources such as MA-funded services, mainstream housing subsidies and income supplements.
- A CoC may utilize more than one assessment tool. However, assessment tools must be implemented consistently across assessment locations and different staff performing assessments.
- The CoC must ensure that staffs administering assessments are trained in culturally and linguistically competent practices.

All assessment tools and processes must be ADA compliant. The legal requirements under the ADA require effective communication strategies that staff should employ to ensure effective communication is provided such as simple language, documents in alternate formats, and checking to ensure participants fully understand the questions being asked.

The CoC must ensure that privacy protections are in place to ensure the following:

- proper informed consent is obtained to administer an assessment and collect *personal protected information*, and
- participants provide written consent to all uses and disclosures of their *personal protected information*, and
- any sharing of *protected personal information* among CoC providers and among CoCs is accompanied by an authorized written consent for release of information obtained from the participant.

The CoC must ensure that written standards are established for data entry into HMIS to facilitate coordinated assessment management and evaluation.

The CoC must ensure that the CoC-defined coordinated entry system processes comply with civil rights requirements, including Fair Housing Act, Title VI of Civil Rights Act of 1964, and Section 504 of Rehabilitation Act of 1973, and that program participants are informed of rights and remedies available under applicable federal, state and local fair housing and civil rights laws, in accordance with the requirement at 24 CFR 578.93(d)(3). CoCs must ensure that people receiving assessments can freely refuse to answer questions without retribution or limiting their access to assistance.

CES Access Points

Access refers to the point of entry for persons experiencing a housing crisis and the point at which a CoC representative determines whether the homelessness assistance system is the appropriate intervention to assist the household in crisis. Access points and models throughout Minnesota will vary by number of access points, services offered at each access point and the type of entity that is responsible for the point of entry and decision-making that occurs there. ***However, any homeless assistance provider agency that serves persons who are homeless but is not a defined access point will only enroll clients who are referred from defined access points.***

Access Point providers could include operators of information and referral telephone hotlines (e.g., 2-1-1), emergency shelter programs, outreach service providers, community action agencies, and other County or community social service providers.

Responsibilities of CoC designated Coordinated Entry System Access Points:

1. Maintain open, fair, and equal access to crisis response services. Do not screen participants out for assistance because of perceived barriers to housing or services such as lack of employment, drug or alcohol use, disability status or having a criminal record.
2. Participants are assessed as quickly as possible without preconditions or service participation requirements in order to be assessed.
3. Offer a standardized access process and assessment approach among all designated CES Access Point providers. 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.
4. Designated Access Point providers may specialize in serving one particular subpopulation such as

domestic violence survivors, youth, or Veterans as long as all other subpopulations are provided access to crisis response services elsewhere within the CoC.

5. Initiate the CES process by conducting, at a minimum, an initial assessment screen to identify participants' needs and preferences. A full comprehensive participant assessment does not need to be administered by each Access Point provider for each participant as long as those services are available elsewhere within the CoC and accessible to persons with disabilities.
6. If a determination is made that crisis response services will be provided by a CoC provider agency the access point provider will collect enough participant data to initiate an HMIS record for the person or household (actual HMIS data entry may be completed by another, non-access point entity), or other comparable system if access point is a victim service provider.

CES Assessment Process

All Minnesota CoCs must adopt the state-defined approach for coordinated assessment, a phased approach that progressively captures information about participant needs and preferences based on defined stages of engagement and the CoC's ability to respond to participants' needs with available service and housing strategies. A standardized assessment tool with uniform assessment questions and response categories must be deployed in each CoC. CoCs are encouraged to expand and customize the state template to reflect locally relevant client characteristics and resource availability. The CES assessment process in use by each CoC must accommodate three (3) distinct stages or phases of assessment:

1. Triage/Diversion
2. Shelter (or crisis response services) Intake
3. Comprehensive Assessment
4. Re-Assessment

Minnesota will not prescribe the specific tools that must be used for each assessment stage or phase, but each CoC must adopt the ***Vulnerability Index – Service Prioritization Decision Assistance Tool*** (VI-SPDAT) as a component of the Comprehensive Assessment phase of assessment. CoCs may incorporate the VI-SPDAT into a locally defined process but must ensure a publicly available, well-crafted, comprehensive tool that includes all three components identified above and must result in an explicit score or referral result for all households that complete the *comprehensive assessment* component of the tool.

Assessment Tool/Process Design Qualities

The CoC must certify that assessment tools used in the coordinated assessment process have the following qualities:

Document participant's homelessness history and housing barriers. Gather sufficient information to allow for appropriate referrals and for the creation of an accurate housing and service plan to address a participant's needs and preferences.

Identify appropriate services. Link participant information and the CoC's resources. Characterize or score the participant's profile against a number of intervention options.

Document discrepancy between participant needs and preferences and available resources to meet need and preference. The specific resource a participant needs or prefers may not be available at the time of referral. Communities should document if there is a demand for housing or services beyond what is currently available.

Respect participant preferences. Ask direct questions about needs and preferences of the participant in order to ensure the best assessment. If the participant appears not to understand

the questions, rephrase each question in simple and concrete language to secure information needed to assess the person's individual needs and preferences.

Capture just enough data to meet program needs and funder requirements. Design assessment forms to represent the intake data needs for the full continuum of services that may be offered at the access point.

Obtain informed, written consent for sharing data with providers. Comply with local, State, and Federal requirements.

Draft, or at least initiate, a housing plan. Work with participants to begin development of a housing plan that can be transferred to the next stage of service.

Standardized practice. Apply standard practices at every point of entry for every participant in order to ensure consistent assessments.

standardized and reliable such that it produces consistent results across staff and locations;

Respect participant privacy. Do not seek information about disability unless it is necessary to determine the need for housing and services and is based on evidence of the risk of becoming or remaining homeless in the event the specific disability is not appropriately managed or addressed. Participants, however, might disclose their disability, thus providing an opportunity to ask about reasonable accommodations needed in housing and/or reasonable modifications needed to fully complete the assessment process.

Use easily understandable questions and language. Questions used in assessment tools are easily understandable for those being assessed. Simple and concrete words and phrases, removing all acronyms and jargon, helps participants respond to questions being asked. If working with a Deaf participant, a certified and qualified American Sign Language interpreter might be needed to ensure effective communication.

Prioritize those with greatest need. To ensure that people experiencing homelessness do not wait on long waiting lists, the CoC must ensure that when there are more people being referred to a program than can be served in a timely manner, the coordinated assessment process has a method for prioritizing people with greater needs.

Assessment Component #1: Triage/Diversion

This initial aspect of assessment is completed upon a participant's first request for emergency response services or when a CoC homeless assistance provider or define CoC system access point first becomes aware that a person/household is experiencing a housing crisis that could result in literal homelessness. The triage/diversion process must address two fundamental questions and provide documentation of results:

1. ***Is the household in immediate danger or at imminent risk of physical harm?*** Households in danger should be immediately referred to the proper crisis response system such as police, hospital, or other appropriate crisis response services.
2. ***Can the household safely remain in their current housing situation, or can the household make arrangements to locate suitable, non-emergency shelter, housing?*** If yes, the household should be diverted to an alternative housing option rather than the CoC's crisis response system (emergency shelter, vouchered shelter, day space, overflow shelter, etc.)

Assessment Component #2: Shelter (Crisis Response Services) Intake

This aspect of the assessment process collects enough data about the person/household to establish or update a record in HMIS. The Shelter Intake portion of the assessment should collect all *Universal Data Elements* at a minimum. Completion of the Shelter Intake phase of assessment is required to enroll a participant in a CoC service, emergency shelter, or housing strategy.

Assessment Component #3: Comprehensive Assessment

The comprehensive assessment must collect all necessary information within an appropriate window of time from initial shelter entry (to be determined locally by each CoC) to make a referral determination or generate a score that aligns with a specific service strategy or CoC program component type. Information collected and participant conditions assessed during this phase will likely include a detailed housing and homeless history, household income and sources, documentation of disability and type for all household members. To increase housing stability and compliance with the Olmstead Plan, assessment should also consider individual and service preferences such as scattered-site or site-based housing, level of desired programming/structure (e.g. meals, activities, and groups), neighborhood and location, security preferences, and sobriety preferences.

At the completion of the assessment, the CoC shall provide the participant with their assessment results, information about possible referrals, referral process and timeline, and referrals to planning resources. This information will be provided in a format that is accessible to the participant (i.e., large print document, Braille document, a recording of some kind or an electronic version for individuals who are Blind or have low vision, etc.).

Assessment Component #4: Comprehensive Re-Assessment

Some circumstances may require that CoC program participants are re-assessed after some period of project enrollment. Participants may desire or need a different program with a different level of service intensity. New information may be revealed or participant circumstances change during the course of project enrollment that suggest a need to update or refresh previously collected comprehensive assessment information. CoCs are encouraged to develop a protocol for re-assessing program participants. The re-assessment protocol should identify the conditions or events that trigger the need for a re-assessment, the re-assessment tool/questions, the process for managing a new referral should the results of the re-assessment identify a new/revised service strategy, and the process for tracking and evaluating participant movement from one CoC project to another or the exit from a CoC project.

Comprehensive Assessment Score or Referral Result

Minnesota CoCs will use the *Vulnerability Index - Service Prioritization and Decision Assistance Tool* (VI-SPDAT) to generate acuity or need scores for all referrals to housing and services (i.e. Transitional Housing, Rapid Rehousing, Permanent Supportive Housing). Each CoC will assign a service strategy or CoC component type to each assessed participant based on the results of the *Comprehensive Assessment* and/or the VI-SPDAT.

CES HMIS Data Collection Requirements

[This section represents a draft approach, outlined for discussion purposes only. Final decisions on required CES data elements, sharing, and reporting requirements will be informed by the work of the HMIS Advisory Task Force.]

1. **Initial Triage/Diversion/Prevention Screen**
    a. Collect minimal Universal Data Elements to create a client record in HMIS
        i. 3.1 Client Name
        ii. 3.2 SSN
        iii. 3.3 DoB
        iv. Date Triage/Diversion Assessment Completed (could be same date as *Initial Intake* and *Comprehensive Assessment*)

2. **Initiate Intake**
    a. Collect Remaining Universal Data Elements
        i. 3.4 Race
        ii. 3.5 Ethnicity
        iii. 3.6 Gender
        iv. 3.7 Veteran Status
        v. 3.8 Disabling Condition
        vi. 3.9 Residence Prior to Project Entry
        vii. 3.10 Project Entry Date
        viii. 3.11 Project Exit Date
        ix. 3.15 Relationship to Head of Household
        x. 3.16 Client Location
        xi. 3.17 Length of Time on Street, in an ES or Safe Haven
    b. Collect Program Specific Data Elements
        i. 4.2 Income and Sources
        ii. 4.3 Non-Cash Benefits
        iii. 4.4 Health Insurance
        iv. 4.5 Physical Disability
        v. 4.6 Developmental Disability
        vi. 4.7 Chronic Health Condition
        vii. 4.8 HIV/AIDS
        viii. 4.9 Mental Health Problem
        ix. 4.10 Substance Abuse
        x. 4.11 Domestic Violence
    c. Collect Other State-Required Data Elements
        i. Date *Initial Intake* Completed (could be same date as *Triage/Diversion* and *Comprehensive Assessment*)
3. **Comprehensive Assessment**
    a. Completed only on clients that do not self-resolve (exit) emergency shelter after 7 days
    b. Collect Remaining Program Specific Data Elements
        i. 4.14 Services Provided
        ii. 4.16 Referrals Provided
        iii. 4.18 Housing Assessment Disposition
        iv. 4.19 Housing Assessment at Exit
    c. Collect State-Required Data Elements
        i. Date *Comprehensive Assessment* Completed (could be same date as *Triage/Diversion* and *Initial Intake*)
        ii. CES Referral (service strategy)
            1. Self-resolve
            2. Emergency Shelter
            3. Rapid Rehousing
            4. Transitional Housing
            5. Permanent Supportive Housing

CES Data Sharing Requirements

[This section represents a draft approach, outlined for discussion purposes only. Final decisions on required CES data elements, sharing, and reporting requirements will be informed by the work of the HMIS Advisory Task Force. Future updates will answer the following questions: What data are shared consistently across all CoCs? What data are shared or customized for sharing only within a CoC?]

Recommended list of data elements for universal sharing:

- Name
- Date of Birth
- Gender
- Race
- Ethnicity
- Relationship to Head of Household
- Veteran Status
- Disability Status
- Minnesota Definition of Homeless
- Living Situation Last Night
- Length of Stay
- Leave Institutional Setting 0-3 or 3-6 months ago
- How Long Since Permanent Place to Live
- State of Last Permanent Residence
- County of Last Permanent Residence (MN only)
- Length of Time Homeless (combined time in shelter, safe haven, or on streets)
- CoC of Service
- Programs Entry and Exit Dates (and provider name)

Recommended list of data elements for sharing only upon referral (all universal above plus the following):

- Any program-specific service transactions (e.g. FHPAP services provided)
- Income sub-assessment
- Non-cash benefits sub-assessment
- Health Insurance sub-assessment
- Disability sub-assessment
- VI-SPDAT sub-assessment OR VI-SPDAT score

Referral Process

Completion of the full Assessment Tool (Diversion Assessment, Shelter Intake, and Comprehensive Assessment) results in a "score" or value which aligns with a service strategy determination. The specific service strategy and referral will be informed by local planning, prioritization, client preferences and resource considerations. The recommended service strategy will include a specific project type that best matches the needs and preferences of the individual or household from among those CoC resources that are available. Clients must be provided the ability to enroll in CoC component types that are less intensive, but not more intensive, than the CES referral choice offered. Responses to assessment questions and scores resulting from completion of the assessment process will be included in HMIS as a component of the participant's HMIS record.

The matching process and eventual referral linkage process will take into account a set of prioritization criteria for each project type. The order of participant priority on the prioritization list will under no circumstances be based on disability type or diagnosis. Priority for each project type will be based on the ***severity of the needs, length of time homeless, or subpopulation characteristics, depending on the specific CoC component type***.

All referrals will be documented in HMIS; including the program type to which the participant is being referred, the date of the referral, and a dead line by which the referral must be either accepted or denied by the "referred to" entity and by the participant.

Program providers operating RRH, TH, and PSH will only accept referrals from the defined Coordinated Entry System (CES) defined by the local CoC.

When offering referral options to clients, the following information shall be provided:

- Simple description of the program type the person is eligible for, and of the less intensive program types, using resources such as web pages, CoC inventory information, and HB101
- Documentation of the person's preferences
- Referral Rejection Policy
- Right to choose options less intensive than the CES referral
- Planning resources (e.g. HB101, DB101, DLL)

Prioritization Guidance

Unfortunately the demand for housing and service supports for persons experiencing homelessness often exceeds the available supply. CoC planners and CoC project staff must make difficult choices about which participants to serve first. Historically prioritization decisions were made locally at each individual homeless assistance project. Implementation of Coordinated Entry institutes a standardized framework for prioritization applied consistently across all homeless assistance projects within each CoC throughout the State of Minnesota. The common framework ensures that all CoC resources are used as strategically and effectively as possible. CoC resources will be targeted to serve persons with the highest needs and greatest barriers obtaining and maintaining housing on their own. This CES Strategic Plan establishes a prioritization approach for each housing assistance type: Rapid Rehousing, Transitional Housing, and Permanent Supportive Housing. Each Minnesota CoC must adopt the State-identified prioritization framework. Additional prioritization standards beyond the State's baseline requirements may be adopted at the discretion of individual CoCs.

Permanent Supportive Housing

Individuals and families will be referred to ***Permanent Supportive Housing*** according to specific prioritization protocols as defined by the State of Minnesota and refined by each CoC. Available Permanent Supportive Housing (PSH) units (both those dedicated to persons experiencing chronic homelessness and PSH projects not dedicated to persons experiencing chronic homelessness) within a CoC must be filled by homeless individuals or families who score for PSH based on the VI-SPDAT and meet at least one of the priority criteria identified below.

- Chronic homelessness as defined by HUD
- Long-Term-Homeless as defined by State of Minnesota
- longest history of homelessness
- most severe service needs as determined by the VI-SPDAT score

CoCs may enact more rigorous standards than those established by the State. For example, a CoC may determine all available PSH units will be filled using the priority criteria of chronic homelessness AND longest length of time experiencing homelessness.

Transitional Housing

At least **75%**[1] of available TH (Transitional Housing) units within a CoC must be filled with participants that score for TH based on the VI-SPDAT **AND** meet the criteria of at least one of the priority groups identified below:

- ***Youth –*** All individuals between the ages of 15-24 who present as a household. This can include unaccompanied youth (household size of one), and multiple youth who are seeking assistance together.
- ***Youth Parents –*** Women and men between the ages of 15-24 who are the custodial parent of at least one dependent child and are seeking assistance with that child(ren).
- ***Domestic Violence survivors –*** Individuals and families with at least one person who identifies a domestic violence experience as the primary reason causing their housing crisis.
- ***Persons being released from correctional facilities*** and were homeless immediately before entering prison/jail.
- ***Pregnant women -*** Women who are pregnant, regardless of their age or whether they have any additional children.
- ***Persons in the early stages of AOD addiction recovery -*** Individuals and families with at least one person who recently began receiving services to assist in their recovery from alcohol or other drug addiction. This can include (but is not limited to) people who were recently released from a treatment center or other institution.
- ***Veterans*** (choosing Grant and Per Diem - GPD).

Rapid Re-housing Priorities

At least **75%** of available Rapid Re-Housing (RRH) resources must be filled with individuals or families that score for RRH based on the VI-SPDAT and as determined by each CoC.

Rapid Re-Housing may also be used as a bridge program for persons who score for more intensive interventions or services but for whom those more intensive programs are not available at the time of referral. CoCs and homeless assistance providers will need to pay special attention to potential changes in eligibility for persons or households placed in RRH. In some circumstances a client or household placed in RRH may no longer be eligible for some TH or PSH projects.

Continuum of Care Participation Expectations

HUD and VA have recently established guidance that instructs all CoC projects to participate in their CoC's Coordinated Entry system. Any project that receives HUD funding (CoC Program, ESG, HOPWA) or VA funding (SSVF, GPD, VASH) must comply with the participation requirements as established by the corresponding CoC jurisdiction. In addition the State of Minnesota will establish minimum statewide requirements for Coordinated Entry participation. At a minimum Coordinated Entry participation will include the following for all CoCs in Minnesota:

Each CoC will execute a CES partnership agreement with any CoC, tribal nation, or other jurisdiction with which CES data will be shared, eligibility criteria and program preferences will be coordinated, cross-jurisdictional referrals will be coordinated, or CES planning and management decisions will be coordinated.

All projects with beds and/or units designated for persons experiencing homelessness are expected to participate in Coordinated Entry.

[1] CoC should justify variances to the 75% threshold (either above or below) using local data to support the difference.

Participating projects must publish written standards for client eligibility and enrollment determination.

Participating projects must communicate project vacancies (bed and/or unit) to the Coordinated Entry administrative entity established by CoC leadership.

Persons experiencing a housing crisis must access CoC services and housing using CoC defined access points.

Participating projects must enroll only those clients referred according to the CoC's designated referral strategy.

Participating projects must participate in the CoC's Coordinated Entry planning and management activities as established by CoC leadership.

CoC Component Definitions

Component descriptions of ESG and CoC Program-funded projects and written standards describing the administration of these projects are required per CoC Program and ESG interim rules

Outreach & Engagement with the Homeless System

Projects providing emergency services and engagement intended to link households who are homeless or at imminent risk of homelessness with available shelter, housing, and/or support services.

Essential Elements

Services include low-demand, services that address basic needs (e.g., food, clothing, blankets) and seek to build relationships with the goal of moving people into emergency shelter or housing and engaging them in services over time. Outreach staff or teams often include multi-disciplinary clinical staff who provide or link persons with: case manager, assistance to develop a person-centered case management plan, housing planning and placement, on-site psychiatric and addictions assessment, medication, other immediate and short-term treatment, and assessment to other programs and services. Ideally outreach case manager would continue to work with client once they are placed in housing. If outreach provider does not serve as person's case manager once person is moved into housing, outreach team should provide appropriate transition services and maintain communication with case manager about client progress and need for additional services.

Target Population

Target population includes persons experiencing homelessness but who have not accessed or are not able to access emergency shelter. Services frequently target those with mental illness, severe addictions, or dual-diagnosis. Target population could also include persons or households living doubled up and at imminent risk of literal homelessness.

Prevention (& Diversion)

Prevention includes a set of strategies to assist people in maintaining permanent housing and/or divert them from entering the homeless system. Service strategies are focused on addressing the immediate housing crisis and can be integrated with other mainstream services to address more long term needs.

- Emergency financial assistance to help people avoid imminent homelessness and maintain housing stability.
- Supportive services, advocacy and mediation to mitigate factors leading to imminent homelessness.

Essential Elements

Services include flexible funding available wherever households present for services. Funding is used to provide financial assistance to pay for current and back rent, security deposits, current and back utility payments, or "whatever it takes" to prevent people from entering the homeless system and wil result in housing stability. Services can include housing and needs assessment; shelter diversion through landlord mediation; family outreach and mediation; legal services; assessment to financial prevention assistance; and negotiation and advocacy on behalf of client to avoid homelessness. Initial assistance is often followed by more comprehensive needs assessment and tertiary prevention efforts, such as assessment to supportive services, including life skills and budgeting, and housing counselor.

Target Population

Households who are at imminent risk of homelessness; without homelessness prevention interventions the client would become literally homeless within 14 days.

Drop-In Centers

Day space programs include those that provide limited services (i.e. only open during limited day-time hours) but also assist in securing basic needs and light touch respite care, information/referral and service connection.

Essential Elements

Collaborative partners provide on-site services and assessment for more comprehensive services offered at different sites (e.g. medical, mental health, basic needs.)

Target Population

Target population includes persons experiencing homeless and families in shelter programs or persons and households at imminent risk of homelessness; frequently targeting those with addiction and physical health problems. Target populations may also include youth who are looking for basic needs services and mental health support.

Emergency Shelter

Emergency Shelter programs provide stabilization and assessment, focusing on quickly moving all persons to stable housing, regardless of disability or background. Emergency shelter is intended to be a short-term service that provides a safe, temporary place to stay (for those who cannot be diverted from shelter) with focus on initial housing assessment, immediate housing placement and linkage to other services

Essential Elements

Entry point into CoC services and housing, emergency shelters often provide temporary night-time sleeping accommodation with showers, laundry, meals, other basic services, and linkage to case manager and housing counselor (co-located on-site) with the goal of helping households move into stable housing as quickly as possible. Shelters can include an array of stabilization options that allow for varying degrees of participation and levels of support based on client needs and engagement at the time clients enter the system (i.e., for those with chronic addictions, mental illness, and co-occurring disorders). On-site supportive service staff should conduct ***next step housing assessment*** of repeat clients or clients requesting such assessment to determine housing needs (e.g., unit size, rent levels, location), subsidy needs, and identify housing barriers, provide ongoing case management, and manage ongoing housing support and services that the client will need to remain stably housed.

Target Population

Emergency shelter is intended for persons who are literally homeless, at imminent risk of literal homelessness, or fleeing or attempting to flee domestic violence. Persons eligible for emergency shelter will meet HUD's homeless definitions of category 1, 2, and 4 homeless individuals, youth and families.

Voucher-based Crisis Response Services (Motel Shelter)

Voucher programs providing reimbursement for temporary motel stays to stabilize homeless persons and families with a focus on quickly moving all persons to stable housing, regardless of disability or background.

Essential Elements

Essential elements include entry point crisis response services with linkage to case manager and housing placement services with the goal of helping households move into stable housing as quickly as possible. Voucher programs include an array of stabilization options that allow for varying degrees of participation and levels of support based on client needs and engagement at the time they enter the program. Supportive service staff should conduct ***next step housing assessment*** of repeat clients or clients requesting such assessment to determine housing needs (e.g., unit size, rent levels, location), subsidy needs, and identify housing barriers, provide ongoing case management, and manage ongoing housing support and services that the client will need to remain stably housed.

Target Population

Similar to persons and households served in emergency shelter, voucher-based emergency services are intended for persons who are literally homeless, at imminent risk of literal homelessness, or fleeing or attempting to flee domestic violence. Persons eligible for voucher-based emergency shelter will meet HUD's homeless definitions of category 1, 2, and 4 homeless individuals, youth and families.

Programmatic Shelter (i.e. Tier II, Longer-Term Service Shelter)

Programmatic shelter programs providing housing focused case management and linkages to mainstream systems and community-based supports. Programmatic shelters provide medium-term (1 to 6 months) stabilization beds for households (who cannot be diverted from shelter) prior to placement into permanent housing.

Essential Elements

Essential elements include crisis response services with linkage to case manager and housing placement services with the goal of helping households move into stable housing as quickly as possible. Programmatic shelters include an array of stabilization options that allow for varying degrees of participation and levels of support based on client needs and engagement at the time they enter the program. Supportive service staff should conduct ***next step housing assessment*** of repeat clients or clients requesting such assessment to determine housing needs (e.g., unit size, rent levels, location), subsidy needs, and identify housing barriers, provide ongoing case management, and manage ongoing housing support and services that the client will need to remain stably housed.

Target Population

Homeless individuals and families with no or inadequate income and moderate barriers to housing stability, including independent life skills needs. Programmatic shelter projects may also serve designated target populations, although the specific target populations and referral and linkage strategies must be approved by the CoC.

Rapid Re-housing

Rapid re-housing (RRH) is an intermediate-term intervention designed to help individuals and families to quickly exit homelessness and return to permanent housing. Rapid re-housing assistance may be offered without preconditions (such as employment, income, absence of criminal record, or sobriety) and the resources and services provided are typically tailored to the unique needs of the household. The core components of a rapid re-housing program are housing identification, rent and move-in assistance, and case management. While a rapid re-housing program must have all three core components available, it is not required that a single entity provides all three services nor that a household utilize them all.

Note that for purposes of the MN CES Strategic Plan scattered site TH funded by the State of Minnesota as Transition in Place is included under the RRH component type for purposes of this statewide planning document.

Housing Identification

Recruit landlords to provide housing opportunities for individuals and families experiencing homelessness.

Address potential barriers to landlord participation such as concern about short term nature of rental assistance and tenant qualifications.

Assist households to find and secure appropriate rental housing.

Rent and Move-In Assistance (Financial)

Provide assistance to cover move-in costs, deposits, and the rental and/or utility assistance

Assistance is typically available for up to six months, but continued assistance for up to 24 months in some circumstances may be warranted based on ongoing re-assessment at 3 month increments. Temporary financial assistance should be made available to allow individuals and families to move immediately out of homelessness and to stabilize in permanent housing.

Rapid Re-housing Case Management and Services

Help individuals and families experiencing homelessness identify and select among various permanent housing options based on their unique needs, preferences, and financial resources.

Help individuals and families experiencing homelessness address issues that may impede access to housing (such as credit history, arrears, and legal issues).

Help individuals and families negotiate manageable and appropriate lease agreements with landlords.

Make appropriate and time-limited services and supports available to families and individuals to allow them to stabilize quickly in permanent housing.

Monitor participants' housing stability and be available to resolve crises, at a minimum during the time rapid re-housing assistance is provided.

Provide or assist the household with connections to resources that help them improve their safety and well-being and achieve their long-term goals. This includes providing or ensuring that the household has access to resources related to benefits, employment and community-based services (if needed/appropriate) so that they can sustain rent payments independently when rental assistance ends.

Ensure that services provided are client-directed, respectful of individuals' right to self-determination, and voluntary. Unless basic, program-related case management is required by statute or regulation, participation in services should not be required to receive rapid re-housing assistance.

Target Population
Homeless households with temporary barriers to self-sufficiency

Transitional Housing
Safe, temporary housing located in project-based or scattered site housing that focus on housing planning, addictions treatment, stabilization, and/or recovery for individuals and families with temporary barriers to self-sufficiency. Recognizing that a zero tolerance approach does not work for all clients, some transitional housing programs will employ a harm reduction, or tolerant approach to engage clients and help them maintain housing stability assuming that the service delivery model allows for appropriate observation of the family environment and care of children. Housing assistance may be provided for up to two years, including rental assistance, housing stabilization services, landlord mediation, case management, budgeting, life skills, parenting support, and child welfare preventive services.

Note that for purposes of the MN CES Strategic Plan scattered site TH funded by the State of Minnesota as Transition in Place is included under the RRH component type for purposes of this statewide planning document.

Essential Elements
Safe units located in project-based or scattered site housing that focuses on housing planning, addictions treatment, stabilization, and recovery for individuals and families with temporary barriers to self-sufficiency.

Target Population
Homeless single adults and families contemplating recovery or newly in recovery, youth, ex-offenders, households fleeing domestic violence, single-parent head of household younger than 25 with children under 6, persons newly discharged from prison or jail, and other subpopulations explicitly allowed and approved by the CoC.

Permanent Supportive Housing
Single-site, project-based, clustered and scattered site permanent housing linked with supportive services that help residents maintain housing.

Essential Elements
Permanent housing with supports that help clients maintain housing and address barriers to self-sufficiency. PSH programs should provide subsidized housing or rental assistance; 24/7 tenant support services; and property management services. Recognizing that relapse is part of the recovery process, PSH programs should hold units open for 30 days while clients are in treatment or in other institutions. If a client returns to a program after 30 days and their unit was given to someone else, staff should work with that client to keep them engaged and place them in a unit when one is available. Some PSH programs should have a tolerant, or harm reduction, approach to engage clients with serious substance abuse issues. While in PSH, clients should receive supportive services appropriate to their needs from their case manager and/or the ACT multidisciplinary team.

Target Population
Persons with significant barriers to self-sufficiency, including chronic disabilities that impede ability to live independently, street homeless adults and dually diagnosed individuals. Also serves families if at least one household member meets the eligibility for a PSH project.

Permanent Housing – Subsidized

Community-based housing where residents sign leases and may stay indefinitely as long as the conditions of tenancy are successfully met. Housing costs are subsidized (either partially or in full) in an effort to make the housing affordable and to support the tenant's long-term residential stability.

Essential Elements

Broad range of clustered or scattered-site permanent housing options for individualsor families who qualify for housing subsidies based on income verification at least once annually.

Target Population

Persons experiencing homelessness or exiting a homeless situation and do not have sufficient resources or access to resources to obtain and maintain housing independently.

Permanent Housing – Market Rate

Community-based housing where residents sign leases and may stay indefinitely.

Essential Elements

Broad range of clustered or scattered-site permanent housing options for individuals with temporary barriers to self-sufficiency, including group living arrangements, shared apartments,or scattered-site apartments.

Target Population

Persons experiencing homelessness and have resources or access to resources to obtain and maintain housing independently.