



CES Committee Meeting

Thursday, February 7, 2019

3:00 PM – 4:30 PM

Nonprofit Innovation Center, 1331 Garden Highway, Sacramento, CA 95833

Meeting Room: VCR (2nd Floor)

Agenda Item	Presenter	Time
I. Welcome & Introductions	John Foley & Jenn Fleming, Co-Chairs	3:00 PM (5 min)
<ul style="list-style-type: none"> • II. HUD Guidance- • Notice CPD-16-11 • Notice CPD-17-01 (Prioritization and CES changes) 	Tristina Stewart & CES Committee Members	3:05 PM (20 Min)
III. Updates <ul style="list-style-type: none"> A. 100 Day Challenge Updates B. HRAP & Access Updates: Coordinated Entry Core Elements- HUD Exchange C. CESH RFQ 	Tristina Stewart & 100 Day team members Ben Avey	3:20 PM (40 min)
IV. Higher Levels of Care: Examination of Contra Costa & Alameda County	Tristina Stewart	4:00 PM (20 min)
V. Adjourn- Upcoming Agenda Topics <ul style="list-style-type: none"> • Next Meeting: 03/07/2019 	John Foley & Jenn Fleming	4:25 PM (5 Min)

ensure participants can freely abstain from disclosing and sharing information without fear of denial of services resulting from the refusal. Certain funders might require disclosure of certain pieces of information for purposes of establishing or documenting program eligibility.

1.2 Components of an Access Process

The four most common access models for coordinated entry are described in Exhibit 1-1. Coordinated Entry Access Models. In some CoCs, the assessment hotline is used for initial triage and initial referrals and then other access approaches are used in later stages of the coordinated entry process.

Exhibit 1-1. Coordinated Entry Access Models

	SINGLE POINT OF ACCESS	MULTISITE CENTRALIZED ACCESS	NO WRONG DOOR	ASSESSMENT HOTLINE
Site Location	Centralized	Located at population centers, high-volume providers, and possibly separated by subpopulation	All existing provider locations	Telephone based or Internet
Number of Access Points	1	Variable, based on geography (2 to 4)	Many	1 telephone number or website access through Internet
Services Offered	Primarily access and assessment; may include triage services, emergency services, or other mainstream services	Primarily access and assessment; may include the services of a co-located provider; may be targeted to one of several subpopulations	Access, at least limited assessment, referrals, and the standard services of each provider	Access to the homeless system, often includes access to mainstream services; limited assessment capability
Operating Entity, Staffing	Permanent independent access specialists; may be shared staff of a central shelter or other organization	Mobile or permanent independent access specialists or shared staff of co-located providers	Independently operated by each provider	Local 211 or other designated hotline agency
Hours of Operation	Hours of the central location	Hours of each access site	Hours depend on and vary with each provider	Typically 24-hour operation, 7 days a week

	SINGLE POINT OF ACCESS	MULTISITE CENTRALIZED ACCESS	NO WRONG DOOR	ASSESSMENT HOTLINE
Considerations	Highest level of control over implementation and compliance for the CoC; also known as “centralized” intake or assessment	Moderate level of control over implementation and compliance for the CoC; the most adaptable model, sometimes called a “hybrid” system	Lowest level of control over implementation and compliance for the CoC; however, still requires standardized forms and coordinated referrals for all	211 is the most popular example; sometimes combined as an initial triage tool with any of the other models; often must build a relationship with an outside provider



1.3 Planning for an Access Process

Access planning requires careful consideration of the CoC’s geography, resources, and capacity in order to select an approach that will be most accessible for people facing a housing crisis. Effective planning requires a clear and formal decision-making process that is inclusive, well documented, and responsive to new information learned through implementation.

1.3.1 Planning Decisions

The coordinated entry planning group should address the following steps and decisions. However, not all of these pieces need to be in place for implementation to begin. Many CoCs opt to implement their coordinated entry process in stages.

Identify access points

Considering the geography of the CoC, the planning group should select the location(s), type of organization, hours, and other descriptive traits of the access point(s) the CoC will use for coordinated entry. Depending on the needs of the CoC, any of the access models shown in Exhibit 1-1. Coordinated Entry Access Models could be appropriate, or a combination of approaches to form a hybrid access model.

Determine whether specialized access points will be developed

The planning group should consider whether any specialized access points for subpopulations would be beneficial for the coordinated entry process. A CoC must keep in mind that HUD’s [Coordinated Entry Notice](#) allows for separately designated access points for only certain subpopulations—single adults, adults with children, unaccompanied youth, persons accessing homelessness prevention assistance, and domestic violence survivors—and only after the CoC has carefully considered the benefits of establishing and maintaining separate access for those subpopulations.

Contra Costa/Alameda County- A Higher Level of Care

Information provided by Natalie Siva (Coordinated Entry System manager) & Michael Fisher (CORE Program Manager) of Contra Costa County

Shelter with a higher level of care: Concord Shelter

With the shelter population seeming to be consisting more of seniors, and harder-to-serve clientele, the community felt that changes needed to be made to their main shelters in an effort to better serve their clients.

- Shelter funding sources: AB109, CDBG, VA, MHSA, County ESG, & anti human trafficking for youth (14 total funding sources for the shelter). Funding sources did not change through this transition.
- C.O.R.E (Coordinated Outreach, Referral, and Engagement) Outreach teams make all referrals into shelter: 4 roaming mobile teams to be dispatched to clients by 211. 6 tied to geographic contracts.
- Case Management was restructured and revamped:
 - Older Adult Case Manager (65+)
 - 3 Housing Specialists
 - 1 Services Coordinator (focus on income)
- Staff are all trained in trauma informed care and motivational interviewing.
- Medical, dental, counseling, and psychiatric services on site in shelter, through partnership with Healthcare for the Homeless (Program Manager Elizabeth Gains), and the Regional Medical Center.



U.S. Department of Housing and Urban Development
Office of Community Planning and Development

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Special Attention of:

All Secretary's
Representatives

Notice: CPD-16-11

Issued: July 25, 2016

Expires: This Notice is effective until it is
amended, superseded, or rescinded

Issued:

All Regional Directors for
CPD

Cross Reference: 24 CFR Parts 578 and
42 U.S.C. 11381, *et seq.*

Expires:

All CPD Division Directors
Continuums of Care (CoC)
Recipients of the Continuum of Care (CoC)
Program

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

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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

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 their 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.²
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.

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 in an emergency shelter and has been identified as having severe service needs. The length of time in which households have been homeless should also be considered when prioritizing households that meet this order of priority, 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,



Special Attention of:

All Secretary's Representatives
All Regional Directors for CPD
All CPD Division Directors
Continuums of Care (CoC)
Recipients and Subrecipients of the
Continuum of Care (CoC) Program
Recipients and Subrecipients of the
Emergency Solutions Grants (ESG) Program

Notice: CPD-17-01

Issued: January 23, 2017

Expires: This Notice is effective until it is
amended, superseded, or rescinded

Cross Reference: 24 CFR Part 578,
42 U.S.C. 11381, *et seq.*, 24 CFR Part 576,
and 42 U.S.C. 11371, *et seq.*, Notice CPD-
014-12, 42 U.S.C. 13925, *et seq.*

Subject: Notice Establishing Additional Requirements for a Continuum of Care

Centralized or Coordinated Assessment System

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attempting to flee, domestic violence, dating violence, sexual assault, or stalking, but who are seeking shelter or services from non-victim specific providers.

This section also requires the coordinated entry process to comply with any additional requirements established by HUD through Notice. Section II.B. of this Notice establishes these additional requirements.

B. CoCs Must Incorporate Additional Requirements into Their Coordinated Entry Process

Each CoC must incorporate additional requirements into their written policies and procedures to ensure that its coordinated entry implementation includes each of the requirements described in this section:

1. **Full coverage.** Provisions at 24 CFR 578.3 require that a CoC's coordinated entry process cover the CoC's entire geographic area; however, 24 CFR 578.3 does not prohibit multiple CoCs from joining together and using the same coordinated entry process. Individual CoCs may only have one coordinated entry process covering their geographic area; however, for CoCs, such as Balance of State CoCs, whose geographic areas are very large, the process may establish referral zones within the geographic area designed to avoid forcing persons to travel or move long distances to be assessed or served. This Notice further establishes that CoCs that have joined together to use the same regional coordinated entry process must implement written policies and procedures that at a minimum describe the following:
 - a. the relationship of the CoC(s) geographic area(s) to the geographic area(s) covered by the coordinated entry process(es); and
 - b. how the requirements of ensuring access, standardizing assessments, and implementing uniform referral processes occur in situations where the CoC's geographic boundaries and the geographic boundaries of the coordinated entry process are different.
2. **Use of Standardized Access Points and Assessment Approaches.**
 - a. Unless otherwise provided in this Notice, the coordinated entry process must offer the same assessment approach at all access points and all access points must be usable by all people who may be experiencing homelessness or at risk of homelessness. The coordinated entry process may, but is not required to include separate access points and variations in assessment processes to the extent necessary to meet the needs of the following five populations:
 - (1) adults without children;
 - (2) adults accompanied by children;
 - (3) unaccompanied youth;

(4) households fleeing domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions (including human trafficking); and

(5) persons at risk of homelessness. See II.B.8 for more information.

Variations for these five populations are permissible but not required.

- b. The CoC may not establish a separate access point and assessment process for veterans; however, a coordinated entry process may allow Veterans Administration (VA) partners to conduct assessment and make direct placements into homeless assistance programs, including those funded by the CoC and ESG programs, provided that the method for doing so is in collaboration between those VA partners and the CoC and that the method is included in the CoC's Coordinated Entry policies and procedures and the written standards for the affected programs.
- c. A CoC or recipient of federal funds may be required to offer some variation to the process, e.g., a different access point, as a reasonable accommodation for a person with disabilities. For example, a person with a mobility impairment may request a reasonable accommodation in order to complete the coordinated entry process at a different location.
- d. If determined necessary, variations in access and assessment approaches for the five populations listed in paragraph (a) may be used to remove population-specific barriers to accessing the coordinated entry process and to account for the different needs, vulnerabilities, and risk factors of the five populations in assessment processes and prioritization. Examples of variations could include the following:
 - (1) A dedicated access point for unaccompanied youth that provides a safe and supportive youth environment and that is located in a space easily accessible to and commonly frequented by youth to increase the likelihood that unaccompanied youth will access the coordinated entry process;
 - (2) An assessment tool used with unaccompanied youth that includes youth-friendly language to elicit a comparable answer to a similar but different question asked of adults over the age of 24;
 - (3) Assessment scoring criteria that weight the risk of immediate harm higher for households with young children when prioritizing persons for housing and services than for households without minor children;
 - (4) Assessment locations and information systems for people fleeing domestic violence that may include separate but comparable processes and databases in order to provide safety, security, and confidentiality; or
 - (5) Assessment scoring criteria that weight a single event of homelessness higher for pregnant women or families with children from the ages of 0 to

5 when prioritizing persons for housing and services than for individuals or families with older children.

- e. Variations in assessment locations and processes shall only be considered necessary for the five populations listed in paragraph a, if the CoC reasonably determines that the variations would facilitate access to the coordinated entry process and improve the quality of information gathered through the assessment.
 - f. CoCs must ensure that households who present at any access point, regardless of whether it is an access point dedicated to the population to which the household belongs, can easily access an appropriate assessment process that provides the CoC with enough information to make prioritization decisions about that household. Similarly, CoCs must ensure that households who are included in more than one of the five populations listed in paragraph a, e.g., a parenting unaccompanied youth who is fleeing domestic violence, can be served at all of the access points for which they qualify as a target population.
 - g. CoCs' written policies and procedures for coordinated entry must:
 - (1) Describe the standardized assessment process, including documentation of the criteria used for uniform decision-making across access points and staff. Criteria must reflect the prioritization process adopted to meet the requirements outlined in Section II.B.2. of this Notice. If the CoC is implementing different access points and assessment tools for the different populations listed above, written policies and procedures must separately document the criteria for uniform decision-making within each population for whom different access points and assessment processes are used.
 - (2) The CoC must have written policies concerning data collected through the assessment as described in Section II.B.12 "Privacy Protections." Additionally, data from the assessment may not be used to prioritize households for housing and services on a protected basis, such as on the basis of a diagnosis or particular disability. Note that determining eligibility is a different process than prioritization (see I.C.4.d for clarification).
3. **Use of Standardized Prioritization in the Referral Process.** The CoC must use the coordinated entry process to prioritize homeless persons within the CoC's geographic area for referral to housing and services. The prioritization policies must be documented in Coordinated Entry policies and procedures and must be consistent with CoC and ESG written standards established under 24 CFR 576.400(e) and 24 CFR 578(a)(9). These policies and procedures must be made publicly available and must be applied consistently throughout the CoC areas for all populations.

The assessment process described in Section II.B.3., including information gathered from assessment tools, case workers, and others working with households, must provide sufficient information to make prioritization decisions. CoCs' written policies and procedures must include the factors and assessment information with which prioritization decisions will be made for all homeless assistance, with caveats made in II.B.7. The CoC

should refer to Notice CPD-016-11, Notice on Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing, or any subsequent notices that update or replace CPD-016-11 for detailed guidance on prioritizing Permanent Supportive Housing (PSH) beds. The prioritization process may use any combination of the following factors:

- a. significant challenges or functional impairments, including any physical, mental, developmental or behavioral health disabilities regardless of the type of disability, which require a significant level of support in order to maintain permanent housing (this factor focuses on the level of support needed and is not based on disability type);
- b. high utilization of crisis or emergency services to meet basic needs, including but not limited to emergency rooms, jails, and psychiatric facilities;
- c. the extent to which people, especially youth and children, are unsheltered;
- d. vulnerability to illness or death;
- e. risk of continued homelessness;
- f. vulnerability to victimization, including physical assault, trafficking or sex work;
or
- g. other factors determined by the community that are based on severity of needs.

These factors are intended to help identify and prioritize homeless persons within the geographic area for access to housing and services based on severity of needs. CoCs are prohibited from using any assessment tool or the prioritization process, including the factors listed in items a. through g. or any other factors adopted by the community, if it would discriminate based on race, color, religion, national origin, sex, age, familial status, disability, type or amount of disability or disability-related services or supports required. In addition, CoCs are prohibited from discriminating based on actual or perceived sexual orientation, gender identity, or marital status.

Assessment tools might not produce the entire body of information necessary to determine a household's prioritization, either because of the nature of self-reporting, withheld information, or circumstances outside the scope of assessment questions that address one or more of the factors discussed above. For these reasons, it is important that case workers and others working with households have the opportunity to provide additional information through case conferencing or another method of case worker input. It is important to note, however, that only information relevant to factors listed in the coordinated entry written policies and procedures may be used to make prioritization decisions, and must be consistent with written standards established under 24 CFR 576.400(e) and 24 CFR 578.7(a)(9).

A community-wide list generated during the prioritization process, referred to variously as a "By Name List," "Active List," or "Master List," is not required, but can help communities effectively manage an accountable and transparent referral process. If a

“On January 23, 2017, the U.S. Department of Housing and Urban Development (HUD) published a Notice Establishing Additional Requirements for a Continuum of Care (CoC) Centralized or Coordinated Assessment System (the Notice) regarding the development and implementation of Coordinated Entry” (HUD Coordinated Entry Notice) . Part of this notice pertained to system access, and a CoC’s core requirement of providing full coverage of all geographic areas within designated CoC (HUD Coordinated Entry Notice: Section II.B.1).

As the primary points of entry into the Sacramento CoC were geographically bound Outreach and shelters, Housing Resource Access Points (H.R.A.P.s) were developed to support the existing CoC Access Points (Outreach, Shelters, additional agencies), in order to provide full geographic coverage. The H.R.A.P.s are part of the larger access system that exists within the CoC, and are not a replacement of any existing service.

To access an H.R.A.P. a client starts by calling into 2-1-1. 2-1-1 will then schedule the client at one of the open access sites, or if the client falls into a subpopulation (TAY, Veteran) to a subpopulation Access Point, if the client so chooses. After being scheduled, the client will be engaged within 1 to 2 weeks by a member of the SSF Phone Triage Team, and enrolled if they choose, in HMIS in the Phone Triage Program. The client will work with the Phone Triage Team, up until their H.R.A.P. appointment, or until they are successfully diverted. If the client is unable to be diverted, the client is handed off to the staff at the H.R.A.P. At the H.R.A.P. the staff develops a case plan with the client dictated by phased engagement strategies and client choice.

Below are the H.R.A.P. outcomes from Jan 1- Dec 31 2018

- 378 Appointments scheduled
- 225 program enrollments
- 153 VI-SPDAT
- 64 households ended their cycle of homelessness
- 16 Shelter placements (Motel Voucher and Winter Sanctuary)

The below listed is the current structure of the H.R.A.P. Project

Sites

- Wellness and Recovery South (6 appointments per week)
- Guest House Connections Lounge (3 appointments per week)
- Francis House (3 appointments per week)
- SVRC (3 Veteran appointment per week)
- Wind Youth Drop In Center (MOU being developed for Feb start date)

YTD Enrollments

- 40 H.R.A.P.
- 24 Phone Triage

Concerns and Resolutions

- Extended waitlists: Opened 6 more weekly appointments for open access clients, and 5 subpopulation appointments. Built out Phone Triage Program. 72, 48, 24 hr. check in before appointment to ensure confirmation, otherwise new client pulled from Phone Triage pool for appt.
- 25% of clients scheduled for February are active in HMIS programs, and do not need access: Work w/ Outreach and shelter providers to standardize handoff back to existing case manager.