System Operations Manual
TX – 700 Continuum of Care
TX – 700 Continuum of Care

Coordinated Access System

Operations Manual

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Purpose and Background</td>
<td>3</td>
</tr>
<tr>
<td>II</td>
<td>Disclaimer</td>
<td>4</td>
</tr>
<tr>
<td>III</td>
<td>Definitions</td>
<td>5</td>
</tr>
<tr>
<td>IV</td>
<td>Staffing Roles and Expectations</td>
<td>8</td>
</tr>
<tr>
<td>V</td>
<td>Target Population</td>
<td>10</td>
</tr>
<tr>
<td>VI</td>
<td>System Overview and Workflow</td>
<td>10</td>
</tr>
<tr>
<td>VII</td>
<td>Coordinated Access Policies and Procedures</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>1. Connecting to the Coordinated Access System</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>2. Housing Models</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>3. Housing Assessing</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>4. Housing Matching</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>5. Housing Referral</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>6. Case Conferences</td>
<td>23</td>
</tr>
<tr>
<td>VIII</td>
<td>Fair Housing, Tenant Selection Plans, and Other Statutory and Regulatory Requirement</td>
<td>23</td>
</tr>
<tr>
<td>IX</td>
<td>Evaluating and Updating Coordinated Access System Policies and Procedures</td>
<td>24</td>
</tr>
<tr>
<td>X</td>
<td>Termination</td>
<td>25</td>
</tr>
<tr>
<td>XI</td>
<td>Appendix</td>
<td>26</td>
</tr>
</tbody>
</table>
Purpose and Background
Under the requirements of the Homeless Emergency Assistance and Rapid Transition to Housing: Continuum of Care Program (HEARTH Act), the TX-700 Continuum of Care has implemented a coordinated assessment system. Coordinated assessment is a powerful tool designed to ensure that homeless persons and persons at risk of homelessness are matched, as quickly as possible, with the intervention that will most efficiently and effectively end their homelessness. The Coordinated Access System described in this manual is designed to meet the requirements of the HEARTH Act, under which, at a minimum, Continuums of Care must adopt written standards that include:

(i) Policies and procedures for providing an initial housing assessment to determine the best housing and services intervention for individuals and families;

(ii) A specific policy to guide the operation of the centralized or coordinated assessment system on how its system will address the needs of individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking, but who are seeking shelter or services from non-victim service providers;

(iii) Policies and procedures for evaluating individuals’ and families’ eligibility for assistance;

(iv) Policies and procedures for determining and prioritizing which eligible individuals and families will receive transitional housing assistance;

(v) Policies and procedures for determining and prioritizing which eligible individuals and families will receive rapid rehousing assistance;

(vi) Policies and procedures for determining and prioritizing which eligible individuals and families will receive permanent supportive housing assistance;

The TX-700 Continuum of Care has designed the Coordinated Access System described in this manual to coordinate and strengthen access to housing for families and individuals who are homeless or at risk of homelessness throughout the city of Houston and Harris County. The Coordinated Access System institutes consistent and uniform assessment and referral processes to determine and secure the most appropriate response to each individual or family’s immediate and long-term housing needs.

The Coordinated Access System is designed to:

- Allow anyone who needs assistance to know where to go to get that assistance, to be assessed in a standard and consistent way, and to connect with the housing/services that best meet their needs;

- Ensure clarity, transparency, consistency and accountability for homeless clients, referral sources and homeless service providers throughout the assessment and referral process;
Facilitate exits from homelessness to stable housing in the most rapid manner possible given available resources;

Ensure that clients gain access as efficiently and effectively as possible to the type of intervention most appropriate to their immediate and long-term housing needs;

Ensure that people who have been homeless the longest and/or are the most vulnerable have priority access to scarce permanent supportive housing resources.

To achieve these objectives the *Coordinated Access System* includes:

- A **uniform and standard assessment process** to be used for all those seeking assistance and procedures for determining the appropriate next level of assistance to resolve the homelessness of those living in shelters, on the streets, or places not meant for human habitation;

- Establishment of **uniform guidelines** among components of homeless assistance (rapid rehousing and permanent supportive housing) regarding: eligibility for services, priority populations, expected outcomes, and targets for length of stay;

- Agreed upon **prioritization for accessing homeless assistance**;

- **Referral policies and procedures** from the system of coordinated access to homeless services providers to facilitate access to services;

- The **policies and procedure manual** contained herein and detailing the operations of the *Coordinated Access System*.

The implementation of the *Coordinated Access System* necessitates significant, community-wide change. To help ensure that the system will be effective and manageable for homeless persons and persons at-risk of homelessness and for the housing and service providers tasked with meeting their needs, a comprehensive group of stakeholders was involved in its design. In addition, particularly during the early stages of implementation, the TX-700 Continuum of Care anticipates adjustments to the processes described in this manual. A periodic evaluation of the *Coordinated Access System* will provide ongoing opportunities for stakeholder feedback. The *Coordinating Entity* will be responsible for monitoring the *Coordinated Access System*. 
History

*The Coordinated Access System* is designed to assess eligibility for housing programs targeted to homeless persons. It is not a guarantee that the individual will meet the final eligibility requirements for - or receive a referral to - a particular housing option.

Definitions

Terms used throughout this manual are defined below:

**Chronically Homeless (HUD Definition):**

(1) An individual who:
   (i) Is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter;
   (ii) Has been homeless and living in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year; OR
   (iii) Has had at least four (4) separate occasions of the above homelessness in the past three (3) years where the combined length of the occasions is twelve (12) months; AND
   (iv) Can be diagnosed with a disability such as a substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000 (42 U.S.C. 15002)), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability;

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

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

**Disability (HUD Definition):**

A Physical, Mental or Emotional Impairment, including impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury that is expected to be long-continuing or of indefinite duration, substantially impedes the individual’s ability to live independently, and could be improved by the provision of more suitable housing conditions; includes:

- **Developmental Disability** Defined in §102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 USC 15002). Means a severe, chronic disability that is attributable to a mental or physical impairment or combination AND is manifested before age 22 AND is likely to continue indefinitely AND reflects need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. An individual may be considered to have a developmental disability without meeting three or more of the criteria listed previously, if individual is 9 years old or younger AND has a substantial developmental delay or specific congenital or acquired condition AND without services and supports, has a high probability of meeting those criteria later in life.
HIV/AIDS Criteria: Includes the disease of acquired immunodeficiency syndrome (AIDS) or any conditions arising from the etiologic agent for acquired immunodeficiency syndrome, including infection with the human immunodeficiency virus (HIV).

Literally Homeless (HUD Homeless Definition Category 1):
(1) Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) Has a primary nighttime residence that is a public or private place not meant for human habitation; (ii) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or (iii) Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

At imminent risk of homelessness (HUD Homeless Definition Category 2)
Individual or family who will imminently lose their primary nighttime residence, provided that: (i) Residence will be lost within 14 days of the date of application for homeless assistance; (ii) No subsequent residence has been identified; and (iii) The individual or family lacks the resources or support networks needed to obtain other permanent housing.

Homeless under other Federal statutes (HUD Homeless Definition Category 3)
Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who: (i) Are defined as homeless under the other listed federal statutes; (ii) have not had a lease, ownership interest, or occupancy agreement in permanent housing at any time during the 60 days immediately preceding the date of application for homeless assistance; (iii) Have experienced persistent instability as measured by two moves or more during the 60-day period immediately preceding the date of applying for homeless assistance; and (iv) can be expected to continue in such status for an extended period of time due to special needs or barriers.

Fleeing domestic abuse or violence (HUD Homeless Definition Category 4)
Any individual or family who: (i) Is fleeing, or is attempting to flee, domestic violence; (ii) Has no other residence; and (iii) Lacks the resources or support networks to obtain other permanent housing.

2019 Area Median Income Limits (Houston, Baytown, Sugarland, Metro Area)

<table>
<thead>
<tr>
<th>Household Size</th>
<th>30% Area Median Income (HUD Extremely Low Income Limit)</th>
<th>50% Area Median Income (HUD Very Low Income Limit)</th>
<th>80% Area Median Income (HUD Low Income Limit)</th>
</tr>
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<tbody>
<tr>
<td>1 person</td>
<td>16,050</td>
<td>26,750</td>
<td>42,750</td>
</tr>
<tr>
<td>2 persons</td>
<td>18,350</td>
<td>30,550</td>
<td>48,850</td>
</tr>
<tr>
<td>3 persons</td>
<td>21,330</td>
<td>34,350</td>
<td>54,950</td>
</tr>
<tr>
<td>4 persons</td>
<td>25,750</td>
<td>38,150</td>
<td>61,050</td>
</tr>
<tr>
<td>5 persons</td>
<td>30,170</td>
<td>41,250</td>
<td>65,950</td>
</tr>
<tr>
<td>6 persons</td>
<td>34,590</td>
<td>44,300</td>
<td>70,850</td>
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<tr>
<td>7 persons</td>
<td>39,010</td>
<td>47,350</td>
<td>75,750</td>
</tr>
<tr>
<td>8 persons</td>
<td>43,430</td>
<td>50,400</td>
<td>80,600</td>
</tr>
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</table>
**Housing Prioritization Tool**

A single assessment tool will be used to prioritize homeless households for entry into permanent supportive housing or rapid rehousing program. The assessment tool is used to target youth, families, and single individuals. The housing prioritization tool focuses on the length of literal homelessness, physical & mental disabilities, frequency of service usage, & lack of adequate mental or health care. Additionally, families with minor children presenting for assessment are asked to provide information regarding what school district the child(ren) attend. Referrals for this population will be sent with this data point so that children do not have to change schools. The assessment asks questions tailored to each population & include the following:

1. Homeless history
2. History of involvement with hospitals or jails
3. Criminal background history
4. Mental health history and lack of care
5. Physical health history and lack of care

**Homeless Management Information System**

A Homeless Management Information System (HMIS) is a database used to record and track client-level information on the characteristics and service needs of homeless persons. HMIS ties together homeless service providers within a community to help create a more coordinated and effective housing and service delivery system.

The U.S. Department of Housing and Urban Development (HUD) and other planners and policymakers at the federal, state, and local levels use aggregate HMIS data to obtain better information about the extent and nature of homelessness over time. Specifically, HMIS can be used to produce an unduplicated count of homeless persons, understand patterns of service use, and measure the effectiveness of homeless programs.

Houston/Harris County’s HMIS is staffed at the Coalition for the Homeless of Houston/Harris County. The software provider is Client Track. The HMIS staff is responsible for the administration of the HMIS software and providing technical assistance to participating agencies and end-users. Agencies that participate in Houston/Harris County’s HMIS are referred to as “participating agencies.” Each participating agency needs to follow certain guidelines to help maintain data privacy and accuracy.

**Staffing Roles and Expectations**

Continuum of Care – Recognizing the need to stimulate community-wide planning and coordination of programs for individuals and families who are homeless, the U.S. Department of Housing and Urban Development (HUD) in 1994 instituted a requirement for communities to come together to submit a single, comprehensive application for HUD funds for housing and support services for people who have experienced homelessness. The organizational concept to embody this effort is the Continuum of Care (CoC), which is governed by a Steering Committee.
composed of representatives from across the community. As a result of its strong leadership, access to resources and high visibility in the community, the Coalition for the Homeless of Houston/Harris County serves as this region’s lead agency for the CoC. The Houston CoC encompasses Houston counties including Harris, Montgomery, and Fort Bend, and its purpose is to:

- Help create integrated, community-wide strategies and plans to prevent and end homelessness;
- Provide coordination among the numerous regional organizations and initiatives that serve the homeless population, and
- Create the region’s single, comprehensive grant application to HUD for McKinney-Vento funding.

Coordinating Entity - The Coalition for the Homeless is the designated Coordinating Entity. The Coordinating Entity is responsible for the day-to-day administration of the Coordinated Access System, including but not limited to the following:

- Creating and widely disseminating materials regarding services available through the Coordinated Access System and how to access those services;
- Designing and delivering training at least annually to all key stakeholder organizations, including but not limited to the required training for CA Staff;
- Ensuring that pertinent information is entered into HMIS for monitoring and tracking the process of referrals including vacancy reporting and completion of assessments;
- Managing case conferences to review and resolve rejection decisions by receiving programs and refusals by clients to engage in a housing plan in compliance with receiving program guidelines;
- Managing an eligibility determination appeals process in compliance with the protocols described in this manual;
- Managing manual processes as necessary to enable participation in the Coordinated Access System by providers not participating in HMIS;
- Designing and executing ongoing quality control activities to ensure clarity, transparency, and consistency in order to remain accountable to clients, referral sources, and homeless service providers throughout the coordinated access process;
- Periodically evaluating efforts to ensure that the Coordinated Access System is functioning as intended;
• Making periodic adjustments to the Coordinated Access System as determined necessary;

• Ensuring that evaluation and adjustment processes are informed by a broad and representative group of stakeholders;

• Updating policies and procedures.

• Managing all PR requests related to Coordinated Access

Project Manager – The Coordinating Entity staffs a Project Manager position. The project manager role includes management of the Coordinated Access System, including but not limited to the following:

• Serving as point person and lead to all workgroups and transition teams

• Providing Coordinated Access training to participating agencies

• Database administering

• Report generating

• Communicating to user agencies and outreach coordinators

• Deactivating/reactivating client records

• Responding to requests for client deletion

• Responding to email generated questions

• Monitoring system performance (CA Staff, Database, Providers, etc.)

Assessment Hubs - Agencies selected to serve as the Assessment Hub sites are responsible for ensuring that all households experiencing homelessness and at-risk of homelessness have prompt access to Intake and Assessments and that Assessments are administered in a safe, welcoming environment.

Housing Assessors – see Policies & Procedures

Housing Navigators – see Policies & Procedures

Receiving Program - All Rapid Re-housing (RRH) and Permanent Supportive Housing (PSH) programs are Receiving Programs and are responsible for reporting vacancies to the Coordinating Entity in compliance with the protocols described in this manual. All programs that receive a referral from the Coordinated Access System are responsible for responding to that referral and participating in case conferences, in compliance with the protocols described in this manual.
Authorized User Agencies - Housing providers who wish to or are required to participate in the 
*Coordinated Access System*. Authorized User Agencies sign a Memorandum of Understanding 
to have access to the database to interview and enroll households for vacancies/anticipated 
vacancies or during lease up of new PSH programs.

**Target Population**

The *Coordinated Access System* is open to all households who meet the HUD definition of 
homeless, as outlined in the new HEARTH Act regulations, and have incomes below 50% of the 
Area Median Income. The system uses a locally developed prioritization tool (described in 
Definitions & located in the Appendix of this manual) to rank Applicants in order of 
vulnerability, with the most vulnerable households ranked at the top.

**System Overview and Workflow**

To illustrate how the *Coordinated Access System* functions, the following overview provides a 
brief description of the path a household would follow from an initial request for housing 
through permanent housing placement. The overview also describes roles and expectations of 
the partner organizations that play a critical role in the system. Additional details can be found 
in the subsequent sections of this manual and the Coordinated Access workflow.

**From Initial Request for Services to Permanent Housing Placement – Pathway through the 
Coordinated Access System**

- **Step 1: Connecting to the Coordinated Access System/Initial Request for Services** - To 
  ensure accessibility to households in need, the *Coordinated Access System* provides 
  access to services from multiple, convenient physical locations. Households in need 
  may initiate a request for services in person through any of the designated *Assessment 
  Hubs*, through the call center, and/or through community outreach teams.

  Detailed information regarding Hub locations and hours of operation are posted on the 
  Coalition for the Homeless Houston’s website [www.homelesshouston.org](http://www.homelesshouston.org) 
  as well as on the community’s website [www.thewayhomehouston.org](http://www.thewayhomehouston.org).

- **Step 2: Housing Assessment** - *Housing Assessors* are available at Assessment Hubs, the 
  call center, and through community outreach staff to conduct the *Coordinated Access 
  Housing Assessment* with households in need. The assessment is completed using 
  HMIS. An additional *Housing Prioritization Tool* is generated in HMIS for all households 
  identified as a match for Permanent Supportive Housing or Rapid Re-housing and to 
  prioritize referrals. Individuals and families must be re-assessed if more than 90 days 
  have passed since the previous assessment and there have been no services in HMIS 
  during that time.
• **Step 3: Housing Match** - Information gathered from the assessment is used to determine which housing intervention is best suited to end the household’s homelessness (Permanent Supportive Housing or Rapid Re-housing). HMIS automatically matches households to a particular housing intervention and then a specific housing program based on program eligibility.

• **Step 4: Housing Referral** - Once the recommended intervention and eligible programs have been identified in HMIS, the Housing Assessor will add the household member(s) to the Centralized Waitlist. Currently there are not enough housing slots available to send referrals in real time.

• **Step 5: Housing Navigation** - After being referred to a housing provider, households will be connected with a Housing Navigator. This connection can be made by pulling from the Coordinated Access Centralized Waitlist. The Housing Navigator can be one of the following: the housing program Case Manager, the original Coordinated Access referring Outreach Worker, or a designated Coordinated Access Housing Navigator. The Housing Navigator begins the process of securing the identified unit. This process may include, but is not limited to the following activities: Obtaining ID, obtaining social security cards, obtaining homeless verification documents, obtaining a security deposit, obtaining application fees, providing transportation to tour available units, etc. **The process from referral to move in should be completed within 30 days.**

Below is an illustration of the CA Workflow:
Coordinated Access Policies and Procedures

1. Connecting to the Coordinated Access System

1.1. Locations & Hours – Assessments are conducted at designated Assessment Hubs. A future call center will also be established at one of the Assessment HUBs. Current Assessment Hub locations and assessment hours can be found on the Coalition for the Homeless Houston’s website www.homelesshouston.org as well as on the community’s website www.thewayhomehouston.org.

1.2. Eligibility – Coordinated Access is intended to facilitate access to the most appropriate housing intervention for each household’s immediate and long-term housing needs and ensure that scarce permanent housing resources are targeted to those who are most vulnerable and/or have been homeless the longest. The Coordinated Access System uses the following criteria to accurately match needs to resources:
**Permanent Supportive Housing**

Permanent housing that is coupled with supportive services that are appropriate to the needs and preferences of residents. Individuals have leases, must abide by rights and responsibilities, and may remain with no program imposed time limits.

Housing may include various combinations of subsidy resources and services. Supportive housing in Houston is Housing First, and follows a harm reduction philosophy.

<table>
<thead>
<tr>
<th>Program Description</th>
<th>Essential Program Elements</th>
<th>Time Frame</th>
<th>Population</th>
<th>Desired /Expected Outcomes</th>
</tr>
</thead>
</table>
| Rental assistance with supportive services for persons who are coming from the street or shelter/interim housing. Majority of programs serve households with a disabled head-of-household, but disability requirement will be based on subsidy source requirements. Programs can operate on a project-based or scattered-site model. | **Case Management**  
- Assistance with lease process  
- Provision of or linkage to: Assessment, Intervention, link to mainstream resources, community building, peer to peer and all other services that assist a person in remaining stably housed  
- Services are voluntary to the clients and are not a condition of the lease  
**Rental Subsidy**  
- Provides a rental subsidy to make the unit affordable  
- Provides assistance in accessing housing relocation resources/supports (security deposits, utilities, furnishings, etc.)  
- Ensure coordination between property manager or landlord  
**Health Care Access**  
- Wellness services  
- Physical and mental health services  
**Harm Reduction and Housing First**  
- All supportive housing embraces and practices Harm Reduction and Housing First  
- Incorporate proven best practices and evidence-based practices  
- Programs do not require sobriety or medication/treatment compliance as a condition of housing attainment or retention | No time limits |  
- Any high needs individual with multiple barriers to housing that is literally homeless (lease-based program)  
- Specialized eligibility requirements for subsidies including veterans, disabled, long term homeless, or domestic violence  
**Prioritizing:** Disabling condition and long-term, multiple episodes of homelessness (Housing Prioritization scores of 28 or higher) and veterans | **Outcome:** Clients will remain in permanent housing.  
**Indicators:**  
Threshold: 80% clients will remain permanently housed for 6 months.  
Threshold (increasing): 20% of all participants have employment income.  
Threshold (increasing): 56% of all participants have non-employment income.  
Threshold (increasing): 56% of participants obtain mainstream benefits. |
Rapid Re-Housing
Program of stabilization and assessment, focusing on re-housing all persons, regardless of disability or background, as quickly as possible in appropriate permanent housing.

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<thead>
<tr>
<th>Program Description</th>
<th>Essential Program Elements</th>
<th>Time Frame</th>
<th>Population</th>
<th>Desired / Expected Outcomes</th>
</tr>
</thead>
</table>
| Short-term rental assistance and supportive services program that rapidly re-houses and stabilizes persons who are homeless into appropriate permanent housing. | Case Management  
  - Housing location  
    - Housing stabilization planning using common tools  
  - Employment assistance  
  - Linkage to mainstream resources  
  - Linkage to mental health services as appropriate  
  - Linkage to medical services as needed  
  - Linkage to substance use treatment services as appropriate  
  - Transportation assistance  
  - Financial management  
  Domestic Violence Specific Considerations:  
    - Access to crisis intervention services  
    - Safety planning  
    - Legal advocacy  
  Temporary Financial Assistance  
    - Rental assistance based on lease and housing stabilization plan  
      - Need based rental assistance  
    - Utility assistance  
    - Childcare  
    - Job Training  
  Housing Relocation  
    - Provision of or formalized partnership to housing referrals and placement services  
    - Linkage to community supports and/or wraparound system of services in relation to housing placement  
    - Temporary financial assistance (security deposits, utility deposits, furniture, household supplies)  
  Harm Reduction and Housing First  
    - All supportive housing embraces and practices Harm Reduction and Housing First  
    - Incorporate proven best practices and evidence-based practices  
    - Programs do not require sobriety or medication/treatment compliance as a condition of housing attainment or retention | Up to 24 months of rent subsidy and supportive services, during which households are stabilized | Literally homeless households or those residing in shelters. Households that show the ability to become self-sufficient in a short period of time as evidenced by: having income potential, and do not need intense services to remain housed; recently became homeless; no serious known disabilities | Outcome: Households will secure and maintain appropriate, affordable permanent housing.  
  Indicators:  
    - The Way Home CoC Threshold: 80% of households will exit to permanent housing.  
    - The Way Home CoC Threshold: 70% of households remain housed 3 months after exit.  
    - The Way Home CoC Threshold: 70% of households increase income during program enrollment.  
    - The Way Home CoC Threshold: 70% of participants obtain mainstream benefits. |
## Rapid Re-Housing for Young Adults (ages 18-24 years old)

Program of stabilization and assessment, focusing on re-housing all persons, regardless of disability or background, as quickly as possible in appropriate permanent housing.

<table>
<thead>
<tr>
<th>Program Description</th>
<th>Essential Program Elements</th>
<th>Time Frame</th>
<th>Population</th>
<th>Desired /Expected Outcomes</th>
</tr>
</thead>
</table>
| Supportive services program that rapidly re-houses and stabilizes young adults (ages 18-24 years old) who are homeless into appropriate permanent housing with up to 24 months of rental assistance. | **Case Management**  
- Housing navigation  
- Housing stabilization planning using common tools  
- Linkage to mainstream resources  
- Linkage to mental health, medical, and substance use treatment services as appropriate  
- Transportation assistance  
- Financial, lease, household management  
- Negotiating housemate agreements | Up to 24 months of rent subsidy and supportive services, during which households are stabilized | Literally homeless 18-24 year old households or those residing in shelters. LGBTQ young adults, pregnant and parenting young adults, young adults with extensive involvement in juvenile justice system and/or child welfare system. | Outcome: Young adult households will secure and maintain employment and permanent housing. |
| Peer Specialist | **Employment Assistance**  
- Rapid Employment Model  
- Job coaching  
- Emphasis on retention methods | | May be used as a bridge to PSH | Indicators:  
The Way Home CoC Threshold: 80% of households will exit to permanent housing.  
The Way Home CoC Threshold: 70% of households remain housed 3 months after exit.  
The Way Home CoC Threshold: 70% of households increase income during program enrollment.  
The Way Home CoC Threshold: 70% of participants obtain mainstream benefits. |
| | **Temporary Financial Assistance**  
- Rental assistance based on lease and housing stabilization plan  
- Utility assistance  
- Childcare | | | |
| | **Best Practices/Evidence-Based Practices**  
- Developmentally appropriate program models are employed  
- Trauma-informed programming and housing  
- Self-Sufficiency focused case planning  
- Job coaching, rapid employment and job retention practices are incorporated into program  
- Housing embraces and practices Harm Reduction and Housing First  
- Incorporate proven best practices and evidence-based practices  
- Programs do not require sobriety or medication/treatment compliance as a condition of housing attainment or retention | | | |

### Program Description

- Supportive services program that rapidly re-houses and stabilizes young adults (ages 18-24 years old) who are homeless into appropriate permanent housing with up to 24 months of rental assistance.

### Essential Program Elements

- **Case Management**
  - Housing navigation
  - Housing stabilization planning using common tools
  - Linkage to mainstream resources
  - Linkage to mental health, medical, and substance use treatment services as appropriate
  - Transportation assistance
  - Financial, lease, household management
  - Negotiating housemate agreements

- **Employment Assistance**
  - Rapid Employment Model
  - Job coaching
  - Emphasis on retention methods

- **Temporary Financial Assistance**
  - Rental assistance based on lease and housing stabilization plan
  - Utility assistance
  - Childcare

- **Best Practices/Evidence-Based Practices**
  - Developmentally appropriate program models are employed
  - Trauma-informed programming and housing
  - Self-Sufficiency focused case planning
  - Job coaching, rapid employment and job retention practices are incorporated into program
  - Housing embraces and practices Harm Reduction and Housing First
  - Incorporate proven best practices and evidence-based practices
  - Programs do not require sobriety or medication/treatment compliance as a condition of housing attainment or retention
1.3 Marketing/Advertising – As needed, the Coordinating Entity will send information & updates regarding the Coordinated Access System via email to stakeholders, the 211 hotline, and the general public. The Coordinating Entity also distributes flyers and brochures and maintains information available on its website.

2. The Housing Assessment Process

2.1. Housing Assessors

2.1.1. Roles and Responsibilities - Housing Assessors are staff from designated community agencies. Housing Assessors may office out of Assessment Hubs, be designated as the Assessor for his/her agency, or may be part of a mobile outreach team. All Housing Assessors are required to complete a HMIS intake and housing assessment with individuals in need of housing and pull, from HMIS, “housing matches” available to each individual. The Housing Assessor will then pass the referrals to the individual’s Case Manager or a Housing Navigator. Housing Assessors’ responsibilities include, but are not limited to the following:

- Operating as the initial contact for the Coordinated Access System
- Conducting Housing Assessments (removed VI & next step)
- Client notification of Eligibility and Referral Decisions
- Submission of referrals to the Receiving Program through HMIS as directed
- Collecting & uploading all documents available at assessment
- Participation in case conferences
- Responding to requests by the Coordinating Entity

2.1.2. Training Requirements – Housing Assessors are trained by the Coordinating Entity. The training consists of the 6 hours “Housing Assessor Orientation” in addition to HMIS training on the Coordinated Access workflow.
2.2. **HMIS Workflow** – The workflow below outlines the CA steps in HMIS:

![HMIS Workflow Diagram]

2.3. **Release of Information** – All clients must sign a release of information prior to the assessment process.

2.4. **Client Photos** – Photos can be taken at the time of assessment but are not required. If a photo is taken and uploaded into HMIS, a photo release must be signed by the client prior to the photo being taken.

2.5. **Timeline** - The *Housing Assessor* notifies the client of his/her eligibility and referral decision immediately. Once a referral is made, the *Receiving Program* has 24 business hours to acknowledge the receipt of the referral. The *Receiving Program* must then enroll or deny the referral within 7 days. The *Receiving Program* can reject or deny the referral if the assigned case manager has been unable to contact the household after 7 days. If a household shows up at the *Receiving Program* after the 7 days have expired, the case manager will assist the household in reentering the system through the CAS. All of this information is tracked in HMIS.

3. **Housing Matching**

3.1. **CFTH HMIS Responsibilities** – HMIS Staff at the Coalition for the Homeless is responsible for the daily administration of the HMIS software and providing technical assistance and user training to participating agencies and end-users.
3.2. Housing Navigators

3.2.1. Roles and Responsibilities - Housing Navigators are staff from designated community agencies. Housing Navigators office out of Assessment Hubs, their home agencies, or in the field. All Housing Navigators work with individuals that do not have an existing case manager and would like assistance in navigating the process of securing housing from housing referral to “lease up”. The Housing Navigator provides the client with a welcome letter explaining both the client and staff’s role in the program. Both the client and staff sign the letter and it is maintained in the client’s chart. All Housing Navigators, Outreach Workers, and Case Managers operating as Housing Navigators carry the following responsibilities:

- Assisting client in obtaining necessary documentation required for housing
- Collecting & uploading necessary documentation, securing additional financial assistance if needed, providing transportation, accompaniment to potential housing options, etc.
- Assisting clients in navigating any challenges related to the housing process (application and/or inspection process, landlord negotiation, etc.)
- Participation in case conferences
- Responding to requests by the Coordinating Entity, as appropriate.

3.2.2. Training Requirements – Housing Navigators are trained by the Coordinating Entity. The training consists of the 6 hours “Housing Navigator Orientation” in addition to training HMIS training on the Coordinated Access workflow in HMIS.

3.3. Timeline - Once the Housing Assessor has made contact with the client’s Case Manager or Housing Navigator, that worker contacts the client within 24 hours and begins the process of scheduling intake appointments. This information is tracked in HMIS.

3.4. Unit Availability/Vacancy Posting – All Rapid Re-housing and Permanent Supportive Housing Programs are required to post vacancies in HMIS within 24 business hours of unit/bed availability. If providers know of an impending vacancy, they are able to post the anticipated availability date up to 14 days before unit vacancy. Programs must update vacancy information in HMIS within 24 business hours of a unit/bed being filled. This information is crucial in determining what resources are available and where to send a client needing housing.
4. Housing Referral

4.1. Waitlist – There is one Centralized Waitlist for both permanent supportive housing and rapid re-housing:

4.1.1. Permanent supportive housing is dedicated to households and individuals that are chronically homeless followed by a prioritization score of 28 or higher.

4.1.2. Rapid re-housing plus is dedicated to households and individuals with high vulnerability scores but are not chronically homeless, followed by a prioritization score between 18-27. This housing intervention is extremely scarce, so long waits are to be expected.

4.1.3. Rapid re-housing is dedicated to households and individuals that are not chronically homeless, followed by a prioritization score between 10-17.

4.1.4. If the waitlist indicates an opening for either PSH or RRH, a referral to that opening will be generated in HMIS by an Assessor.

4.1.5. If the program to which the referral was made is one that requires a Navigator, then the Assessor will also generate a referral to the appropriate Navigator.

4.1.6. Navigators or Case Managers attempt to make contact with the client for seven (7) business days.

4.1.7. If the client cannot be contacted within that timeframe, then staff move on to the next client on the list.

4.1.8. Once staff makes contact with the client, the client must decide immediately whether to accept or decline the unit.

4.1.9. If the client accepts the unit, he/she moves forward in the next steps towards move-in.

4.1.10. If the client declines the unit, then the next client on the waitlist is contacted and the client that refused is moved down to the bottom of the appropriate waitlist based on their housing prioritization score.

4.2. Receiving Program Responsibilities – Once a referral is made, the Receiving Program has 24 business hours to acknowledge the receipt of the referral. The Receiving Program must then enroll or deny the referral within 7 days. The Receiving Program can reject or deny the referral if the assigned case manager has been unable to contact the household after seven (7) days. If a household shows up at the Receiving Program after the seven (7) days have expired, the case manager will assist the household in reentering the system through the CAS. All of this information is tracked in HMIS.
4.2.1. Document Requirement Updates - Receiving Programs make eligibility determination decisions within one business day of the intake interview (or when all required application materials are complete). The Receiving Program orally reviews the intake decision notification with the client to ensure that the client understands the decision, and applicable next steps, including the client’s right to appeal the decision. An intake decision notification includes at a minimum:

- first available move-in date, if applicable; and
- reason the client cannot enter the program, including reason for rejection by client or program (which includes redirection to the Housing Navigator), if applicable.
- instructions for appealing the decision.

4.2.2. Reasons for denial – Receiving Programs may only decline individuals and families found eligible for and referred by the Housing Assessor under limited circumstances including:

- there is no actual vacancy available;
- the individual or family missed two intake appointments;
- the Receiving Program has been unable to make contact with the individual or family for seven (7) consecutive business days;
- the household presents with more people than referred by the Housing Assessor and the Receiving Program cannot accommodate the increase;
- the individual or family was denied by independent property owner/landlord due to certain criminal behaviors; or
- based on their individual program policies and procedures the Receiving Program has determined that the individual or family cannot be safely accommodated or cannot meet tenancy obligations with the supports provided by the program.

Programs may not decline persons with psychiatric disabilities for refusal to participate in mental health services. The Receiving Program must update the referral outcome in HMIS for any decisions to accept or reject a client. If the ineligible client has not otherwise been accommodated for the night, e.g. via an intervention by emergency services, the Receiving Program must notify the Housing Navigator, refer the client back, and document that outcome in HMIS. Reason for denial forms must be submitted to the client the same day the decision was made if possible.
4.2.3. **Client Choice** – Clients may decline a referral because of program requirements that are inconsistent with their needs or preferences. For example, clients may decline participation in programs requiring sobriety. The client may decline a referral up to three times, after the third denial the client will be reassessed and placed on the bottom of the waitlist.

4.3. **Move-In** – If the homeless individual or family is accepted, the *Receiving Program* must update the referral outcome in HMIS and arrange for move-in within 30 days. If the client does not move-in as scheduled or within three (3) business days of the original move-in date, the *Receiving Program* must notify and refer the client back to the *Housing Navigator* so that the outcome is documented in HMIS. To the extent feasible given available funding and as necessary, the *Receiving Program* will provide the individual or family with move-in assistance including transportation of household members and personal belongings.

4.4. **PSH to PSH** – under the CoC Program, permanent supportive housing projects may serve individuals and families from other permanent supportive housing projects who originally met the eligibility requirements for permanent supportive housing so long as the program participants were eligible for the original permanent supportive housing (Section 423(f) of the McKinney-Vento Act, as amended by the HEARTH Act). This means that an individual or family may transfer from one permanent supportive housing program to another under the CoC Program. This could occur under the following circumstances:

- If there were another permanent supportive housing program that better met the service needs of the program participant;
- The program participant is evicted by the landlord or housing program and the participant is still eligible for case management services; or
- The current permanent supportive housing program in which the individual or family is enrolled has lost their funding.

4.4.1. **PSH to PSH Referral** – If any of the above scenarios apply, a staff member from the current PSH must notify the *Coordinated Access Project Manager* in writing via email to initiate the process of transferring the client. The *Coordinated Access Project Manager* will verify that the request falls within the guidelines for the transfer as outlined in this manual. The *Coordinated Access Project Manager* will determine if a PSH unit is available, create the referral in HMIS, and notify the current PSH. The current PSH will then be responsible for assisting the program participant in completing the documentation necessary for the new PSH. Transfer requests outside of the ones outlined in this manual will not be approved. If no
PSH unit is available, then the current PSH will have to continue to work with the program participant in securing alternate housing options.

4.5. **Referrals to and from other systems not using HMIS** – The *Coordinated Access System* appropriately addresses the needs of Veterans and individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking.

4.5.1. **Domestic Violence (DV)** – When a homeless or at-risk individual/household is identified by the *Coordinated Access System* to be in need of domestic violence services, that individual/household is referred to the domestic violence hotline immediately. If the individual/household does not wish to seek DV specific services, the individual/household will have full access to the *Coordinated Access System*, in accordance with all protocols described in this manual. If the DV helpline determines that the individual/household seeking DV specific services is either not eligible for or cannot be accommodated by the DV specific system, the helpline will refer the client to an Assessment Hub for assessment and referral in accordance with all protocols described in this manual.

4.5.1.1. **Emergency Transfer Plan** – An individual or household who is a victim of domestic violence, dating violence, sexual assault, stalking, and/or human trafficking and is currently residing in a non-DV housing program may request a transfer if: the individual reasonably believes that there is a threat of imminent harm from further violence if the individual remains within the same unit. If the individual is a victim of sexual assault, the he/she may also be eligible to transfer if the sexual assault occurred on the premises.

A client/tenant requesting an emergency transfer must expressly request the transfer by notifying their Case Manager. Case Manager and Client will troubleshoot any other possible options to resolve the solution in a safe way. Case Manager and Client will discuss how much of the situation the Client wants to reveal to the Landlord to possibly resolve the situation. If the situation cannot be resolved and moving the Client is the only option, the Case Manager will contact Coordinated Access and request a transfer.

Coordinated Access will discuss options with the Client and determine if the Client is eligible for a program that has an available space. The Client will be offered the option to go through the DV Coordinated Access process and receive services from a DV provider. In this situation
the DV Coordinated Access system will take over and the Client’s record in HMIS will be closed upon transfer. If client declines DV services/programs, Coordinated Access will the next possible transfer and informs the Client of the program/location. At that point the Client can accept or deny the referral. If the Client approves of the transfer, the Case Manger will complete a warm hand off to the next program, assist with the transfer, and facilitate a mutual rescission with the Landlord. If the Client wants to deny the transfer, they will stay at the top of the list and wait for the next vacancy in a program they are eligible for. If the Client is in a Scattered Site program with a voucher or rental assistance through Rapid Re-Housing, the Case Manager can assist the Client with a unit transfer to a safer location.

4.5.2. Veterans – When a homeless or at-risk individual is identified by the Coordinated Access System to be a Veteran, additional questions concerning service era, length of service, and discharge status will be asked. If eligible for VA services, the Veteran will be given the option of being referred to the VA Drop-In Center. If the Veteran chooses that option, then that individual is referred to the VA Drop-In Center immediately. If the VA Drop-In Center determines that the individual seeking veteran specific services is not eligible for VA services, the Housing Assessor at the VA Drop-In Center will complete the CA Assessment in HMIS and will either a) refer the household to an available unit or b) add the household to the appropriate waitlist in accordance with the processes outlined in this manual.

5. Case Conferences

5.1. The Coordinating Entity will require a case conference to review and resolve rejection decisions by Receiving Programs. The purpose of the case conference will be to resolve barriers to the client receiving the indicated level of service. Such a case conference will be held in all instances in which an individual or family is declined by a Receiving Program. Case conferences will be held in all instances in which an individual or family has declined more than two placements.

Providers may also request a case conference, at their discretion, in other circumstances in which a client household is insufficiently engaged in actions necessary to secure a permanent placement.

In cases in which a homeless individual or family is facing program termination, the Provider will notify the Coordinating Entity. The Coordinating Entity may then require a case conference to review and determine next steps. The purpose of the case conference will be to discuss interventions used to date and resolve barriers to securing
permanent housing including plans to have the individual or family re-assessed for a more suitable housing program.

The Coordinating Entity will determine which parties will attend a case conference, including but not limited to the Housing Assessor, the Housing Navigator, the Receiving Program, the client, and other contacts as determined necessary. The Coordinating Entity will make all logistical arrangements for the case conference, including but not limited to notifying all parties.

Fair Housing, Tenant Selection Plan, and Other Statutory and Regulatory Requirements

The Coordinating Entity takes all necessary steps to ensure that the Coordinated Access System is administered in accordance with the Fair Housing Act by promoting housing that is accessible to and usable by persons with disabilities. The Coordinated Access System complies with the non-discrimination requirements of the Fair Housing Act, which prohibits discrimination in all housing transactions on the basis of race, national origin, sex, color, religion, disability status and familial status. This also includes protection from housing discrimination based on source of income. Additional protected classes under state law include sexual orientation (including gender identity), marital status, military discharge status, age (40+). Agencies cannot preference any protected class unless allowed by statute/regulation, or written waiver from their funding or regulatory body (i.e. U.S. Department of Housing and Urban Development).

All Authorized User Agencies who enter into an MOU for the Coordinated Access System agree to take full accountability for complying with Fair Housing and all other funding and program requirements. The MOU requires User Agencies to use the Coordinated Access System in a consistent manner with the statutes and regulations that govern their housing programs.

The Coordinating Entity will request from each Authorized User Agency their tenant selection plan and any funding contract that requires or allows a specific subpopulation of persons to be served. For instance, Housing Opportunities for Persons with AIDS (HOPWA) programs will show funding contract, a single-gender program must produce its HUD waiver. It is further recognized that the Fair Housing Act recognizes that a housing provider may seek to fulfill its “business necessity” by narrowing focus on a subpopulation within the homeless population. The Coordinated Access System may allow filtered searches for subpopulations while preventing discrimination against protected classes.

Evaluation and Updating Coordinated Access System Policies and Procedures

The implementation of the Coordinated Access System necessitates significant, community-wide change. To help ensure that the system will be effective and manageable for homeless and at-risk households and for the housing and service providers tasked with meeting their
needs, particularly during the early stages of implementation, THE TX-700 Continuum of Care anticipates adjustments to the processes described in this manual. To inform those adjustments, the Coordinated Access System will be periodically evaluated, and there will be ongoing opportunities for stakeholder feedback, including but not limited to Referral and Receiving Program work groups convened and managed by the Coordinating Entity. Specifically, the Coordinating Entity is responsible for:

- Leading periodic evaluation efforts to ensure that the Coordinated Access System is functioning as intended; such evaluation efforts shall happen at least annually.
- Leading efforts to make periodic adjustments to the Coordinated Access System as determined necessary; such adjustments shall be made at least annually based on findings from evaluation efforts.
- Ensuring that evaluation and adjustment processes are informed by a broad and representative group of stakeholders
- Ensuring that the Coordinated Access System is updated as necessary to maintain compliance with all state and federal statutory and regulatory requirements

Evaluation efforts shall be informed by metrics established annually by the Coordinating Entity, in conjunction with the CoC Steering Committee and Coordinated Access Transition Team. These metrics will be displayed on dashboards located on the Coordinating Entity’s & community’s websites and shall include indicators of the effectiveness of the functioning of the Coordinated Access System itself, such as:

- Wait times for initial contact
- Extent to which expected timelines described in this manual are met
- Number/Percentage of referrals that are accepted by receiving programs
- Rate of missed appointments for scheduled assessments
- Number/Percentage of persons declined by more than one (1) provider
- Number/Percentages of Eligibility and Referral Decision appeals
- # of program intakes not conducted through Coordinated Access System
- Completeness of data on assessment and intake forms

These metrics shall also include indicators of the impact of the Coordinated Access System on system-wide Continuum of Care outcomes, such as:

- Persons referred have length of stays consistent with system guidelines
- Waiting lists are reduced for all services; eliminated for shelter
- Program components meet outcome targets
- Reductions in long term chronic homeless
- Reduction in family homelessness
- Reductions in returns to homelessness
• Reduced rate of people becoming homeless for first time

**Termination**

Any Authorized User Agency may terminate their participation in the *Coordinated Access System* by giving written notice. Housing programs that are required to participate due to HUD guidelines will need HUD approval to terminate participation.
Appendix

A. Coordinated Access Housing Intervention Assessment ........................................28
B. The Way Home Prioritization Policy ..................................................................30
C. The Way Home Housing Prioritization Tool ......................................................31
D. CoC Verification of Disability ............................................................................32
E. Coordinated Access User Agency MOU ............................................................33
Coordinated Access Housing Intervention Assessment

A. History of Homelessness

Where did you stay last night?

**Literally Homeless**
- □ Place not meant for human habitation
- □ Emergency Shelter
- □ Transitional Housing (not chronic)
- □ Hotel paid for by an agency
- □ Institution (□ <90 days)
  → Prior to institution must be 1, 2, or 4 above

**Not Literally Homeless**
- □ Friend or Family
- □ Own Housing/Permanent Housing
- □ Motel paid for by client
- □ Institution (>90 days)
- □ Other ____________________________

How many people are in your household?

<table>
<thead>
<tr>
<th>Adults</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Desired area for housing:

- □ Harris County – Southwest
- □ Harris County – Northwest
- □ Harris County – Northeast
- □ Harris County – Southeast
- □ Ft. Bend County
- □ Montgomery County

Document your housing for the past 3 years. (“Let’s start with last night and work our way backwards.”)

Homeless occasions can only be streets, emergency shelter, hotels paid for by agencies, or <90 days institution (if in one those locations prior)

<table>
<thead>
<tr>
<th>Dates</th>
<th>Location (Be specific; street names, over pass, building):</th>
</tr>
</thead>
<tbody>
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</table>

Are you a veteran?  □ Yes □ No

If yes, what was your discharge?  □ Honorable  □ General  □ Other than Honorable

- □ Bad Conduct  □ Dishonorable

If yes, how many months of active duty did you serve? ________________

Are you interested in access VA services?  □ Yes □ No

**If yes, refer directly to a Veteran service agency for appropriate housing.**
Are you homeless because someone is hurting you?  □ Yes  □ No
Are you interested in accessing DV services?  □ Yes  □ No
Would you like a referral to access DV services?  □ Yes  □ No

**If yes, refer directly to a domestic violence service agency for appropriate housing.**

### B. Health History

<table>
<thead>
<tr>
<th>Have you been diagnosed with any of the following?</th>
<th>□ Serious mental illness □ Developmental disability □ Chronic physical illness or disability that limits your ability to work or perform daily activities □ HIV/AIDS □ Substance Use Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Check all that apply.</td>
<td>□ How frequently do you use? □ Daily □ Weekly □ Monthly □ No longer using □ Have you ever been involuntarily hospitalized for a mental health condition? □ Yes □ No □ How many times have you been to the ER in the past 2 years? ______</td>
</tr>
</tbody>
</table>

Do you have health insurance?  □ Yes  □ No
If yes: What type of insurance do you have?
□ VA □ Medicaid □ Medicare □ Gold Card □ Private □ Other

If Medicare or Medicaid: Who is your insurance company?
□ United Healthcare □ Molina □ Amerigroup/Anthem

### C. Criminal History

1. How many times have you been incarcerated/in jail in the past 2 years? □ Yes □ No
2. Do you have a past felony conviction(s)? □ Yes □ No
3. Have you or anyone who will live with you been convicted of a sexual offense? □ Yes □ No

### C. Employment & Income

<table>
<thead>
<tr>
<th>Please describe your current employment situation or income received.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you currently have income? □ Yes □ No</td>
</tr>
<tr>
<td>If yes, how much? ______</td>
</tr>
<tr>
<td>2. Where does your income come from?</td>
</tr>
<tr>
<td>□ Employment □ SSI/SSDI □ VA □ Retirement</td>
</tr>
<tr>
<td>3. When was the last time you worked?</td>
</tr>
<tr>
<td>□ Currently employed □ 30 days □ 31-90 days □ 3-6 months □ 6-12 months □ 1 yr or more</td>
</tr>
<tr>
<td>4. How often do you go to Workforce Solutions?</td>
</tr>
<tr>
<td>□ Every Day (Where? ________________)</td>
</tr>
<tr>
<td>□ Once per week □ Once a month □ Twice a year □ Never</td>
</tr>
<tr>
<td>5. Do you need to secure disability income?</td>
</tr>
<tr>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

If yes: □ Are you currently applying?
□ Were you in Special Ed classes?
□ Have you seen a doctor in the past 6 months?
□ Have you ever been involuntarily hospitalized for a mental health condition?
□ Have you been diagnosed with any life threatening conditions? (_________________)
PURPOSE:
To ensure that homeless individuals and families assessed through Coordinated Access receive services in the most expeditious way possible and that access to homeless assistance prioritizes those with the greatest needs who are least likely to end their homelessness in the absence of CoC support.

POLICY:
It is the policy of The Way Home that individuals and families with the most severe service needs and the longest lengths of time homeless are prioritized for housing.

PROCEDURE:
The Harris, Montgomery, and Fort Bend County Continuum of Care and The Way Home, with the input from area homeless providers, have established guidelines that outline the order of priority for housing homeless individuals and families. All current and newly developed Permanent Supportive Housing beds have been dedicated to individuals and families that are chronically homeless. All Permanent Supportive Housing turn-over beds have been prioritized for individuals and families that are chronically homeless. All Rapid Rehousing beds have been dedicated to literally homeless individuals and families. The goal of this policy is to ensure that those individuals and families who have spent the longest times in places not meant for human habitation or in emergency shelters, and who have the most severe service needs are prioritized for housing. Severity of service needs refers to individuals or families who have a history of high utilization of crisis services such as emergency rooms, jails, and psychiatric facilities and significant health or behavioral challenges such as substance use disorders or functional impairments.

ORDER OF PRIORITY IN CoC PROGRAM FUNDED PERMANENT SUPPORTIVE HOUSING

1. **First Priority – Chronically homeless individuals and families with a disability with the longest history of homelessness and the most severe service needs.**
   a. The chronically homeless individual, head of household of a family, or youth, when assessed through Coordinated Access, will be assigned a vulnerability score between 28-51, with 51 being the most severe service needs.

2. **Second Priority – Literally homeless individuals and families with a disability and the most severe service needs.**
   a. The literally homeless individual, head of household of a family, or youth, when assessed through Coordinated Access, will be assigned a vulnerability score between 18-27, with 27 being the most vulnerable; and
   i. the CoC has not identified any chronically homeless individuals, families, or youth who meets all of the criteria for housing under the first priority.

3. **Third Priority – Literally homeless individuals and families with the most severe service needs.**
   a. The literally homeless individual, head of household of a family, or youth, when assessed through Coordinated Access, will be assigned a vulnerability score between 18-27, with 27 being the most severe service needs; and
   i. the CoC has not identified any chronically homeless individuals, families, or youth who meets all of the criteria for housing under the first priority.

ORDER OF PRIORITY IN CoC AND ESG PROGRAM FUNDED RAPID REHOUSING

1. **Priority – Literally homeless individuals and families**
   a. The literally homeless individual, head of household of a family, or youth, when assessed through Coordinated Access, will be assigned a vulnerability score between 10-17, with 17 being the most vulnerable.
## Housing Prioritization Tool

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a Chronic?</td>
<td>Yes/No/Logic</td>
<td>25</td>
</tr>
<tr>
<td>1b Where did you sleep last night? (only show if chronic = no)</td>
<td>Streets/Logic</td>
<td>4</td>
</tr>
<tr>
<td>1c Have you been homeless before? (only show if chronic = no)</td>
<td>Shelter/Logic</td>
<td>2</td>
</tr>
<tr>
<td>1d How many times have you been homeless in the past 3 years? (only show if chronic = no)</td>
<td>Yes</td>
<td>2</td>
</tr>
<tr>
<td>1e How many times have you been homeless in the past 3 years? (only show if chronic = no)</td>
<td>&gt;4</td>
<td>2</td>
</tr>
<tr>
<td>2 Frequent yes/no from dashboard (don’t ask)</td>
<td>Yes</td>
<td>2</td>
</tr>
<tr>
<td>3 Do you or anyone in your household have a disabling condition? (only show if chronic = no)</td>
<td>Yes/Logic</td>
<td>4</td>
</tr>
<tr>
<td>4 How many times in the past 6 months have you accessed medical services in the ER?</td>
<td>1/Logic</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>2</td>
</tr>
<tr>
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<td>3</td>
<td>3</td>
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<td></td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>5+</td>
<td>5</td>
</tr>
<tr>
<td>5a Do you have a serious physical health condition that requires frequent medical care? (Examples: symptomatic AIDS, cancer, tracheotomy, colostomy, open wounds with instructions to keep clean, end-stage renal disease, end-stage liver disease, amyotrophic lateral sclerosis (ALS or Lou Gherig’s disease) terminal illness, or in hospice)</td>
<td>Yes/No/Logic</td>
<td>3</td>
</tr>
<tr>
<td>6a Observation: Assessor, do you observe signs or symptoms of a serious physical health condition?</td>
<td>Yes</td>
<td>5</td>
</tr>
<tr>
<td>6b Has a doctor or professional ever recommended mental health services?</td>
<td>Yes/No/Logic</td>
<td>2</td>
</tr>
<tr>
<td>7a In the past year, have your drugs or alcohol usage had a negative impact on your life?</td>
<td>Yes/No/Logic</td>
<td>2</td>
</tr>
<tr>
<td>7b Observation: Assessor, do you observe signs or symptoms of drugs or alcohol use?</td>
<td>Yes</td>
<td>2</td>
</tr>
<tr>
<td>8 How many times in the past year have you been arrested or been in jail/prison/juvenile detention?</td>
<td>1/Logic</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>3</td>
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<td></td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>5+</td>
<td>5</td>
</tr>
<tr>
<td>9 Have you experienced domestic violence in the past 60 days?</td>
<td>Yes</td>
<td>2</td>
</tr>
<tr>
<td>10a Has someone asked (or forced) you to have sex or sell anything in exchange for something?</td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>10b Is someone threatening to harm you or your family if you don’t do what they ask?</td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>11 Do you have income?</td>
<td>No/Logic</td>
<td>1</td>
</tr>
</tbody>
</table>

**Observation: Assessor, do you observe signs or symptoms of a mental health condition?**

**Observation: Assessor, do you observe signs or symptoms of drugs or alcohol use?**

**Have you been homeless before? (only show if chronic = no)**

**How many times have you been homeless in the past 3 years? (only show if chronic = no)**

**In the past year, have your drugs or alcohol usage had a negative impact on your life?**

**Observation: Assessor, do you observe signs or symptoms of a serious physical health condition?**

**Has a doctor or professional ever recommended mental health services?**

**How many times in the past year have you been arrested or been in jail/prison/juvenile detention?**

**Have you experienced domestic violence in the past 60 days?**

**Has someone asked (or forced) you to have sex or sell anything in exchange for something?**

**Is someone threatening to harm you or your family if you don’t do what they ask?**

**Do you have income?**

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**Chronic Max:** 51

**Non C:** 27-18

**RRH:** 17-10

**Income:** 9 & below
This form verifies that the applicant named above has a disability necessary for determining eligibility for a HUD CoC Permanent Supportive Housing Program. A person shall be considered to have a disability if he or she has one or more of the following and that the disability is expected to be long-continued or of indefinite duration and substantially impedes the applicant’s ability to live independently:

1. Serious mental illness;
2. A developmental disability as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002);
3. Substance use disorder;
4. Post-traumatic stress disorder;
5. Cognitive impairments resulting from brain injury; OR
6. Chronic physical illness or disability.

Diagnosis: ________________________________

Printed Name of Physician or Licensed Professional: ________________________________

License Number: ________________________________

Agency or Clinic Name: ________________________________

Phone Number: ________________________________ Fax Number: ________________________________

By signing below, you are verifying that this applicant has the condition as stated above & that you are qualified to make that diagnosis.

Signature/Credentials: ________________________________ Date: ________________________________

In addition to MD’s, the following is a list of acceptable qualified professionals determined by HUD to diagnose a disability:

LCSW (Licensed Clinical Social Worker) LPHP (Licensed Practitioner Health Professional) LNP (Licensed Nurse Practitioner)
LNP (Licensed Family Nurse Practitioner) LCDC (Licensed Chemical Dependency Counselor) LPC (Licensed Professional Counselor)
LMFT (Licensed Marriage Family Therapy) PhD (Licensed Psychologist)

If not able to sign, please explain: ____________________________________________________________

_____________________________________________________________________________________

Signature/Credentials: ________________________________ Date: ________________________________

APPLICANT’S AUTHORIZATION TO RELEASE INFORMATION

I, ________________________________, hereby authorize the release of the requested information pertaining to my disability to the Agency named above.

_________________________________________  ________________________________
Applicant’s Signature Date
Coordinated Access System

Memorandum of Understanding (MOU) between the **Coalition for the Homeless Houston/Harris County (CFTH), and ____________________________**

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**PURPOSE**

The Department of Housing and Urban Development (HUD)’s new regulations requires that all Continuums of Care (CoCs) develop and implement a coordinated access and assessment system for all CoC funded programs. A Coordinated Access System (CAS) is a *centralized or coordinated process designed to coordinate program participant intake, coordinate assessments, and coordinate the provision of referrals to housing*. The CAS will enable clients to move quickly through the system and be matched to the best intervention strategy that will permanently and effectively end their homelessness. The CAS will also reduce duplication of efforts, reduce returns to homelessness, and assist with ending homelessness.

In order to accomplish effective coordination with mainstream and homeless services, formal agreements dictating client eligibility, intake, service provision expectations, and staffing are being developed with mainstream and homeless service providers on behalf of the system of homeless providers. The agreements will also ensure that all providers are using the system in an open, transparent, and consistent way.

**GENERAL PROVISIONS**

*(CFTH)* will:

1) Serve as the Lead Agency in the Continuum of Care (COC);
2) Maintain the Homeless Management Information System (HMIS), including the CAS Workflow;
3) Coordinate the system of homeless and homelessness prevention services in the Harris, Fort Bend, and Montgomery County continuum area;
4) Provide lead staff to guide the CAS Workgroup and any relevant subgroups;
5) Coordinate, integrate, and leverage resources to maximize impact of services for individuals who are experiencing homelessness;
6) Develop and implement policies and procedures on how the CAS will be operated;
7) Provide training to all staff dedicated to the CAS including Housing Assessors and Navigators;
8) Provide guidance and supervision to CAS staff as it relates specifically to the CAS;
9) Evaluate performance and progress of the CAS and make adjustments as necessary.
10) Oversee the Case Conferences and Appeals process as necessary.
11) Provide branding materials (shirts, business cards, etc.) for the use of CAS staff upon start-up only; and
12) Approve any press releases and communication with the media in regards to CAS.
will:

1) Serve as a member of the CAS Workgroup for the purpose of engaging in a joint venture to develop and implement an array of integrated services designed to stabilize housing for people who are literally homeless or imminently at-risk of homelessness;

2) Provide XX primary staff who, as members of the _______ Team and supervised by a ________ manager, will serve as CA Housing Assessors;

3) Agree to assess and refer clients for services through the CAS only;

4) Enter and maintain timely client data in HMIS;

5) Name a designated staff contact for the CAS.

6) Provide all necessary supplies and technology equipment at Assessment Hub location;

7) Ensure all CAS staff wear and use materials related to CAS (shirts, business cards, etc.); and

8) Coordinate and receive approval for and press releases and communication with the media in regards to the CAS.

CONFIDENTIALITY

All parties agree that they shall be bound by and shall abide by all applicable Federal or State statutes or regulations pertaining to the confidentiality of client records or information, including volunteers. The parties shall not use or disclose any information about a recipient of the services provided under this agreement for any purpose connected with the parties’ contract responsibilities, except with the written consent of such recipient, recipient’s attorney, or recipient’s parent or guardian.

EQUAL OPPORTUNITY

CFTTH, and __________ mutually agree to be bound by and abide by all applicable anti-discrimination statutes, regulations, policies, and procedures as may be applicable under any Federal or State contracts, statutes, or regulations, or otherwise as presently or hereinafter adopted by the agency.

TERMS OF AGREEMENT

This MOU shall be effective upon adoption by each signatory agency and entity.

This MOU shall be reviewed and revised as needed to further implementation of strategic and long-term goals of the project.
This MOU can be expanded, modified, or amended, as needed, at any time by the consent of all agencies.

This MOU shall be in effect until the end of this project unless terminated by mutual agreement in writing prior to the project end date.

__________________________________
By: _______________________________

Name: ____________________________

Title: _____________________________

Date: _____________________________

COALITION FOR THE HOMELESS OF HOUSTON/HARRIS COUNTY

By: _______________________________

Name: ____________________________

Title: _____________________________

Date: _____________________________