Coordinated Access Navigators

Coordinated Access Navigators are service providers trained to assist individuals and families experiencing homelessness with submitting a Vulnerability Assessment, and gathering the necessary documentation needed to complete formal housing applications. Any Baltimore City service provider whose official job responsibilities include finding housing for homeless clients can register as a navigator. Navigator agencies must be funded to provide behavioral health services, homeless outreach, or case management. Navigators must have a supervisor who is responsible for ensuring they carry out their responsibilities ethically and appropriately. Agencies can submit a request to become a navigation agency; however, the request must be approved by MOHS.

The MOHS approval process is as follows:

- Interested agencies complete the interest form.
- The Coordinated Access Manager meets with the agency for vetting and to discuss expectations, roles and responsibilities as a navigating agency.
- The CA Manager informs the HRS Committee of agency interest, and makes a recommendation on if the agency is a good fit or not.
- For approved agencies, the Navigator Agency application is sent to the agency to complete. Once completed, the CA Manager sends the application to the HMIS team.
- HMIS facilitates next steps with the agency for training and any additional information needed.

Please click here to review the Policies and Procedures for the Navigator duties. Register your organization as a Navigator Agency by clicking here.

Coordinated Access System Policies and Procedures

Coordinated Access Overview

Coordinated Access is a centralized process for assessing persons in need of homeless services to determine the appropriate service type and housing option. Coordinated Access will streamline access to housing and services rather than having to apply separately at each program location. The vision of the Coordinated Access system is "to ensure that individuals and families at-risk of or experiencing category 1 or 4 homelessness will have an equitable and centralized process for timely access to appropriate resources, in a person-centered approach that preserves choice and dignity". Coordinated Access is required by the U.S. Department of Housing and Urban Development for all Continuums of Care (CoC) as stated in 24 CFR 578.7 (a)(8) of the Continuum of Care Program Interim Rule.

The Coordinated Access system is overseen by the HRS Committee of the Journey Home Board. The Journey Home Board oversees the work of Baltimore City's Continuum of Care with the vision of making homelessness rare and brief.

The HRS Committee is responsible for overseeing development of the system's policies and procedures. The Committee is staffed by the Coordinated Access Lead Agency, currently the Baltimore City Mayor's Office of Homeless Services, Homeless Services Program (MOHS-HSP). Any Continuum of Care member may join the committee.

Policy and procedure revisions occur as follows:

1. MOHS is primarily responsible for day-to-day updates and revision to provide clarity and add information.
2. The HRS Committee must approve by vote any significant policy changes.
3. Any Committee member can propose a change by contacting the HRS Committee Chair.
4. The proposed change will be raised at a future HRS Committee meeting. (Changes that contradict regulatory requirements cannot be considered.)

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, in transitional/Interim housing or places not meant for human habitation;

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

Evaluating and Updating the 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 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 Journey Home anticipates adjustments to the processes' described in this manual. The HRS Committee shall at least annually evaluate the CAS and release that evaluation to the Journey Home CoC membership. That evaluation shall include at minimum the following elements:

A narrative description of the CAS implementation current status, including successes, challenges, ongoing barriers, and plan for future expansion and improvement.

Performance indicators over the previous 12-month period, including at minimum:

- Total number of persons who sought or received assistance through CAS;

- Total number of persons and total number of households;
- Score Ranges for all assessments completed by subpopulation group;
- Total number of people in score ranges (min, max, median);
- Demographics of all persons who received assistance through CAS;
- Tracking of assessments completed by Access point and navigating agency;
- Total number of persons and total number of households referred to a Rapid Rehousing Project;
- Total number of persons and total number of households referred to a Permanent Supportive Housing Program;
- Exit destinations for households referred to:
    - Rapid Rehousing;
    - Permanent Supportive Housing
- Months of financial assistance provided
- Total number of unsuccessful matches
- Length of time homeless after contact:
    - Average length of time from completion of assessment to project entry for Rapid Rehousing;
    - Average length of time from completion of assessment to project entry for Permanent Supportive Housing;
    - Average length of time on the By Name list before referral to and successful enrollment in Rapid Rehousing;
    - Average length of time on the By Name list before referral to and successful enrollment in Permanent Supportive Housing;
    - Length of time from CA Assessment to first housing referral.

A periodic evaluation of the Coordinated Access System will provide ongoing opportunities for stakeholder feedback. The Coordinated Access Lead Agency will be responsible for monitoring the Coordinated Access System. All client data used in the evaluation will be aggregate and de-identified.

Guiding Principles

Housing First

The Coordinated Access system is Housing First oriented, with the intention that participants are housed quickly without preconditions or service participation requirements. Housing First is a proven approach in which people experiencing homelessness are offered permanent housing with few to no treatment preconditions, behavioral contingencies, or barriers to entry. It is based on overwhelming evidence that all people experiencing homelessness can achieve stability in permanent housing if provided with the appropriate levels of services. Studies have indicated that Housing First yields higher housing retention

rates, reduces the use of crisis services and institutions, and improves people's health and social outcomes.

Housing First is an approach that can be adopted by housing programs, organizations, and across the housing crisis response system. The approach applies in both short-term interventions, like rapid re-housing, and long-term interventions, like Permanent Supportive Housing. For crisis services like emergency shelter, Transitional Housing, and outreach, the Housing First approach means referring and helping people to obtain permanent housing. Housing First does not mean that a housing resource will be available for every individual or family that seeks services. Instead, it provides a way of ensuring within a resource-limited environment that the most vulnerable are prioritized for housing.

Nondiscrimination and Equal Opportunity

The Coordinated Access system does not use data collected from the assessment process to discriminate or prioritize households for housing and services on a protected basis, such as race, color, religion, national origin, sex, age, familial status, disability, actual or perceived sexual orientation, gender identity or marital status. Participating projects must comply with the nondiscrimination and equal opportunity provisional of Federal civil rights laws, including the following:

- Fair Housing Act prohibits discriminatory housing practices based on race, color, religion, sex, national origin, disability, or familial status. This includes steering clients to particular neighborhoods based on protected factors.

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

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

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

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

- HUD Equal Access Rule prohibits discriminatory eligibility determinations in HUD-assisted or HUD-insured housing programs based on actual or perceived sexual orientation, gender

identity, or marital status, including any projects funded by the CoC Program, ESG Program, and HOPWA Program.

- CAS will not screen people out of programs/housing due to perceived barriers including but not limited to income, active or history of substance use, domestic violence history, lack of interest in services, disabling condition, evictions or poor credit, lease violations or any type of criminal record.

Compliance with Housing First and Nondiscrimination and Equal Opportunity requirements will be monitored by MOHS as the Coordinated Access Lead for all participating projects. All decisions declining a client to a participating project will be reviewed to ensure compliance with Housing First, Non-Discrimination, Equal Opportunity and Coordinated Access Protocols.

Fair Housing grievances related to discrimination should be made directly to the U.S. Department of Housing and Urban Development.

http://portal.hud.gov/hudportal/HUD?src=/program_offices/fair_housing_equal_opp

Grievances can be filed online using the link below.

https://www.hud.gov/program_offices/fair_housing_equal_opp/online-complaint

Criteria For Defining Homelessness

Coordinated Access participating programs use only Categories 1 and 4 for the purposes of determining eligibility.

Category 1 – Literally Homeless per HUD definition
Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:

- Primary nighttime residence that is a public or private place not meant for human habitation;
- Living in a publicly or privately-operated shelter designated to provide temporary living arrangements; or
- 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

Category 2 – Imminent Risk of Homelessness
Individual or family who will imminently lose their primary nighttime residence, provided that:

- Residence will be lost within 14 days of the day of the application for homeless

assistance;

- No subsequent residence has been identified; and
- The individual or family lacks the resources or support networks needed to obtain other permanent housing

Category 3 – Homeless under other Federal statutes

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:

- Are defined as homeless under the other listed federal statutes;
- Have not has a lease, ownership interest, or occupancy agreement in permanent housing during the 60 days prior to the homeless assistance application;
- Have experienced persistent instability as measures by two moves or more during the preceding 60 days; and
- Can be expected to continue in such status for an extended period of time due to special needs or barriers

Category 4 – Fleeing/Attempting to Flee Domestic Violence

Any individual or family who:

- Is fleeing, or is attempting to flee, domestic violence;

Has no other residence; and

- Lacks the resources or support networks to obtain other permanent housing

HUD Chronic Homeless Definition

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

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

   b. Has been homeless and living as described in paragraph (a) continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (a). 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 the institutional care facility;

2. An individual who has been residing in an institutional care facility, including a jail, substance abuse or

mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; **or**

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

Persons Fleeing Domestic Violence

Coordinated Access appropriately addresses the needs of individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking (24 CFR 578.7). When a homeless household is identified by Coordinated Access to be in need of domestic violence services, that household is referred to the domestic violence hotline immediately. In addition to DV specific services, the household will have full access to Coordinated Access, in accordance with all protocols described in this document.

Assessments completed for persons fleeing domestic violence can be entered as anonymous assessments following the instructions provided in this document. This process should be followed by all providers working with persons fleeing or attempting to flee domestic violence, regardless of whether or not the navigator is working with a victim specific provider.

Coordinated Access Entry Points

Access points ensure that people experiencing homelessness have the ability to meet with a trained Assessor to complete the Baltimore CoC Standardized Assessment, the first step towards movement to housing options coordinated through the Coordinated Access System. Baltimore utilizes existing service providers as access points for the system and plans to expand access points to additional entities that encounter people experiencing homelessness. These access points cover and are accessible throughout Baltimore City and will be affirmatively marketed to eligible persons regardless of race, color, national origin, religion, sex, gender, gender identity, age, familial status, disability or who are least likely to complete a Coordinated Access System Assessment in the absence of special outreach.

Various access points will accommodate cohorts within the population such as Youth, Veterans, Families, survivors of domestic violence, and adults experiencing either homelessness or chronic homelessness to ensure fair and equal access for all populations into the coordinated access process. While marketing will encourage people, who are part of a particular cohort to connect with particular access points, any person will be accommodated at any access point.

When households present for services at access points, the assessor shall administer a list of standardized assessment questions to the individual or family. If the assessor determines the applicant is neither experiencing homelessness nor at imminent risk of homelessness, the assessor shall refer the

applicant to Homeless Prevention or other local/mainstream resources.

A listing of access points can be found on the Street Outreach Cards distributed by the Mayor's Office of Homeless Services. The Street Outreach Card is available using the link below or by contacting the MOHS office.

Street Outreach Card

Street Outreach workers may be the primary contact for Coordinated Access to those living on the street and least likely to engage with mainstream service providers.

See handout: "Tips for Explaining Coordinated Access to Clients."

Agencies Required to Use the Coordinated Access System

All Agencies serving households experiencing homelessness are encouraged to use the Coordinated Access System for referrals. Agencies receiving Housing and Urban Development (HUD) Continuum of Care (COC) and City of Baltimore, Mayor's Office of Homeless Services (MOHS) funding must participate. All participating agencies are required to use Coordinated Access as their sole source for filling vacancies.

Types of Housing Models and Programs

The Coordinated Access System includes housing options of all types. Households experiencing homelessness will be given the opportunity to choose the type of housing best suited to them. Referrals will be made to all housing types based on availability and eligibility. All participating housing providers are required to fill all of their vacancies through the Coordinated Access System.

Description of Housing types found here

Housing Models

1. **Project-Based** – Housing assistance is attached to specific housing units

2. **Sponsor-Based** – Program participants reside in housing owned or leased by a sponsor organization.

3. **Tenant-Based** – Participants can choose and lease safe, decent, and affordable privately-owned rental housing.

Program Types

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

Individuals and families defined as Homeless under the following categories are eligible for assistance in PSH projects:

a. Category 1: Literally homeless per the HUD definition, head of household is residing on the streets, in a shelter, or in a place not meant for human habitation.

i. PSH programs also require that Category 1 clients who are currently residing in transitional housing programs must have been staying on the street, in a shelter, or in a place not meant for human habitation *immediately* before enrollment in that transitional housing program.

b. Category 4: Fleeing/Attempting to Flee DV.

i. PSH programs may focus on specific eligible subpopulations such as those experiencing mental health or substance abuse disorders if they meet the required categories of homelessness outlined above.

2. **Rapid Rehousing (RRH)** - Rapid re-housing is designed to quickly connect connects families and individuals experiencing homelessness to permanent housing through a tailored package of assistance that may include the use of time-limited financial assistance and targeted supportive services. Rapid rehousing programs help families and individuals living on the streets or in emergency shelters solve the practical and immediate challenges to obtaining permanent housing while reducing the amount of time they experience homelessness, avoiding a return to homelessness, and linking to community resources that enable them to achieve housing stability in the long-term.

a. Category 1: Literally homeless per the HUD definition, head of household is residing on the streets, in a shelter, or in a place not meant for human habitation.

b. Category 4: Fleeing/Attempting to Flee DV.

3. **Transitional Housing (TH)** – The City of Baltimore has transitional housing programs funded with ESG or CoC funding so Coordinated Access will include transitional housing programs.

**Please refer to the Prioritization section in this document*

Roles, Targeting, and Populations

Roles

These are the specific roles in the Coordinated Access process:

Applicant: An Individual/Household in the City of Baltimore who is experiencing literal homelessness per the HUD definition including individuals and households of more than one person needing permanent housing. An applicants current living situation meets the definition of homelessness according to the Homelessness Emergency and Rapid Transition to Housing (HEARTH) Act. Youth under the age of 25 who are unstably housed will meet the homeless definition for programs funded to serve this population.

Assessor*:* Assessors are supportive service staff trained to use the Coordinated Access Standardized Assessment tool. Assessors conduct initial vulnerability assessments with presenting clients and serve as the ongoing point of contact for the Coordinated Access System. Assessors are trained to complete the Coordinated Access Assessment documentation, enter data into HMIS, and obtain signed confidentiality agreements.

- *Assessor Responsibilities*

1. Make every effort to locate and engage the client, build trust with the client, and help the client prepare for the housing placement.
2. Help the client assemble required Coordinated Access assessment documentation
    a. Vulnerability assessment
    b. Consent form

Authorized User Agencies: Housing providers who wish to or are required to participate in the Coordinated Access System (CAS).

Collaborative Applicant*: The* eligible applicant designated by the Continuum of Care (CoC) to collect and submit the CoC Registration, CoC Consolidated Application, and apply for CoC planning funds on behalf of the CoC during the CoC program Competition.

HRS Committee*:* This entity is the governing body of the CAS and provides oversight of the planning and implementation of CAS. MOHS manages the CAS by name list, which is used to prioritize and match clients to housing.

Coordinated Access Lead*:* MOHS is the lead agency for the Coordinated Access System. MOHS serves as the project manager for CAS implementation.

Emergency Services*:* Emergency services such as shelters and drop-in centers may serve as access points to the Coordinated Entry System by connecting people to a trained Assessor. Clients will be able to access emergency services independent of the operating hours of the system's intake assessment process for CAS.

***HMIS Administrator**:* The Baltimore City Mayor's Office of Homeless Services, Homeless Services Program (MOHS) is the CoC HMIS Lead. MOHS provides training for new users of the HMIS system and Coordinated Access System. MOHS creates agency and staff new user profiles.

***Navigator**: Navigators* are staff trained to assist the client with gathering the necessary documentation needed to complete formal housing applications. Navigators and Assessors are frequently the same person and receive identical training.

Navigator Responsibilities

1. If your client is identified as ready to move to the Navigation Phase, assemble the required ID documents, proof of income, disability, and homeless status, and any additional eligibility verification.
2. Help clients matched with housing programs attend housing appointments.
3. Remove barriers to housing such as applying for income benefits, health insurance, security deposit assistance, and energy assistance (if needed and resources are available).
4. When the client is connected to another agency for navigation, ensure that agency is prepared to take on this role and ensure the Coordinated Access system is updated.
5. Understand and follow the process and timeline to help clients obtain housing and services.

***Outreach Worker**:* Outreach Workers assist the Applicant in accessing the CAS, including assisting the Applicant in getting to a drop-in center to complete a Standardized Housing Assessment. Outreach workers may also be Trained Assessors. Once a housing option is identified, Outreach Workers may serve as a secondary contact between Agencies and Applicants. Outreach Workers may assist Applicants with gathering the necessary documentation needed to complete formal housing applications.

Referral to Street Outreach can be made by calling 311.

***Shelters and Interim Housing**:* Access to MOHS emergency shelter and interim housing resources will not change. For households in need of emergency shelter, they may access information on shelter availability by calling the hotline at **443-984-9540**. Referrals to street outreach can be made by calling 311. For emergency services please call 911. Crisis response programs will not create barriers to entry such as requiring a CAS assessment for entry. Emergency services staff will connect households to the CAS by offering space to Trained Assessors, informing participants of the CAS process and how to complete a CAS assessment, and in some instances serving as an access point.

***System Coordination** – Matchers:* MOHS Coordinated Access team reviews assessments and sends appropriate matches to the navigator agency and housing providers with vacancies. In the event the match is unsuccessful the matcher will return the client to the BNL for future match consideration. The matching entity reviews the response to the referral and will connect the individual to subsequent

housing options as needed. Matchers also monitor and receive vacancies.

Targeting Resources: Standardized Assessment

The Coordinated Access System is open to all households who meet the HUD definition of experiencing homelessness. The Coordinated Access standardized assessment is open to all individuals/households experiencing homelessness and is separated into sections which assist in determining homelessness, vulnerability, barriers, and other criteria related to eligibility for housing programs.

HUD requires that programs prioritize chronically homeless persons. Within HUD Guidelines,[1] Baltimore's Coordinated Access workgroup developed a local prioritization policy.

The system will include the following program types dedicated to serve homeless persons:

- Rapid Re-housing, and
- Permanent Supportive Housing

The Coordinated Access process for permanent supportive housing uses vulnerability indices (described below) to rank Applicants in order of vulnerability, with the most vulnerable households at the top of the list. More directly, Applicants may be offered housing regardless of vulnerability ranking, but more vulnerable persons will likely be offered housing before less vulnerable persons. Applicants will be prioritized in the following order:

1) Chronic Homelessness first, (With at least 9 months of 3rd Party Verification and 12 months of reported homelessness over the past 3 years)
2) VI Score (descending) second,
3) Number of days homeless (descending) third.

Baltimore has adopted a practice of filling all supportive housing units with people facing chronic homelessness first. If no person facing chronic homelessness can be found for the unit the level of vulnerability will be taken into consideration as the next priority.

Referrals to programs (PSH or RRH) will not be assigned to different levels of service within the program based on vulnerability scores. Instead, households will be matched based on availability, system-wide eligibility, client preferences, and prioritization criteria. Regardless of vulnerability ranking, people will be able to access Rapid Rehousing Services.

Programs with a less intensive and ongoing service model can accommodate people with a lower vulnerability score who may or may not be facing chronic homelessness. Those with lower vulnerability and facing chronic homelessness will be prioritized above those with higher acuity who are not facing chronic homelessness for permanent housing with short term supports and rapid rehousing programs.

Single Adults

Individual: A single person, who may be an elderly person, displaced person, disabled person, near elderly person, or any other single person.

The standardized assessment tool is used to identify members of the homeless population who are considered highly vulnerable and who will face an increased risk of mortality if homelessness persists. Baltimore has adapted the assessment to include questions specific to our community. Key areas assessed include:

- Somatic health issues
- Mental health
- Substance use
- Risk and protective factors

Households with Children under 18

Family: includes, but is not limited to, regardless of marital status, actual or perceived sexual orientation, or gender identity, any group of persons presenting for assistance together with or without children and irrespective of age, relationship, or whether or not a member of the household has a disability. A child who is temporarily away from the home because of placement in foster care is considered a member of the family.

Family vulnerability is evaluated on the same conditions as single adults with additional assessment of the following family-specific conditions:

- Children being separated from parents
- Children missing 20 or more days of school in the past school year
- More than 3 children under 18 in household
- Family has moved 2 or more times in the last 12 months

Additional Points for families with children

To ensure access to the appropriate service for households with minor children who are also experiencing homelessness, additional points may be added to the Vulnerability Assessment Score.

Households with minor children receive **one** additional point for each child in their custody or expected to return to their custody once they are housed.

Example: Mary is residing in a women's shelter. Her two children are staying temporarily with their

grandmother. Once Mary finds housing the children will return to live with her full-time. Two additional points would be added to Mary's Assessment score, one for each child expected to return to her custody.

Households with minor children who are also experiencing homelessness may receive one additional point per child.

Example: Mary and her two children are residing in a family shelter. **One** additional point may be added to Mary's assessment score for each child in her custody AND **one** additional point for each child who is experiencing homelessness with her for a maximum of two points per child.

Youth (Unaccompanied Young Adults Age 18-24)

Youth vulnerability is evaluated using 2 assessment tools, the Tay SPDAT and Vulnerability Assessment. The Tay SPDAT is used for Youth dedicated housing programs.

Parenting youth will fill out both the family and youth sections of the vulnerability assessment.

Minors

Minors are youth under the age of 18. Minors will not be assessed and instead should be immediately connected to a Minor Access Point.

Clients Fleeing Domestic Violence

Clients fleeing or attempting to flee domestic violence (including dating violence, sexual assault, or stalking) are encouraged to work with **House of Ruth** (Hotline: 410-889-7884), but may choose to work with any service provider.

Providers serving clients fleeing or attempting to flee domestic violence must obtain consent to collect and share the client's information and the consent must specify with whom the information is shared. Sharing should be minimized as much as possible according to the client's safety needs. Data should be entered using the Anonymous Assessment procedures. Within the Coordinated Access system, sharing of a client's information can be restricted to the client's navigator organization, the Mayor's Office of Human Services, and the housing program(s) to which the client agrees to be matched.

Clients fleeing or attempting to flee domestic violence qualify for Permanent Supportive Housing under Category 4. Their status should be documented using the Category 4 Form.

Please see a copy of the Coordinated Access Vulnerability Assessment and Scoring Sheet.

Targeting Beyond Vulnerability Assessments

Agencies that serve a specific target population may receive referrals of that target population. To target a specific population, agencies must provide documentation of receipt of funding that supports the unit and maintains funder-defined targeting criteria.

Examples of targeting criteria include:

- Area Median Income
- Household Composition
- Gender (applied to shared housing)
- Youth/Senior
- HIV/AIDS
- Veteran Status
- Disabling Condition (presence of, not specific condition)
- Dual Diagnosis (presence of, not specific condition)
- Domestic Violence provider

Agencies receive referrals from CAS that meet the stated targeting criteria, following the same system wide prioritization for matches. Applicants experiencing chronic homelessness and those with the highest vulnerability scores in the designated range will be matched first.

Navigator Trainings

Navigator trainings will be held annually, at a minimum. The purpose of the training is to provide all staff administering assessments with access to materials that clearly describe the methods by which assessments are to be conducted with fidelity to the CoC's coordinated entry written policies and procedures. Training will include a review of CoC's written CE policies and procedures, requirements for use of assessment information to determine prioritization and Criteria for uniform decision-making and referrals.

Coordinated Access System Workflow

Step 1: Connecting to the Coordinated Access System

To ensure accessibility to the households in need, the Coordinated Access System provides access to services from multiple, convenient physical locations. Households have access to assessment at various points of entry within the homeless system. The most common entry points will be overnight shelters, MOHS Housing Navigators located in public libraries, interim housing programs, through an outreach team or at a drop-in center. Included in the assessment packet is a consent for release of information

for Coordinated Access.

To see a list of MOHS Housing Navigation locations click here.

Step 2: Assessment Phase

Households are not required to be enrolled in a shelter or interim program to complete the Coordinated Access assessment. Assessments can and should be updated as contact information or life circumstances change. It is recommended that the Vulnerability Assessment is revised and updated every six months if the household continues to experience homelessness or more frequently if life changes dictate this need such as emergency room visits, hospitalizations, learning about a new diagnosis, involvement in the child welfare system, or juvenile detention center encounters.

If a person is in crisis and requires shelter the first step will be to connect this person with a shelter as capacity allows and then follow up with a connection to a Trained Assessor to complete this assessment. The general guideline for assessment completion is within 2-7 business days in shelters and within 7 -10 business days in Interim housing to account for households who may be able to self-resolve..

Training for Assessors, Navigators and agency staff serving as access points will be held, and required, at minimum annually and more frequently as needed. All households experiencing homelessness should be assessed and may not be prevented from accessing the Coordinated Access System because of any barriers including but not limited to income, active or history of substance use, domestic violence history, lack of interest in services, disabling condition, evictions or poor credit, lease violations or any type of criminal record.

Applicants may refuse to answer questions included in the standardized assessment. However, doing so may limit the Applicant's possible permanent housing and service opportunities if the questions that are not answered are related to eligibility criteria for specific programs. However, refusing to provide specific information during the assessment phase will not limit access to other forms of assistance. The assessment process does not require that the Applicant share a specific disability. Coordinated Access assessment procedures follow federal Fair Housing Laws for protected classes such as race, color, religion, national origin, sex, age, familial status, disability, actual or perceived sexual orientation, gender identity or marital status. Data will be stored by MOHS in a password protected local drive while the system is offline. When the HMIS update is implemented, data will be protected by HMIS and only shared as allowed for based on the consent of the Applicant.

Anonymous Assessments

Clients may still enroll in the Coordinated Access System even if they do not consent to share their information with MOHS. Clients who do not consent to share their personal information will still need to complete a vulnerability assessment in order to be prioritized for housing. In order to submit an anonymous assessment, Assessors/Navigators should contact MOHS to obtain a random sequence of 10 characters. This code should be used in place of **all** personally identifying information (including name, date of birth, SSN, and any names of minors in the household). The client will then appear on the by-name list identified just by this code.

By-Name List

A by name registry will be maintained through the Homeless Management Information System (HMIS) that records all households experiencing homelessness in Baltimore. This list can only be viewed with identifying information by the Coordinated Access System managing entity, MOHS. This list includes an active and inactive list.

Active List

Clients on the Active List are currently enrolled in Coordinated Access.

Inactive List

Clients who have exited from Coordinated Access. Clients can exit from Coordinated Access when…

- Moving into housing (e.g., Moving with family, friends, Moving in to PSH or RRH housing)
- Client is found not eligible for Coordinated Access
- Auto Exit (client has not had contact with navigator for over 90 days)
- Client decides they are no longer interested in pursuing housing through Coordinated Access

Only people on the active list within the By-Name List will be matched to housing providers. This practice allows our community to connect people thought to be experiencing homelessness to housing providers while accounting for the inconsistency of updates regarding people who may no longer face homelessness or live in Baltimore. If a person moved to the inactive list due to not having any contact with any HMIS reporting agency in 90 days re-engages with any part of the system reporting to HMIS, the person will be moved back onto the active list. Applicants are removed from the By-Name List when they move into housing such as transitional housing, rapid rehousing, permanent housing with short term supports, permanent supportive housing, affordable or market rate housing or move out of the City of Baltimore and this is known by providers updating HMIS with his/her information.

Step 3: Navigation Phase

MOHS regularly reviews the by-name list and will be able to use current availability to predict which applicants will likely be at the top of the list in the next 1-3 months. Eligibility confirmation will be necessary to move forward with placing the clients into housing programs. This includes obtaining documents to verify chronic homeless status, disability, income, ID, and any other program-specific eligibility documents. To do this, applicants will be connected with a Housing Navigator. The Housing Navigator can be one of the following: the original Assessor, an existing case manager for the applicant or from the new housing provider.

Step 4: Housing Match

Applicants at the top of the by-name list will be referred to housing interventions best suited to end the household's homelessness (Permanent Supportive Housing or Rapid Rehousing) based on program eligibility and availability and client preferences. MOHS will connect the most vulnerable Applicants to housing providers with vacancies. Agencies notify MOHS each time a new unit or set of units becomes available to indicate they require Applicants to be matched to their program. MOHS matches applicants to housing opportunities based on the established system-wide prioritization standards. One Applicant from the active list is matched to each vacancy with a 1:1 ratio. A follow up email will be sent to the Trained Assessor, Navigator, Housing Provider, and any Case Managers listed in the assessment.

Once a client has been notified of a match they will have 10 business days to decide whether they will accept the match. After a client has tentatively accepted the match, they will complete an intake with the program type and depending on the program type, will have the opportunity to view the unit. Applicants will only be matched with one unit at a time. Housing providers may request a new match after 10 days if they have followed all contact protocol and cannot locate the Applicant. A minimum of 5 unique attempts to contact the Applicant should be made within the 10-day period.

A Coordinated Access match is not a guarantee of housing, it simply means that a unit in a housing program has been identified and is being held for the client for a designated period of time.

Step 5: Intake

Housing programs must follow up with clients matched to them through Coordinated Access. The client will then do an intake at the housing program and begin the process for moving in. At project-based programs (project-based or sponsor based), the client should have the opportunity to tour the facility. Different housing programs may have additional steps in their intake process. Certain funding sources may require a background check as part of the intake process. Clients might benefit from the opportunity to meet or speak with current tenants.

After the intake appointment, the client may still decide to decline placement in the housing program. If this happens, the client is placed back on the by-name list and the housing program is given another name.

At Intake client should be advised of:

- Supportive services available but not required
- Program rules
- Client/tenant responsibilities
- Rent/utility calculations
- Grievance policy
- Termination policy

Clients cannot be required to participate in services (as a condition of their tenancy) except those required by the funding source, e.g. case management appointments.

Clients can be strongly encouraged to participate, but cannot be threatened with termination for failure to participate.

Every reasonable effort should be made to help the client find a unit that matches their preferences. Reasonable accommodations for clients with disabilities must be granted throughout this process, especially pertaining to requests for time extensions related to medical issues or hospitalizations.

Step 6: Inspection

This step depends specifically on the housing program. Tenant-based units will assist clients with finding a unit in the area and initiating an inspection. Housing programs are encouraged to collaborate with the client's navigator as much as possible during this phase. Once the inspection is complete, the program will communicate inspection results to the client and navigator. If the unit is tenant-based, the client may have multiple units to choose from.

Every reasonable effort should be made to help the client find a unit that matches their preferences. Reasonable accommodations for clients with disabilities must be granted throughout this process, especially pertaining to requests for time extensions related to medical issues or hospitalizations.

Step 7: Move-In

Once the client has been approved by the program and has a unit that has passed inspection, they are able to move into the unit. The housing programs work with the client to move into the unit.

Housing move-in date should only be shared based on the following.

- Client has signed lease
- Client has keys
- Client has physically stayed at the property for one night

Barriers to Housing

Once the client has an address that they are prepared to move into, navigators and housing programs will make every effort to help clients matched with housing overcome barriers to moving in.

There are two funds available to provide assistance to clients who need assistance with moving in.

Flex Fund: The Flex Fund is temporarily available each year for clients who may need assistance either with moving into their housing unit, or remaining in their unit. The following items are eligible uses of the Flex Fund.

1. *Rent Relief*
2. *Security Deposit and 1st Months Rent*
3. *General Arrears (Rent and/or Utilities)*
4. *Short Term Shallow Subsidy*
5. *Relocation Assistance for One-Way Travel*
6. *Minor Upgrades or Cleaning for Mental/Medical Health*

All Flex Fund applications must have exhausted mainstream resources before applying to Flex Funds. Clients must meet all of the requirements for the Eligible use they are requesting.

BGE Debt: Navigators who have clients that need assistance with resolving BGE debt can apply to the Office of Home Energy Programs (OHEP) and the Fuel Fund directly through Coordinated Access through the Power of Home (PoH) program. Power of Home is an additional source of money for OHEP and Fuel Fund clients that apply through Coordinated Access to help cover any outstanding BGE back debt that may be a barrier to the client moving in. Clients must be homeless and entering a PSH or RRH program. The referral must be submitted by the housing program or a Coordinated Access navigator.

Declining a Match

There are 5 reasons why a program can move on from the client that is matched through Coordinated Access:

1. **No actual vacancy is available:** MOHS attempts to ensure that all vacancies listed in Coordinated Access actually exist. However, a program may list a vacancy based on anticipated vacating of a unit that does not occur. This is very rare, but does occasionally happen.
2. **Unable to make contact with the household.**
3. **Household presented with more/fewer people than were referred by MOHS and the receiving program's unit size is not a match for the increase/decrease in household size.**
4. **Client does not meet program requirements:** The Coordinated Access system attempts to ensure that all matched clients meet the requirements of the programs they are matched to. A client not meeting the program's requirements can occur for the following reasons:
    a. When a client completes intake at the housing program, the program may discover that information provided to Coordinated Access during the assessment or navigation phase is not accurate. This could be the result of an error on the part of MOHS or the navigator to properly document eligibility. Coordinated Access may not screen for specific factors that may be used to determine a client's eligibility for some programs. For example, some providers may be required to conduct a criminal background check for all residents. Coordinated Access does not participate in these intake procedures, so a client who is matched through the system may be determined to not meet the specific program criteria.
    b. When a household is deemed ineligible for a HABC subsidized unit, that client has the right to appeal this decision, and that housing offer must be held for the household until the appeal is resolved.
5. **Client refused placement**: The client may decline the placement in the program for any reason. In this case, the client is placed back on the list and offered the next unit based on their prioritization score. Once a client refuses placement, the unit is offered to the next client on the list. Refusing a placement has no negative impact on a client but clients are not guaranteed the same level of priority previously established if a more vulnerable client enters the system.

All decisions declining a client to a participating project will be reviewed to ensure compliance with Housing First, Non-discrimination, Equal Opportunity and Coordinated Access Protocols.

Coordinated Access Grievance and Appeals Process

An appeal is a request to reconsider a decision on eligibility, a grievance is an official complaint filed if a client is dissatisfied with the behavior or actions of a provider agency or MOHS.

Coordinated Access partners must provide all individuals and families with the Coordinated Access Appeals and Grievance Policies. Individuals and families must have the option to file their appeals or grievances orally or in writing. All appeals and grievances must be resolved promptly and fairly, in the most informed and appropriate manner.

Agency grievances are grievances that are related to the individual's or family's experience with a CA Partner agency, including the agency providing the Assessment, Navigation Services, and/or Housing Providers. These grievances should be redirected back to the agency to follow the agency's grievance policy and procedures.

Coordinated Entry Appeals are appeals related to the Coordinated Access Policies and Procedures and/or related to CA decisions, including decisions made by MOHS. These appeals shall be directed to Baltimore City Mayor's Office of Homeless Services, Homeless Services Program (MOHS-HSP) 7 East Redwood Street Baltimore, Maryland.

Rapid Resolution/Shelter Diversion

The Coordinated Access system is designed to match clients with Permanent Supportive Housing and Rapid Re-Housing resources. Both of these project types require that clients be either literally homeless (as defined by HUD) or fleeing or attempting to flee domestic violence.

As a result, the Coordinated Access process does not triage clients for Homeless Prevention services. Clients can access homeless prevention services directly at one of the following sites. All Coordinated Access Navigators who encounter clients seeking homeless prevention services should refer their clients directly to these sites.

1. Baltimore City Department of Social Services

   443-378-4600 | 1910 N. Broadway Street

Transfer Policy

This Transfer policy applies to the following types of transfers through the Coordinated Access System.

- Rapid Rehousing to Rapid Rehousing
- Rapid Rehousing to Permanent Supportive Housing
- Permanent Supportive Housing to Permanent Supportive Housing
- Permanent Supportive Housing to Rapid Rehousing

Under certain circumstances, a client may be better served by a transfer from one housing program to another. Transfers will be facilitated by the Continuum of Care Collaborative Applicant, The Mayor's Office of Human Services (MOHS).

Transfers may be initiated by a housing provider that no longer has the ability to serve a client or by the client directly. Housing providers are required to contact the Coordinated Access Team at MOHS to request transfer if a change in client's circumstance makes them ineligible for their specific service. Housing programs receiving transfers are required to accept these incoming clients through the Coordinated Access system. Clients enrolling in a housing program through a transfer must meet the

same standards and have the same rights as a client enrolling through the typical Coordinated Access process.

Transfers may be requested for the following reasons:

1. The provider and client feel that another program is better suited to the client's individual needs.
2. The client feels that they are not getting the services they need, or are being treated unfairly by the current housing provider and all attempts to resolve the client's concern without a transfer have been unsuccessful.
3. The client has experienced a change in household composition that can't be accommodated by the current housing provider.
4. There is a significant risk of harm to the client in the current placement
5. The client needs a reasonable accommodation that the provider needs the assistance of a transfer in accommodating. All requests will be reviewed as part of the transfer request process. 6. Other issues affecting a current client's placement that will be reviewed on a case-by-case basis.

Client Initiated Transfers

Clients seeking a transfer should complete the Client Transfer Request Form (Attachment B). A client may request a transfer through their current housing provider or by contacting MOHS directly. Clients will only be considered for transfers to programs for which they meet the eligibility requirements.

Coordinated Access matches clients to multiple types of housing programs funded by different federal, state, and local grants operating under different eligibility requirements. As a result eligibility and procedures for transfers may vary for clients living in certain housing programs. Residents newly enrolling in these programs will be informed of any variations or limitations in transfer policy and will have the opportunity to decline the housing opportunity.

If a transfer request involves a client grievance, MOHS will investigate the grievance as part of the transfer review process. Requests will be considered on a case-by-case basis.

All transfers are based on current unit availability and prioritization methods.

Provider Initiated Transfers

Providers seeking to transfer a client must complete and submit a Provider Transfer Request Form (Attachment A) to MOHS. Provider-initiated transfers can only occur in circumstances where the transfer is necessary to prevent a client's return to homelessness. This may occur when a client has a change in household composition that the program cannot accommodate or if the client is facing

termination from a site-based program. Documentation of the reason(s) for the transfer request must be submitted with the transfer request form as well. All transfers are based on current unit availability and prioritization methods. Clients will only be considered for program transfers to programs for which they meet the eligibility requirements. For clients in units funded by the Housing Authority of Baltimore City there may be additional requirements for transfer that must be met.

Providers who are considering termination of a client must use transfer as an option to prevent the client's return to homelessness. Providers must continue to provide services until the transfer is made.

A client has the option to decline a transfer. If the transfer is declined the client may lose their housing through the termination and eviction process. They can complete another vulnerability assessment, however length of homelessness will be newly calculated using the exit date from the previous housing program.

Special grant considerations for programs include:

- *CoC-Funded Tenant-Based Rental Assistance (TBRA) Programs*: May not terminate a client from the program unless the client no longer meets HUD eligibility for housing or are not fulfilling HUD program requirements. If a client faces or experiences an eviction due to serious lease violations or non-payment of rent to the landlord, the program must continue to work with the client and assist them in locating a new unit.
- *CoC-Funded Sponsor-Based Rental Assistance (SBRA) Programs*: May terminate a client from the program if the landlord evicts the client from the unit due to serious lease violations, no longer meets HUD eligibility, or is not fulfilling HUD program requirements. However, this should occur only as a last resort and only if the program has exhausted all other reasonable, alternative options available. The program must consult directly with MOHS if the cause for a transfer request is related to a pending termination from the program.
- *CoC-Funded Project-Based Programs*: May terminate a client from the program if the client commits serious lease violations, no longer meets HUD eligibility, or is not fulfilling HUD program requirements. However, this should occur only as a last resort and only if the program has exhausted all other reasonable, alternative options available. The program must consult directly with MOHS if the cause for a transfer request is related to a pending termination from the program.

Transfer Request Processing

Once the Transfer Request form is submitted, MOHS will acknowledge receipt in writing within ten business days. Client must remain in place until transfer can be accomplished or is denied. Final determination will be made within 15 business days. If the client needs emergency accommodations before the transfer review process can be completed, MOHS should be notified by phone as soon as possible. Providers do not need MOHS approval before making emergency accommodations in the

interest of a client's safety.

Transfer Request Processing: Request to Split Households within a CoC Funded Program

To make sure rent support can be used to assist as many individuals and families as possible, a household receiving an ongoing subsidy from a CoC funded program should only be split in the event of an existing verified safety concern. e.g.,

a. violence in the household
b. medical need

In the event a split is approved, the new household requesting to receive rental support for a unit separate from the currently subsidized unit is still required to provide the HUD regulated documentation needed to determine their eligibility for a CoC funded Permanent Supportive Housing (PSH) or Rapid Rehousing (RRH) programs. Including:

1. Verification of Disability (PSH only)
2. Verification of Category 1 or 4 homelessness before entering their current CoC Program

References on HUD Homeless Definition and Documentation

Homeless *Definition: 24 CFR § 576.500 .*

- *Rule and Rationale: Homeless Definition Final Rule.*
- *Eligibility by Program Type: The Homeless Definition and Eligibility for SHP, SPC, and ESG,*
- *Recordkeeping Requirements: Recordkeeping and reporting requirements (b) (5).*, *Criteria and Recordkeeping for Definition of Homeless, and HUD CPD 014-12.*

Chronically Homeless *Definition (see above)*

- *Rule and Rationale: Defining "Chronically Homeless" Final Rule*
- *Recordkeeping Requirements: ~~HUD CPD 014-12~~ replaced by CPD-16-11.*
- *Maintaining CH status in RRH.*
- *Maintaining CH status in TH and Bridge Housing.*
- *Maintaining homeless and CH status in VA Programs.*
- *See also: Webinar on Chronic Definition.*
- 3rd party documentation and definition of breaks AAQ on the CH Rule
- More on 3rd party documentation and definition of AAQ on CH Documentation Requirements