Policies and Procedures

A Program of The Alliance to End Homelessness in Suburban Cook County

 Adopted by Alliance Board February 22, 2019
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**Purpose and Background**

Entry Point is the Coordinated Entry System for Suburban Cook County Continuum of Care (CoC). The purpose of Entry Point is to ensure that all people experiencing homelessness have fair and equal access to housing, regardless of race, color, national origin, religion, sex, age, familial status, disability, actual or perceived sexual orientation, gender identity, or marital status. The system aims to work with households to understand their strengths and needs, provide a common assessment, and connect them with housing and homeless assistance. Entry Point will help suburban Cook County better target limited resources provided by the homeless assistance system to people who are experiencing homelessness and need them the most. By standardizing the intake process across the region, by sharing information in real-time, and by adopting uniform prioritization policies, homeless service agencies will be able to refer people to the right program based on their preferences and level of need.

The Alliance to End Homelessness in Suburban Cook County adopted the following four goals for the Entry Point system (*Coordinated Entry Protocol for Suburban Cook County, adopted 2/26/2016*):

1. Entry Point will match participants to resources based on their preferences and needs within the capacity of the available community resources.
2. Entry Point will improve access to all homeless-specific resources, particularly rapid re-housing, homelessness prevention, and permanent supportive housing.
3. Entry Point will promote low-barrier and Housing First principles in all programs that work with people experiencing homelessness or who are at imminent risk of homelessness.
4. Entry Point will meet HUD’s requirements and will be responsive to the needs of the community.

Entry Point is intended to be comprehensive and accessible to everyone in the region who experiences a housing crisis. In compliance with HUD’s requirements, all programs funded by the Continuum of Care (CoC) and the Emergency Solutions Grant are required to participate in the Coordinated Entry process. Over time, other housing programs will be invited to participate in Coordinated Entry, and the system will be open to all programs regardless of funding source.

Entry Point is designed to:

- Allow anyone who needs assistance for a housing crisis to know where to go to get that assistance and to be assessed in a standard and consistent way;
- Ensure that households who are experiencing homelessness gain access as efficiently and effectively as possible to available community interventions;
- Prioritize households for limited housing resources based on need and vulnerability;
- Provide clarity, transparency, consistency, and accountability throughout the assessment and referral process for households experiencing homelessness, community partners, and homeless and housing service providers; and
- Facilitate exits from homelessness to stable housing in the most rapid manner possible.
To achieve these objectives, Entry Point includes:

- A **standard assessment process** to be used for all households who are seeking assistance, and procedures for determining the appropriate next level of assistance;

- Establishment of **uniform guidelines** among homeless housing programs (emergency shelter, transitional housing, rapid re-housing, and permanent supportive housing) regarding eligibility for services, screening criteria, prioritized populations, expected outcomes, and targets for length of stay;

- Consistent **referral policies and procedures** from Entry Point to housing programs and other resources;

- The **Operations Manual** contained herein and detailing the operations of Entry Point.
Requirements of a Coordinated Entry Process

Since the CoC Program interim rule was published in 2012, HUD has learned a great deal about what makes a Coordinated Entry process most effective and has determined that additional requirements are necessary. Those requirements are outlined in CPD-17-01.


In alignment with these requirements and continued HUD guidance, the Cook County Continuum of Care has implemented a Coordinated Entry system, Entry Point, for all households who are experiencing homelessness. Entry Point, as described in this manual, is designed to meet the Federal and State requirements of a Centralized or Coordinated Assessment System which, at a minimum, must adopt the following minimum requirements (CoC Program interim rule: 24 CFR 578.3 & 24 CFR 578.7(a)(8)):

1. Cover the entire geographic area claimed by the CoC;
2. Be easily accessed by individuals and families seeking housing or services;
3. Be well-advertised;
4. Include a comprehensive and standardized assessment tool;
5. Provide an initial, comprehensive assessment of individuals and families for housing and services;
6. Include a specific policy to guide the operation of the centralized or coordinated assessment system to 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 specific providers.

HUD Participation Requirements

The Departments of Housing and Urban Development (HUD) and Veteran’s Affairs (VA) have established guidance that instructs all CoC projects to participate in their CoC’s Coordinated Entry system. Any project that receives HUD funding (CoC Program, Emergency Solutions Grant, and Housing Opportunities for People with AIDS) or VA funding (Supportive Services for Veteran Families, Grant and Per Diem, Veterans Affairs Supportive Housing) must comply with the participation requirements as established by the corresponding CoC jurisdiction (CoC Program interim rule: 24 CFR 578.7(a)(8); ESG interim rule: 24 CFR 576.400(d)).

Entry Point Participation Expectations

- CoC and ESG funded projects must communicate project vacancies, including bed/unit-specific information to the Entry Point Lead Team
- Households experiencing a housing crisis must access CoC and ESG services and housing using Entry Point defined access points.
- CoC and ESG projects must enroll only those clients referred according to the Entry Point’s designated referral process, and
- CoC and ESG projects must commit to participate in the CoC’s Entry Point planning and management activities as established by CoC leadership.
As part of the annual CoC and ESG application processes, each project must submit a report that identifies the number of participants its project referred, accepted, rejected and/or served from the CE process.

Note: certain exceptions apply to domestic violence service providers, see Special Populations.

**CoC and ESG Coordination**

The CoC is committed to aligning and coordinating policies and procedures governing assessment, eligibility determination and prioritization with its written standards for administering CoC and ESG Programs funds. *(CoC Program interim rule: 24 CFR 578.7(a)(9); ESG interim rule: 24 CFR 576.400(d) and (e)).*

Each CoC and ESG recipient operating within the CoC’s geographic area will work together to ensure the CoC’s coordinated entry process allows for coordinated screening, assessment, and referrals for ESG and CoC funded projects. The CoC, in consultation with recipients of ESG program funds, will establish and consistently follow written standards for providing CoC assistance and establish formalized policies and procedures for:

- Guidance for evaluating household’s eligibility for assistance under 24 CFR Part 578.
- Guidance for determining and prioritizing which eligible households will receive transitional housing assistance.
- Guidance for determining and prioritizing which eligible households will receive rapid re-housing assistance.
- Guidance for determining what percentage or amount of rent each program participant must pay while receiving rapid re-housing assistance.
- Guidance for determining and prioritizing which eligible households will receive permanent supportive housing assistance.

**Fair Housing and Non-Discrimination**

CoC’s must develop and operate a coordinated entry process that permits recipients of Federal and state funds to comply with applicable civil rights and fair housing laws and requirements *(HUD Coordinated Entry Notice: Section I.D).* Recipients and subrecipients of CoC Program- and ESG Program- funded projects must comply with the nondiscrimination and equal opportunity provisions of federal civil rights laws, as specified at 24 CFR 5.105(a). Civil Rights and Fair Housing Laws and Requirements are outlined in *Appendix D.*

Cook County CoC is committed to take all necessary steps to ensure that Entry Point policies and procedures are administered in accordance with the Fair Housing Act by promoting housing that is accessible to and usable by persons with disabilities. Entry Point 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. See Entry Point Non-Discrimination and Client Inclusion policies in *Appendix F.*

All Partner Agencies take full accountability for complying with Fair Housing and all other funding and program requirements. Contracts require the Partner Agencies to use Entry Point in a consistent manner with the statutes and regulations that govern their housing programs.
Affirmative Marketing

CoC Program interim rule 24 CFR 578.93(c); 24 CFR 5.105(a)(2) and HUD Coordinated Entry Notice: Section I.C.1, requires Coordinated Entry systems to affirmatively market CoC supportive services and housing to eligible persons least likely to apply in absence of special outreach.

The Entry Point Affirmative Marketing Strategy is designed to ensure all suburban Cook County households have fair and equal access to Entry Point and CoC services and housing regardless of sex, gender identity, age, color, creed, disability status, family status, marital status, sexual orientation, ethnicity, national origin, religion, limited English proficiency, or any other attribute or characteristic that could be perceived as a barrier to gaining entry to services and/or housing.

Entry Point Affirmative Marketing Procedures will include the following:

1. An outreach program that includes measures designed to attract those groups identified as least likely to apply and other efforts designed to attract persons from the total population;
2. Advertising in locations or media that are used by those identified as least likely to enter Entry point or CoC services and housing;
3. Marketing Entry Point and CoC services and housing at CoC participating agencies as well as community, religious, support organizations or other groups frequented by those least likely to enter CoC services and housing;
4. Developing a brochure or handout that describes the Entry Point processes to be used by persons experiencing a housing crisis to locate, identify, and access Entry Point services;
5. Developing a website that describes the Entry Point processes to be used by persons experiencing a housing crisis to locate, identify, and access Entry Point services, see www.myentrypoint.org;
6. Ensuring that the Entry Point lead staff, staff at Entry Point access locations, Entry Point assessors and staff at CoC and ESG participating agencies have been trained about the Fair Housing Act, and the purpose and objectives of Entry Point Affirmative Marketing Policy;
7. Good faith efforts will be made to ensure that marketing media is accessible by eligible persons in suburban Cook County regardless of sex, gender identity, age, color, creed, disability status, family status, marital status, sexual orientation, ethnicity, national origin, religion, limited English proficiency/literacy or any other attribute or characteristic that could be perceived as a barrier to gaining entry to services and/or housing.

For Entry Point Affirmative Marketing Policy see Appendix E.
Training

HUD Coordinated Entry requirements *(HUD Coordinated Entry Notice: Section II.B.14)* specify that Entry Point will provide training opportunities at least once annually to organizations and or staff persons at organizations that serve as access points or administer assessments. Entry Point will distribute training protocols at least annually. 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 Entry Point’s written policies and procedures.

Additionally, Entry Point’s training curricula must include the following topics for staff conducting assessments:

- Review of CoC’s written CE policies and procedures, including any adopted variations for specific subpopulations;
- Requirements for use of assessment information to determine prioritization; and
- Criteria for uniform decision-making and referrals.

To comply with HUD regulations and to conduct assessments with fidelity to Alliance coordinated entry goals and guiding principles, and Entry Point written policies and procedures, Entry Point will follow the following training standards as outlined in Appendix C.

Evaluation

CoC must ensure through written CE policies and procedures the “frequency and method by which the [CE system] evaluation will be conducted, including how project participants will be selected to provide feedback, and must describe a process by which the evaluation is used to implement updates to existing policies and procedures. *(HUD Coordinated Entry Notice: Section II.B.15.c)*. The Alliance, CE Oversight Committee and Entry Point Lead Agency will conduct ongoing evaluation of the system to ensure that improvement opportunities are identified, that results are shared and understood and that the CE system is held accountable. See Appendix O for Entry Point Evaluation and Monitoring guidelines.
Guiding Principles

The Alliance to End Homelessness in suburban Cook County (Cook County CoC) establishes the following guiding principles for its coordinated entry system:

1. Entry Point will operate with a person-centered approach and with person-centered outcomes. Entry Point will ensure that participants quickly receive access to the most appropriate services and housing resources available.

2. Entry Point will reduce the stress of the experience of being homeless by limited assessments and interview to only the most pertinent information necessary to resolve the participant’s immediate housing crisis.

3. Entry Point will incorporate cultural and linguistic competencies in engagement, assessment, and referral coordination activities.

4. Entry Point will implement standard assessment tools and practices and will capture only the limited information necessary to determine the severity of the household’s needs and the best referrals strategy for the household.

5. Entry Point will integrate mainstream service providers into the system, including HACC and Hines VA.

6. Entry Point will utilize HMIS for the purposes of managing household information and facilitating quick access to available CoC/ESG resources.

7. Entry Point will strive to create policies and procedures and support the capacity of CoC and ESG funded projects to ensure that households do not wait on the prioritization list for referrals to housing or services more than 60 days, in conjunction with HUD recommendations.
Roles and Responsibilities

Alliance to End Homelessness in Suburban Cook County

The Alliance to End Homelessness in Suburban Cook County coordinates the Cook County Continuum of Care (IL-511), which encompasses homeless assistance efforts throughout all of Cook County except for the city of Chicago. Established in 1997 as the Task Force on Homelessness, the group changed its name and formally incorporated in August 2004. To shift its focus from managing homelessness to ending homelessness in our county, the Alliance also hired a full-time staff and secured nonprofit 501(c)(3) status in 2005.

As the lead agency for suburban Cook County’s Continuum of Care, the Alliance brings together a range of services and housing options for homeless people. The Alliance convenes a variety of stakeholders to cooperatively set priorities, collect data, rank project applications, and measure outcomes. In coordinating the annual application to the US Department of Housing and Urban Development (HUD) for homeless assistance grants, the Alliance brings in approximately $9 million per year to support over fifty homeless programs in the region.

The Alliance organizes its work at the local grassroots level into three Community Based Service Areas (CBSAs) for Homeless Assistance. These CBSAs—serving the north, west, and south areas of suburban Cook County—form a collaborative homeless assistance information, referral, shelter, and service delivery system within their local communities. The CBSAs have been instrumental in the overall development and implementation of the Continuum of Care strategy.

The mission of the Alliance to End Homelessness is to strive for the elimination of homelessness in suburban Cook County through the coordination and maximization of available resources to assist homeless individuals and families. The Alliance serves as a convener for the collaborative, community-based endeavors of homeless service providers, affordable housing developers, local governments, foundations, and the private sector.

Homeless Management Information System (HMIS)

The 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 Alliance to End Homelessness in Suburban Cook County is the HMIS Lead Agency for Suburban Cook County CoC and will provide all data collection, quality, management and reporting required for the Entry Point Lead Agency and Participating Agencies to design, implement and administer Coordinated Entry services. Personal information is not entered in HMIS for people who are 1) receiving services from domestic violence agencies; 2) fleeing or in danger from domestic violence, dating violence, sexual assault or stalking situation; or 3) have revealed information about being HIV positive or having AIDS. All HMIS users will receive training from HMIS staff how to determine when information should not be included in the database and how to lock down information when it can be entered.

The policies and procedures concerning the protection of all data collected in HMIS is outlined in the Suburban Cook County HMIS Standard Operating Procedures and HMIS End User Manual. These HMIS documents and additional information can be found on the Alliance to End Homelessness in Suburban Cook County website: http://www.suburbancook.org/hmis
Entry Point Oversight Committee

The Entry Point oversight committee will provide governance and oversight of the system. The committee will be made up of Alliance staff, representatives from nonprofit partner agencies, and the Entry Point Lead Team. Participation in the committee will be encouraged by a broad representation of our continuum including individuals with lived experience, transition-aged youth, and any interested community representatives. The oversight committee will have two co-chairs elected annually by the committee; co-chairs may not work for or be affiliated with the Entry Point lead agency. Additionally, Alliance Staff and the Entry Point Lead Team will not be voting members.

The oversight committee is responsible for:

- Providing general oversight and support to the Coordinated Entry system.
- Receiving, investigating, and resolving grievances from participants and providers that cannot be resolved by the Coordinated Entry Lead agency.
- Adjudicating appealed referrals from housing programs.
- Evaluating the efficiency and effectiveness of the Coordinated Entry process by reviewing performance data on a regular basis.
- Conducting an annual review of the Coordinated Entry Protocol.
- Recommending policy changes or protocol improvements to the Continuum of Care Board of Directors for final approval.
- Regularly providing updates to the Continuum of Care and community partners to ensure the transparency of the Coordinated Entry system.

Entry Point Lead Agency

The Alliance to End Homelessness in Suburban Cook County has contracted with an Entry Point Lead Agency along with a consortium of Implementing Partner agencies to design and implement a Coordinated Entry system guided by Coordinated Entry Protocols adopted February 26, 2016 and in compliance with HUD Coordinated Entry requirements and guidelines. The Coordinated Entry lead agency, selected through a competitive RFP process and compensated through the CoC Coordinated Entry grant, is responsible for day-to-day implementation and evaluation of the Coordinated Entry system, as follows:

- **Project Management:** Responsible for the successful implementation of Coordinated Entry, including all access points, assessments, and the referral process. Provides leadership to staff, operational support, and appropriately engages with community stakeholders. Provides oversight and manages grant budget and monitors contractual compliance for Implementing Partner Agencies. Actively participates in the Coordinated Entry governance structure.

- **Due Process:** Responsible for developing and maintaining a process to receive and respond to grievances of participants and providers. Grievances that cannot be resolved by the Entry Point Lead and all provider appealed referrals will be forwarded to the oversight committee for resolution. Any grievances against the Entry Point Lead Team or Housing Forward sending or receiving projects will be delivered to the Alliance and brought to the oversight committee if the Alliance and Entry Point Lead Team are unable to resolve the grievance.

- **Outcome Measurement:** Oversees data entry, tracks system progress as defined by the Coordinated Entry performance metrics, runs performance reports, and shares them with community stakeholders.
• **Participating Program Coordination:** Responsible for facilitating homeless service providers’ participation in Coordinated Entry to ensure full participation, communication, and coordination. Identifies additional organizations that can receive referrals from Coordinated Entry for non-homeless assistance services and works with them to ensure quality and appropriate referrals from the Entry Point system.

• **Referral Coordination:** Facilitates the housing referral process and ensures that the referral process is smooth and successful for participants, sending agencies and receiving agencies.

• **Training:** Responsible for designing and implementing a training curriculum that will comply with minimum HUD requirements as well as meet the goals and objectives of the CoC.

## Implementing Partners

Implementing Partners are homeless service agencies that are contracted with the Entry Point Lead Agency to operationalize the Coordinated Entry system for Suburban Cook County. Implementing Partners share in grant funds that the CoC has allocated to enhance system-wide capacity to successfully implement Coordinated Entry functions. Implementing Partners are monitored annually by the Entry Point Lead Team to ensure compliance with terms sub-recipient agreements which include match requirement and scope of work to provide staffing. Including:

• **Intake (Phone):** First point of contact at the Suburban Cook Call Center. Responsible for entering all data into HMIS, conducting pre-screen assessments, and making referrals to homelessness prevention, housing interventions, stabilization services, or other mainstream and community resources.

• **Intake (Walk-In):** First point of contact at an Entry Point walk-in center. Responsible for entering all data into HMIS, conducting pre-screen assessments, and making referrals to homelessness prevention, housing interventions, stabilization services, or other mainstream and community resources.

• **Stabilization Services:** Responsible for providing short-term, solutions-focused crisis intervention and resource advocacy to participants who are not eligible for homeless system resources or for whom no resources are currently available.

• **Diversion Services:** Responsible for providing short-term, solutions-focused crisis intervention or small amounts of financial assistance to allow imminently homeless (within 24-48 hours) or newly homeless individuals to remain housed or connect to alternate housing arrangements, bypassing entry into the homeless system of care.

• **Street Outreach:** Street Outreach efforts funded under ESG or the CoC are required to link to the coordinated entry process (HUD Coordinated Entry Notice Section II.B.6). Responsible for outreach to locations where people experiencing homelessness spend their nights (overpasses, parks, bus stations, etc) outreach staff will serve as an additional access point to Coordinated Entry for those who may not call the phone line or visit a walk-in center. Street Outreach workers will help design, implement and participate in the continuum’s comprehensive street outreach plan. *Comprehensive Street Outreach Plan in development and will be included in appendix upon completion.*

• **Housing Navigation:** Responsible for connecting participants to permanent housing opportunities. They do this by working closely with participants, gathering documentation, driving them to appointments as needed, attending case conferencing calls/meetings, and working closely with the Entry Point team. Housing navigation is often the responsibility of a team of case managers already working with the participant and is also a function performed by other provider agencies outside the implementing partnership.

See Appendix A for additional information about Entry Point Lead Agency and Implementing Partners.
Provider Agencies

The Department of Housing and Urban Development (HUD) requires provider agencies receiving Continuum of Care (CoC) or Emergency Solutions Grant (ESG) funding to participate in their jurisdiction’s Coordinated Entry system. The Alliance, with support from the Entry Point Lead Team, will monitor agency performance through reports generated to track housing assessments, matching, referrals, placements and other HUD Coordinated Entry outcome measures. In addition, community service and housing providers not funded through CoC or ESG are encouraged to participate in the Coordinated Entry system, as referral sources, entry points, and providers of housing and services. Provider agencies participating in Entry Point will:

• **Adopt and follow Entry Point policies & procedures** regarding access points, assessment procedures, client prioritization, and referral and placement in available services and housing.
• **Maintain low barrier enrollment in services and uphold Housing First principles** making every effort to screen participants “in” to services, rather than screen participants “out.”
• **Maintain fair and equal access** to programs and services for all clients regardless of actual or perceived race, color, religion, national origin, age, gender identity, pregnancy, citizenship, familial status, household composition, disability, Veteran status, or sexual orientation.
• **Provide appropriate safety planning** and security protections for persons fleeing or attempting to flee family violence, stalking, dating violence, or other domestic violence situations. Minimum safety planning must include a threshold assessment for presence of participant safety needs and referral to appropriate trauma-informed services if safety needs are identified.
• **Create and share written eligibility standards** and detailed written guidance for client eligibility and enrollment determinations. Eligibility criteria should be limited to that required by any funder as documented in the contract.
• **Communicate project vacancies**, either bed, unit, or voucher, to the Entry Point Team in a manner outlined in this document.
• **Fill project vacancies through Entry Point processes.** Any agency filling mandated units from alternative sources will be reviewed by the Oversight Committee for compliance.
• **Ensure staff who interact with the Entry Point system receive regular training and supervision** as outlined in the Entry Point training guidelines in this document.
• **Ensure client rights are protected and clients are informed of their rights and responsibilities.** Clients will have rights explained to them verbally and in writing when completing an initial intake. At a minimum, client rights will include:
  o The right to be treated with dignity and respect;
  o The right to appeal Coordinated Entry system decisions;
  o The right to be treated with cultural sensitivity;
  o The right to have a support person, as authorized in a signed release of information form, present during the appeals process;
  o The right to request a reasonable accommodation in accordance with the project’s tenant/client selection process;
  o The right of choice regarding available housing/services;
  o The right to confidentiality and information about when confidential information will be disclosed, to whom, and for what purposes, as well as the right to deny disclosure.

For a list of Participating Agencies, see Alliance to End Homelessness in Suburban Cook County website [http://www.suburbancour.org/hmis/agencies](http://www.suburbancour.org/hmis/agencies)
Key Components

A CoC’s coordinated entry process will establish and advertise (1) access points which use a standardized (2) assessment process to gather information on people’s needs, preferences, and the barriers they face to regaining housing. Once the assessment has identified the most vulnerable people with the highest needs, the CoC follows established policies and procedures to (3) prioritize households for (4) referral to appropriate and available housing and supportive services resources.

System Overview

Entry Point covers the CoC’s entire geographic area. Persons at-risk or experiencing homelessness in suburban Cook County can be assessed for eligibility and connected to available resources by trained assessors at Entry Point Access Locations. Individuals will be screened for eligibility and their level of vulnerability and service need will be assessed. Resources will be allocated first to individuals least likely to stabilize without intervention. Assessment information gathered for all individuals and families will be stored in the CoC’s data management system, HMIS. An HMIS report will prioritize all eligible participants based on level of vulnerability service need and the Entry Point team will first match highest vulnerability individuals, or those with the most severe service need, to available resources. Following sections of this manual describe Entry Point processes.

Diagram of Entry Point Process Flow

Eligibility

Entry Point is designed to serve anyone in suburban Cook County who is experiencing a housing crisis. This includes those who are:

- **Unsheltered** (e.g., living outside, in a car, on the streets, or in an encampment),
- **Sheltered** (e.g., in emergency shelter or transitional housing), or
- **At imminent risk of homelessness** (e.g., being evicted, unable to pay rent, doubled up, or in an unsafe living situation).
See [https://www.hudexchange.info/resources/documents/HomelessDefEligibility%20_SHP_SPC_ESG.pdf](https://www.hudexchange.info/resources/documents/HomelessDefEligibility%20_SHP_SPC_ESG.pdf) for HUD definition of homelessness and eligibility requirements for a referral to HUD funded homeless housing and services.

**Assuring the contractual eligibility for HUD funded housing or services is the responsibility of the service agency and/or housing provider, in accordance with the programs funding sources.**

Entry Point is designed to coordinate and prioritize access to housing and homeless programs for households experiencing homelessness. There is no guarantee that the household will meet final eligibility requirements, be referred to a housing resource, or receive a referral to a housing option. There is also no guarantee of available resources for all eligible households.

### Terms and Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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</thead>
</table>
| Chronically Homeless          | **HUD’s definition:**  

A “homeless individual with a disability,” as defined in Section 401(9) of the McKinney-Vento Homeless Assistance Act, who:

1. Lives in a place not meant for human habitation, a Safe Haven, or an emergency shelter; AND
2. Has been homeless continuously for at least 12 months or on at least four separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in (1) above. |
<p>| Case Conferencing             | Process for Entry Point staff, Sub Cook Zero Committee, and Sending and Receiving Agencies to coordinate and discuss ongoing work with persons experiencing homelessness in the community, including the prioritization or active list. The goal of case conferencing is to provide holistic, coordinated, and integrated services across providers, and to reduce duplication. |
| Continuum of Care (CoC)       | Group responsible for the implementation of the requirements of <a href="https://www.hudexchange.info/resources/documents/CoCProgramInterimRule.pdf">HUD’s CoC Program interim rule</a>. The CoC is composed of representatives of organizations, including nonprofit homeless providers, victim service providers, faith-based organizations, governments, businesses, advocates, public housing agencies, school districts, social service providers, mental health agencies, hospitals, universities, affordable housing developers, law enforcement, organizations that serve homeless and formerly homeless veterans, and homeless and formerly homeless persons. |
| Continuum of Care (CoC) Program | HUD funding source to (1) promote communitywide commitment to the goal of ending homelessness; (2) provide funding for efforts by nonprofit providers, and state and local governments to quickly rehouse homeless individuals and families while minimizing the trauma and dislocation caused to homeless individuals, families, |</p>
<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis Response System</td>
<td>Denotes all services and housing available to persons who are at imminent risk of experiencing literal homelessness and those who are homeless.</td>
</tr>
</tbody>
</table>
| DedicatedPlus                 | A DedicatedPLUS project is a permanent supportive housing (PH-PSH) project where the entire project will serve individuals and families that meet one of the following criteria at project entry:  
1. Experiencing chronic homelessness as defined in 24 CFR 578.3;  
2. Residing in a transitional housing project that will be eliminated and meets the definition of chronically homeless in effect at the time in which the individual or family entered the transitional housing project;  
3. Residing in a place not meant for human habitation, emergency shelter, or safe haven; but the individuals or families experiencing chronic homelessness as defined at 24 CFR 578.3 had been admitted and enrolled in a permanent housing project within the last year and were unable to maintain a housing placement;  
4. Residing in transitional housing funded by a Joint transitional housing (TH) and rapid re-housing (PH-RRH) component project and who were experiencing chronic homelessness as defined at 24 CFR 578.3 prior to entering the project;  
5. Residing and has resided in a place not meant for human habitation, a safe haven, or emergency shelter for at least 12 months in the last three years, but has not done so on four separate occasions; or  
6. Receiving assistance through a Department of Veterans Affairs (VA)-funded homeless assistance program and met one of the above criteria at initial intake to the VA’s homeless assistance system.  
For more information see Section III.A.3.d. of the [FY 2017 CoC Program Competition NOFA](#). |
<p>| Emergency Shelter             | Short-term emergency housing available to persons experiencing homelessness.                                                                   |
| Emergency Solutions Grant (ESG) Program | HUD funding source to (1) engage homeless individuals and families living on the street; (2) improve the quantity and quality of emergency shelters for homeless individuals and families; (3) help operate these shelters; (4) provide essential services to shelter residents; (5) rapidly rehouse homeless individuals and families; and (6) prevent families and individuals from becoming homeless. |
| Homeless Management Information System (HMIS) | Local information technology system used by a CoC to collect participant-level data and data on the provision of housing and services to homeless individuals and families and to persons at risk of homelessness. Each CoC is responsible for selecting an HMIS software solution that complies with HUD’s data collection, management, and reporting standards. |
| Homeless System               | Services and housing only available for persons who are literally homeless.                                                                      |
| Initiating Agency             | An agency that initiates the housing assessment process for literally homeless households by administering the VI-SPDAT assessment. The Initiating Agency may complete the housing assessment process and provide housing navigation. |</p>
<table>
<thead>
<tr>
<th>Program/Service</th>
<th>Description/Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Entry Point Policies and Procedures</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Projects for Assistance in Transition from Homelessness (PATH)</strong></td>
<td>Substance Abuse and Mental Health Services Administration (SAMHSA)—funded program to provide outreach and services to people with serious mental illness (SMI) who are homeless, in shelter or on the street, or at imminent risk of homelessness.</td>
</tr>
<tr>
<td><strong>Homeless Prevention (HP)</strong></td>
<td>Short-term financial assistance and stabilization services to prevent shelter entrance and promote housing retention.</td>
</tr>
<tr>
<td><strong>Housing Authority of Cook County (HACC)</strong></td>
<td>Entity that administers public housing and Housing Choice Vouchers (HCV) (aka Section 8 vouchers).</td>
</tr>
<tr>
<td><strong>Housing First</strong></td>
<td>Rather than moving homeless individuals and families through different levels” of housing until they are “housing ready,” this evidence-based best practice moves households immediately from the streets or emergency shelter into their own housing with wraparound services.</td>
</tr>
<tr>
<td><strong>Permanent Supportive Housing (PSH)</strong></td>
<td>Permanent housing with indefinite 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.</td>
</tr>
<tr>
<td><strong>Rapid Re-Housing (RRH)</strong></td>
<td>Program emphasizing housing search and relocation services and short- and medium-term rental assistance to move homeless persons and families (with or without a disability) as rapidly as possible into permanent housing.</td>
</tr>
<tr>
<td><strong>Receiving Agency</strong></td>
<td>The agency with a housing vacancy to which a household is referred.</td>
</tr>
<tr>
<td><strong>Release of Information (ROI)</strong></td>
<td>Written documentation signed by a participant to release his/her personal information to authorized partners.</td>
</tr>
<tr>
<td><strong>Supportive Services for Veteran Families (SSVF)</strong></td>
<td>A program of the U.S. Department of Veterans Affairs to provide supportive services, which may include short- and medium-term rental assistance, to very low-income Veteran families living in or transitioning to permanent housing.</td>
</tr>
<tr>
<td><strong>Sending Agency</strong></td>
<td>The agency where a household is most actively engaged in services at the time of a potential housing resource match. An agency will be designated as Sending Agency on the upon completion of a client’s “VI-SPDAT and Entry Point Assessment Consent”. If the household is no longer actively engaged in services with the original Sending Agency, they can be assigned a new Sending Agency.</td>
</tr>
<tr>
<td><strong>Transitional Housing (TH)</strong></td>
<td>Program providing homeless individuals and families with the interim stability and support to successfully move to and maintain permanent housing. Transitional housing funds may be used to cover the costs of up to 24 months of housing with accompanying supportive services. Program participants must have a lease (or sublease) or occupancy agreement in place when residing in transitional housing.</td>
</tr>
<tr>
<td><strong>VI-SPDAT</strong></td>
<td>An evidence-based assessment tool that combines the Vulnerability Index (VI) to determine the chronicity and medical vulnerability of homeless individuals.</td>
</tr>
</tbody>
</table>

Entry Point Policies and Procedures
February 22, 2019

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individuals, and the Service Prioritization Decision Assistance Tool (SPDAT) to help service providers allocate resources in a targeted way.
Access

Entry Point covers the CoC’s entire geographic area. One of the primary goals of suburban Cook County’s coordinated entry system is for the system to be easily accessible and welcoming to the wide range of people who may experience a housing crisis in the region. Therefore, multiple types of access points are available for people experiencing or at imminent risk of homelessness. The intake and referral process will be consistent across all access points, so that participants receive seamless care regardless of which access point they use to enter the system.

Accessibility and Language Support

The CoC will ensure that Entry Point services are physically accessible to persons with mobility barriers and communications and documentation will be accessible to persons with limited ability to read and understand English (HUD Coordinated Entry Notice: Section II B.5.c and d).

Access Points will be accessible by public transportation and located in an environment where additional community resources can be accessed as needed. In addition, Entry Point will be accessible to individuals with disabilities, including those needing physical locations accommodating wheelchairs, or those needing hearing, site or language support.

Good faith efforts will be made to ensure that all persons eligible for Entry Point services will have fair and equal access to the system. This includes:

- sub populations like people experiencing chronic homelessness, veterans, families with children, youth, and survivors of domestic violence; and
- households that have perceived barriers to housing or services, including but not limited to, too little or no income, active or a history of substance abuse, domestic violence history, resistance to receiving services, the type or extent of a disability-related services or supports that are needed, history of evictions or poor credit, lease violations or history of not being a leaseholder, or criminal record.

Entry Point will provide services in the language preferred by the household when completing an assessment and making a housing referral. If staff at an access location are unable to provide in-person interpretation, access to interpretation services will be available through a phone service. In addition, households needing hearing and speech assistance will be supported through 711 for Telecommunications Relay Service.

Resource Availability

It is important to note that Entry Point will only be able to offer those resources that are currently available within the homeless service system, and that the current supply of resources does not match demand. The goal of coordinated entry is to better target the limited resources available to those who need it most.

Entry Point services can be accessed as follows:

Phone

The Suburban Cook Entry Point Call Center will initially operate Monday – Friday 8:30 am to 4:30pm with the goal of expanding hours to include nights and weekends, with priority given to times when the walk-in centers are closed to expand accessibility. Initial features of the phone access point include, but will not be limited to:

- All calls to be answered live during open hours.
• During closed hours, recorded message instructing callers to call back later.
• A contracted translation service to serve people who speak languages other than English.
• Trained call specialists will administer a standardized pre-screen tool to identify the participant’s immediate needs: emergency shelter, homelessness prevention resources, diversion, stabilization services or referral to specialized services (e.g., domestic violence or Veterans).
• Call specialists will make informed referrals based upon preliminary determination of eligibility from the pre-screen tool and participant choice.
• A procedure for efficiently handling repeat callers and following up with referrals made but not accepted and completed by referring agencies

The Entry Point lead agency and oversight committee will review call volume data on a regular basis and make recommendations to increase hours and staff capacity as necessary to meet demand.

Walk-In Centers

Entry Point will initially have four sites where participants can walk in and meet with an intake professional in person. In the initial two grant years until true demand and capacity can be evaluated, the Entry Point Walk-In Centers will be open, at minimum, 4 hours daily M – F with evening hours one of those days. Initial features of the walk-in access point include, but will not be limited to:

• Trained intake specialists will administer a standardized pre-screen tool to identify the participant’s immediate needs: emergency shelter, homelessness prevention resources, diversion, stabilization services or referral to specialized services (e.g., domestic violence or Veterans).
• Intake specialists will make informed referrals based upon preliminary determination of eligibility from the pre-screen tool and participant choice.
• STSS Case Managers and Homeless Prevention Case Managers located at Walk-In Center agencies will attempt to reserve two hours each day for walk-in assessments in addition to accepting referrals from call specialists and intake specialists.
• If stability services or diversion case management indicate an individual requires and is potentially eligible for HUD homeless housing assistance, a housing assessment may be initiated and appropriate referrals made to homeless service providers.

The Entry Point lead agency and oversight committee will review walk-in volume data on a regular basis and make recommendations to increase hours and staff capacity as necessary to meet demand.

Emergency Shelter/Daytime Support Centers and Street Outreach

Entry Point also relies on the services provided by emergency shelters/daytime support centers and street outreach providers. Individuals and families who present at emergency shelters and their daytime support centers or who are found via street outreach can access the Entry Point system through these access points. Street outreach team members may also be tasked to provide assessment services to mobility impaired individuals who cannot access other Entry Point locations. These access points are managed by existing providers within guidelines established by Entry Point policies and procedures the Entry Point oversite committee. **Individuals and families may present at emergency shelter without an Entry Point referral.**

Edward Hines Jr. VA Hospital

Supporting and assisting Veterans who are at risk and/or homeless is a top priority for Hines. The Healthcare for Homeless Veterans (HCHV) Program assists Veterans in accessing stable housing, obtaining a regular source of income and establishing medical and mental health services. Veterans in suburban Cook County may access
Entry Point services at the HCHV office at Hines VA, at a Supportive Services for Veteran Families (SSVF) providers, through Veteran-specific transitional housing programs and at any of the other Entry Point access locations. Veterans who are eligible for VA funded housing are encouraged to present at the VA or one of the other Veteran-specific access locations for more direct connection to VA housing and supportive services. Veterans who are not eligible for VA funded housing services will be connected to CoC providers through the Entry Point process. See Special Populations section for more information about Veteran services.

**Domestic Violence Agencies**

All persons who are fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking shall have immediate, safe and confidential access to Entry Point and victim services, including access to the comparable coordinated housing process used by victim service providers and immediate access to emergency services such as domestic violence hotlines and shelter (HUD Coordinated Entry Notice: Section II.B.10).

All Entry Point access locations shall incorporate a safety risk assessment as part of the initial CE triage and intake procedures, evaluating, to the greatest extent possible, the physical safety and well-being of all persons who are fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking. In the event risk is deemed to be present, the participant will be linked to available specialized victim services and housing assistance, using a trauma-informed approach designed to address the particular service needs of survivors of abuse, neglect and violence.

All persons who are fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking that present for assistance at a victim services agency can confidentially access Entry Point services through the comparable coordinated housing process used by victim service providers. See Special Populations section for more information about Domestic Violence services.

**Youth Service Providers**

Unaccompanied youth in suburban Cook County may access Entry Point services through any Entry Point access location. Additionally, to address the unique needs of this population, specialized unaccompanied youth access locations are available. See Special Populations section for more information about unaccompanied transition aged (18-24) and unaccompanied minor (under 18) youth services.

**Other Limited Access Community Service Providers**

To help ensure that Entry Point services are easily accessible for all eligible persons in suburban Cook County, it may be determined beneficial to initiate housing assessments at other key community service providers, such as hospitals or mental health agencies, who are the main point of contact for certain vulnerable homeless individuals. One or more staff at these agencies will be fully trained Entry Point assessors following Entry Point policies and procedures. It is not anticipated, however, that these agencies will become Entry Point access locations for the general population.

See Appendix B and www.myentrypoint.org for Entry Point Access Locations

**Resource Database pending**

Entry Point will utilize a resource database to provide agencies with information about available community resources. The database may exist in HMIS, another system or connected to www.myentrypoint.org and will initially be used by participating agencies to enhance case management services. As the system matures it may be possible to have a more interactive public site.
Assessment

The CoC’s coordinated entry process will document and provide a standardized assessment process to all participants ensuring uniform decision-making and coordination of care for households experiencing a housing crisis (HUD Coordinated Entry Notice: Sections II.B.2.g (1) and II.B.3). Entry Point utilizes a phased assessment approach to assess individuals and families over time and only as necessary. The goal of the Entry Point Phased Assessment process is to gather and share, with appropriate consent, only as much information as necessary to make a successful referral. Evaluation steps may vary depending on which phase of the process an individual first enters the system, but the eligibility and vulnerability assessments for homeless system services and housing are identical no matter where the process starts. Participants enrolled in HUD funded homeless services (such as shelter or street outreach) or prevention services (homeless prevention) project will complete the HMIS SubCook Initial Assessment (described further below) regardless of whether they complete the rest of the Entry Point Assessment (HUD Coordinated Entry Notice: Section III.C.2).

No one will be screened out of the Entry Point process due to perceived barriers to housing or services, including, but not limited to, too little or no income, active or past substance abuse, domestic violence history, resistance to receiving services, the type or extent of a disability, the services or supports that are needed because of a disability, a history of evictions or of poor credit, a history of lease violations, a history of not being a leaseholder, or a criminal record (HUD Coordinated Entry Notice: Section II.B.4).

All participants in the Entry Point process will be free to decide what information they provide during the assessment process and to refuse to answer assessment questions. Although participants may become ineligible for some programs based on a lack of information, a participant’s refusal to answer questions will not be used as a reason to terminate the participant’s assessment, nor will it be used as a reason to refuse to refer the participant to programs for which the participant appears to be eligible (HUD Coordinated Entry Notice: Section II.B.11).

While some assessment questions may provide the opportunity for the client to disclose a disability or health diagnosis, no diagnosis details are required to participate in the Entry Point system. Any diagnostic information that is disclosed will only be used for the purpose of determining specific program eligibility to make appropriate referrals, or to provide a reasonable accommodation for the participant being served (HUD Coordinated Entry Notice II.B.12.f).

Pre-Screen Tool and Safety Assessment

The pre-screen tool will be administered by intake specialists at the Call Center and Walk-In Centers for Individuals who are at-risk of homelessness, newly experiencing homelessness, or uncertain about how to connect with resources.

Intake specialists will use a brief safety assessment and pre-screen tool to help determine next steps. If the individual is at-risk for domestic or intimate partner violence, an immediate referral will be made to domestic violence-specific resources. If the individual’s safety is not at issue, the Entry Point intake/call-specialist will proceed with the pre-screen tool. The pre-screen tool is designed as a decision tree that helps identify if the person is at-risk of homelessness or literally homeless and the person’s immediate needs: homelessness prevention resources, short-term stabilization or diversion services, emergency shelter or referral to specialized services (e.g., Veterans, transitions aged youth(18-24) or domestic violence). The Entry Point intake/call-specialist conducts a brief 5-10-minute conversation with the participant to complete the tool and to determine what the appropriate next step should be.
At-Risk of Homelessness – Homelessness Prevention, Diversion and Stability Services

Homeless Prevention

It is expected that all IDHS, ESG, EFSP and Reade homeless prevention funds will be distributed to households referred through coordinated entry processes. Referrals for homeless prevention assistance will be made after the intake/call-specialist completes a short eligibility questionnaire with the individual. If an individual appears to meet the eligibility requirements for homeless prevention, he or she will be referred to a homeless prevention case manager. Suburban Cook County CoC is piloting a vulnerability screening to enable targeted homeless prevention services to households most likely to become literally homeless without assistance. CoC written Homeless Prevention standards pending

Short Term Stability Case Management (STSS)

If the individual does not appear eligible for homeless prevention assistance, the intake/call-specialist will provide other options to the participant, including offering a short-term stabilization referral or information about community resources. If the individual appears eligible for homelessness prevention resources but no resources are available at that time, he or she will also be offered a short-term stabilization referral. The goal of STSS is to provide short-term, solutions-focused intervention that may resolve or lessen the housing crisis. Individuals may become eligible for homeless prevention services after working with STSS case managers and may be re-evaluated for homeless prevention services. CoC written STSS standards pending

System-wide diversion services pending

Entry Point Implementing Partners are participating in a pilot to design and implement system-wide diversion services. Diversion services are for clients who are imminently homeless within 24 hours or newly homeless and might be able to resolve their housing crisis without accessing or greatly reducing time spent in homeless crisis services like shelter. Diversion services may include financial and other services to remain housed or connect clients to alternate housing arrangements, bypassing entry into the homeless system of care.

Literally Homeless – Homeless System Services

If an individual is literally homeless, intake/call specialists offer a diversion appointment if safe, alternative options may be available to avoid staying in shelter. If safe, alternative options do not exist, intake/call specialists provide information about accessing emergency shelters. Referral from the call/intake specialist is not required for access to emergency shelter. An individual may also be offered a STSS referral. The stabilization case manager may administer a VI-SPDAT assessment to initiate the housing assessment process (see Entry Point Phased Assessment) and connect the individual to the appropriate street outreach or shelter day center case managers to complete the housing assessment and provide housing navigation services. Ongoing housing assessment and navigation services may also be provided by the STSS case manager.

Entry Point Phased Assessment

The Entry Point Phased Assessment will be administered to literally homeless households who have asked for assistance obtaining stable housing.

The Entry Point Phased Assessment can be initiated at any Access Location other than the Call Center. All Entry Point assessors must complete Entry Point Basic Training and will understand how to administer trauma informed, culturally competent, client centered assessments. The assessment will be completed in stages according to the information required at each step of the process. See Appendix I for Entry Point Phased Assessment Documents and Instructions, Report Instructions and HMIS workflow instructions.
Part 1 - Safety Screening

Individuals who are already enrolled in emergency shelter or engaged with street outreach do not need to complete a pre-screen and will begin their assessment process by completing the Entry Point safety screening. Individuals at-risk for domestic violence or intimate partner violence or facing other physical safety risks, such as suicide, can be connected to the appropriate resources to ensure participant safety. All Entry Point assessors will be trained to identify and respond to these safety needs. Additionally, all areas where in-person assessments are conducted will be made as safe and confidential as possible within reason so that people will feel comfortable identifying sensitive information or safety issues.

Part 2 - HMIS Sub Cook Initial Intake Assessment

When a participant enrolls in a homeless services program, an HMIS Sub Cook Initial Intake Assessment is performed by intake or case management staff (http://suburbancook.org/hmis for Initial Intake Assessment). All participants must be informed of HMIS privacy and data protection standards and sign an HMIS consent form before the assessment is completed. The Sub Cook Initial Intake Assessment collects demographic, income, protected health information and homelessness history about a participant. The Initial Intake Assessment is done for all participants even if they do not want assistance securing stable housing. Certain information collected in this assessment is used to determine eligibility and inform prioritization for housing and services. See HMIS Section for more information about HMIS data standards.

Part 3 - Child and Family Needs Assessment

Homeless services providers are encouraged to administer this assessment to families with minor children as soon as possible after presenting for assistance. The information gathered in the form is used to help case managers identify and connect the family with mainstream resources the household might need.

Part 4 - Determination of Housing Interest and Vulnerability Assessment

Entry Point is striving to be low-barrier and to uphold Housing First principles. Vulnerability assessments are not used to determine eligibility or screen participants “out” of services. Vulnerability assessments are utilized for the purposes for prioritizing the most vulnerable for services first and to inform housing project placement to suit individual client needs. HUD or other funder requirements will guide eligibility decisions and the Entry Point system will make every effort to screen participants “in” to services. The community is looking to all participating providers to embrace these same principles.

Part 4A – Determination of Housing Interest

The housing assessment process beings by identifying whether the household wants assistance securing stable housing. Entry Point timing guidelines state that the housing assessment process should begin:

- As soon as clinically appropriate for all chronically homeless individuals, all households with minor children, TAY households, and other extremely vulnerable individuals.
- No sooner than 7 – 14 nights of stay/services/contacts for all other individuals

Record client’s decision in HMIS. If a client declines interest in housing, agencies should regularly revisit the conversation, so they can work with the client when they are interested. If a client is unable to complete the assessment, agencies should contact the Entry Point lead team for further guidance. If a client wants to be considered for housing, continue by obtaining the Entry Point Assessment and VI-SPDAT Consent and completing the appropriate VI-SPDAT.

Part 4B - VI-SPDAT and Vulnerability and Severity of Service Needs Assessment
The Alliance has selected the VI-SPDAT as the assessment tool to determine a household’s vulnerability and to help determine prioritization for housing. The VI-SPDAT (Vulnerability Index – Service Prioritization Decision Assistance Prescreen Tool), developed by OrgCode Consulting, is a research-based assessment tool, which is widely used nationally by homeless system agencies and aims to identify a household’s level of service need.

**Entry Point Assessment and VI-SPDAT Consent Form**

All persons must sign an Entry Point Assessment and VI-SPDAT Consent form before being assessed for housing services.

**Clients unable or unwilling to sign an Entry Point Assessment and VI-SPDAT Consent**

If clients are unable to sign the form due to a disabling condition, they can sign their standard mark or symbol if needed, and/or provide verbal consent. In these cases, at least two witnesses must be present and attest to the consent.

Clients have the right to pursue housing even when they do not want to sign consent to share the information in their assessment. The worker should try to ascertain whether the client wishes to work toward housing, but just needs more privacy than sharing would provide, or whether they do not wish to be assessed. The worker can offer to introduce the client to someone on the Entry Point Lead team or brainstorm other workarounds with the Entry Point Lead team or the Zero team, while not disclosing the identity of the client.

**VI-SPDAT**

Suburban Cook County uses population specific VI-SPDAT tools as defined below:

<table>
<thead>
<tr>
<th>Transition-Aged Youth</th>
<th>Family</th>
<th>Individual</th>
</tr>
</thead>
<tbody>
<tr>
<td>TAY-VI-SPDAT</td>
<td>F-VI-SPDAT</td>
<td>VI-SPDAT</td>
</tr>
<tr>
<td>Use for young adult households with all members between 18-24 of age</td>
<td>Used for households with minor children or a pregnant individual</td>
<td>Used for adult-only households</td>
</tr>
</tbody>
</table>

Assessors will complete the appropriate VI-SPDAT assessment in HMIS (paper forms also available but answers must be entered into HMIS) and ensure that all appropriate HMIS sections are complete.

**Estimated VI-SPDAT Score when a client’s VI-SPDAT score appears inaccurate or when a client is unable to do a VI-SPDAT**

The VI-SPDAT has been designed to objectively evaluate a client’s risk and vulnerability while surviving homelessness. While it is our goal for the prioritization process to be as objective and transparent as possible, we recognize that there are occasions when the score does not truly represent someone’s vulnerability factors, including:

- The client does not self-identify as having a particular difficulty, risk, or disability, but one or more of these can be observed by staff
- The client is unable to accurately recall and/or report their history and experiences
- The client is afraid of negative repercussions of acknowledging risks, diagnoses or difficulties
- The client is unable or unwilling to focus on the interview and attend to and answer the full list of questions

If a client’s case manager believes the client’s VI-SPDAT score is inaccurate or is unable to complete a VI-SPDAT with the client, the case manager can complete a paper VI-SPDAT form (not in HMIS) on behalf of the client.
and render an “estimated score” with notes detailing the need for the estimation. Staff should enter these findings and rationales on the Vulnerability and Severity of Service Needs Assessment according to the procedure outlined on that form, and then contact the Entry Point Lead Team. Subject to Entry Point Lead review and approval, the Entry Point team will enter the “estimated score” in HMIS and that score will be used to determine prioritization. In the event a case manager does not agree with the Entry Point Lead Team’s decision about the estimated VI-SPDAT score, the case manager may present their request at the next case conferencing meeting or call. Estimated VI-SPDAT scores should not be considered standard practice and should only be considered when absolutely necessary to provide a fair ranking.

**Domestic Violence Prioritization Indicator Score**

If household is fleeing or attempting to flee (Category 4) domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening situations related to violence; have no other residence; and lack the resources or support networks to obtain other permanent housing, the Domestic Violence Prioritization Indicator Assessment will help identify prioritization for housing placement. Households scoring at highest risk for imminent danger will be prioritized over other households for vacancies for which they are eligible. Follow all HMIS safety protocols to protect client information.

**Noteworthy factors impacting severity of service needs**

Case managers should capture other factors observed by the worker but not adequately described in prior sections of the vulnerability assessment. These factors will help convey the severity of a need for service, can be used to justify need for estimated VI-SPDAT score and are useful to assist with case conferencing.

**Part 5 – Eligibility Verifications**

Each housing intervention and service have different eligibility requirements. Part 5 of the Entry Point Phased assessment provides detailed instructions, forms and tools for case managers to help verify the household’s eligibility for admission to the referred program.

Entry Point does not want eligibility verification to become a barrier to housing and as such, housing navigation staff at Sending Agencies (see Referral Process), case managers at housing programs and the Entry Point team will be in frequent communication through email and case conferencing calls and meetings. Additionally, the Sending Agency report tracks progress for all assessed clients and identifies when eligibility documents are slowing the process or missing.

**Part 6 – Housing Preference, History and Other Considerations**

Client choice is a central component of coordinated entry and as such, it is important to understand where the client wants to be housed, any special accessibility needs and household members who will be included in the unit to determine bedroom requirements. This information will be used in the Entry Point referral process when considering whether vacancies would suit a client’s need. This information will not impact eligibility or be used to screen clients out of housing. For instance, a client who wants a wheelchair accessible unit in the South will not be referred to a site-based program in the North where the only vacancy is on the second floor of a walk-up building. The client will be referred to the next available vacancy in the South that can accommodate a wheelchair.

If the client has housing barriers that might deter certain landlords from accepting tenancy, such as prior eviction history or background issues, it is important that housing programs understand this information and work with their lower barrier landlords from the beginning for a smoother process. This information will not impact eligibility or be used to screen clients out of housing but may impact referral options. For instance, a
client who is a registered sex offender will not be referred to vacancy in a site-based program located near parks or schools.

**Part 7 – Housing Stabilization Plan**

Questions in this assessment should be completed by the housing case manager at their first meeting with the client to ensure appropriate supports and assistance to stabilize and succeed in housing. The information is not used as criteria for program eligibility.

See Appendix I for Entry Point Phased Assessment Documents and Instructions, Report Instructions and HMIS workflow instructions.

**HMIS Entry Point Phased Assessment Progress Tracker**

The HMIS Entry Point Assessment Progress Tracker (Tracker) is the mechanism that initiates the housing process for clients. The Entry Point team will not be able to match clients to resources if a Progress Tracker has not been initiated. The Progress Tracker not only tracks client status in the Coordinated Entry process, it also enhances coordination and information sharing between staff in Suburban Cook agencies eliminating redundant work and will help staff more quickly locate and efficiently communicate with clients in the housing process. The HMIS Entry Point Assessment Progress Tracker is used in conjunction with the Entry Point Phased Assessment documents.

Assessors begin entering client data into the Tracker after completing the VI-SPDAT assessment. Detailed instructions for using the Tracker are located with other Phased Assessment Instructions at http://myentrypoint.org/for-providers/.
Prioritization

Households experiencing a housing crisis will be prioritized for HUD housing and services based upon how long the household has been homeless and the severity of the household’s service needs. The household’s level of vulnerability or need is determined by information obtained from the VI-SPDAT and other vulnerability factors reported in Part 4 of the Entry Point Phased Assessment. Entry Point will use the data collected during the assessment process to make uniform, standardized prioritization decisions for all homeless assistance (HUD Coordinated Entry Notice: Section II.B.3).

Prioritization Lists

Vulnerability, eligibility factors and locational preferences will be used to create centralized lists. Households will be ranked on the lists based upon severity of service needs and length of time homeless. Veterans, Individuals and Families with minor children have separate lists. Transition Aged Youth (under 25 years old) households on each of those lists are sorted separately.

The lists are maintained by the Alliance within HMIS. Individual and Families with minor children lists are managed by the Entry Point Referral Manager. The Veteran list is managed by Hines VA CE Specialist. (Veterans unwilling to share their data with the VA are managed by the Entry Point Referral Manager). Participants are placed on the by-name list, from a report generated by the Alliance, after their CE Consent form and VI-SPDAT are completed (or Entry Point alternative work flow for clients unable or unwilling to complete, see Part 4B of the Entry Point Phased Assessment).

Prioritization across sub-populations

Individuals, Families with Minor Children and TAY

The following factors determine household priority order in the Individual and Families with minor children lists and within each TAY subsection:

Vulnerability:  
1. Victimization/DV Prioritization Indicator score of 8+  
   • Next available match for which they are eligible  
2. VI-SPDAT (highest to lowest)

Length of Time homeless:  
1. 5+yrs  
2. 3-5yrs  
3. 1-3yrs  
4. Aging into chronicity in 60 days  
5. < 10 mos.

In the event two or more households have the same priority score, other factors that impact the household’s vulnerability as reported in Entry Point Phased Assessment Part 4B or during case conferencing may be considered in the placement.
Veterans

Chronically homeless and literally homeless veterans are given priority for VA funded housing resources. Veterans who are not eligible for VA funded housing resources are prioritized for CoC veteran TH programs over veterans who are eligible for VA funded resources. Veterans who are not willing to work with the VA are prioritized in the Individual and Families with Minor Children lists as above.

Prioritization across housing interventions

One of HUD’s main objectives for Coordinated Entry is to prioritize the most vulnerable individuals in our community for the most intensive housing interventions. To ensure that housing resources funded through the CoC or ESG Programs are used as strategically and effectively as possible, interventions need to be targeted to serve persons with the greatest barriers towards obtaining and maintaining housing on their own. In 2016, HUD issued Notice CPD-16-11: Notice on Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing (PSH): (https://www.hudexchange.info/resources/documents/notice-cpd-16-11-prioritizing-persons-experiencing-chronic-homelessness-and-other-vulnerable-homeless-persons-in-psh.pdf).

The overarching goal of this Notice is to ensure that those individuals and families who have spent the longest time in places not meant for human habitation, in emergency shelters, or in safe havens and who have the most severe service needs within a community are prioritized for PSH.

Dynamic Prioritization

PSH and safe havens are the most service intensive housing interventions in our CoC and are generally intended for the highest vulnerability households. The shorter-term interventions, RRH and TH, are generally intended for households with more moderate vulnerability.

Dynamic prioritization, newly encouraged by HUD, is a process wherein all available housing resources for persons experiencing homeless are flexibly and immediately offered to the individuals who need them most acutely in that moment, regardless of whether the individuals might be better-served in the future by a more intensive program not presently available to them.

Prioritization processes of this kind are intended to ensure that each community’s high-acuity individuals are always provided with some level of immediate support, rather than left to wait on a list for a higher-intensity intervention that will likely become available for only a very small percentage of individuals in any given year.

Entry Point will initially adopt modified dynamic prioritization processes that allow flexibility across housing interventions instead of strictly defined vulnerability parameters for each intervention type. Entry Point will match the highest ranked eligible household with the available housing intervention that best meets the household’s strengths, needs, housing barriers and preferred housing location. All available housing interventions for which the household is eligible will be considered prior to referral.

Entry Point will review and monitor prioritization processes annually to ensure the prioritization process is functioning as planned and not routinely leaving out any one category of people in crisis. The CoC will consider how other information, including assessor judgment, and other vulnerability factors such as high utilization of medical facilities or ongoing victimization can be considered without jeopardizing the integrity of that process.
Prioritization Guidelines:

**PSH Priority:** VI-SPDAT 8+ Individual/9+ Family w/MC, CH, Dedicated Plus (D+)

In accordance with HUD guidance, our CoC will prioritize PSH for Chronic and, when applicable, Dedicated Plus (see definitions page) households. Chronically homeless (CH) households scoring over 8 on VI-SPDAT, if Individual, or 9, if family w/MC, will be prioritized for CH dedicated PSH. Household’s meeting the definition of Dedicated Plus (D+) will also be prioritized for D+ PSH. If, through our comprehensive outreach strategy and reasonable due diligence, eligible CH or D+ households who want an existing PSH vacancy eligible cannot be located, non-CH or D+ PSH eligible households scoring above 8/9 on VI-SPDAT can be referred to PSH. Periodically, consistent with HUD goals to house households with the most severe service needs, our CoC may determine through case conferencing that a non-chronic PSH eligible household with acute medical needs may be prioritized for a PSH vacancy.

TAY households eligible for PSH will be considered for PSH openings in conjunction with non-TAY households. Case conferencing with staff familiar with the TAY household may determine that housing other than PSH would better serve the household needs. If case conferencing and the vulnerability of the TAY household indicates, our CoC will prioritize the TAY household for the next available PSH opening.

Since all available housing interventions for which the household is eligible will be considered prior to referral, CH and VI-SPDAT 8/9+ will not automatically result in a match to PSH. If a CH household is placed in housing other than PSH, CE will work with Sending and Receiving Agencies to document chronicity prior to placement to preserve the household’s PSH eligibility if a PSH placement is required later.

**Safe Haven Priority:** CH, severe mental health diagnosis

Safe haven placement is reserved for chronically homeless individuals with severe mental illness, such as schizoaffective disorder, bi-polar disorder or severe major depressive disorder.

**RRH Priority:** 4+ VI-SPDAT, CH, D+ and non-CH households

RRH as a housing intervention is generally intended for households with more moderate vulnerability. Dynamic prioritization encourages RRH placement for households that score in PSH range instead of extending waiting time for PSH that may never become available. Our CoC will strive to balance RRH placement across moderate and slightly higher vulnerability households as we build system-wide capacity for RRH to work with higher vulnerability households. Additionally, we will strive to ensure all sub-populations have a chance for RRH placement.

Certain RRH programs are intended for households with minor children. TAY HH w/MC will be considered for placement prior to adult HH w/MC. Openings will be filled with the highest-ranking eligible HH w/MC whose strengths, needs, housing barriers and preferred housing location matches the funding and program parameters of the vacancy.

Certain RRH programs are intended for Adult-only households. TAY, Chronic and Non-Chronic adult-only households with be considered for placement on a rotating basis. Openings will be filled on this rotating basis with the highest-ranking eligible household whose strengths, needs, housing barriers and preferred housing location matches the funding and program parameters of the vacancy.

Certain RRH programs can accommodate all household types. We will strive to fill openings evenly between HH w/MC and Adult-only households with adult-only household placements following the rotating model outlined in the paragraph above. It should be noted that these RRH programs in our CoC tend to have smaller amounts of funding available per household and may not optimally support households with multiple members. Openings will be filled on this rotating basis with the highest-ranking eligible household whose
strengths, needs, housing barriers and preferred housing location matches the funding and program parameters of the vacancy.

Households with high service needs may be placed in RRH and transitioned to more intensive housing interventions later, if required.

**TH Priority: 4+ VI-SPDAT, CH, D+ and non-CH households**

TH programs in suburban Cook County CoC are for specialized populations, and placement priorities may fluctuate based upon observed shift in need and services available for those populations.

As of Dec 1, 2018:

- Placement priorities in Transition Aged Youth TH will be solidified during the 100-Day Challenge.
- Domestic Violence TH placements are made through the parallel DV Entry Point processes and are pending final determination.
- Veteran TH placements will prioritize Vets who are not eligible for VA funded housing services.

**Removing People from Prioritization Lists**

Clients will be removed from the BNL after it is reported to the Entry Point Lead team and documented in HMIS that:

- The client has acquired permanent housing
- The client is deceased
- The client has been incarcerated or placed in an institution for a duration expected to be 90 days or more.
- The client is designated as “inactive” after it is reported to the CE Lead Team and documented in HMIS that they could not be located, and have had no contacts with, and received no services from, any Suburban Cook Alliance agency for a period of 90 days or more for the BNL (PSH or SH placement) and 30 days or more for the Prioritized List (RRH, TH placement).

**Clients can be re-added to Prioritization Lists** if they again present in need of housing. In this instance, the case manager should determine if the client’s CE Assessment and VI-SPDAT needs to be updated in order to accurately reflect the client’s most current situation. Case managers will ensure that all updates are properly reflected in HMIS.

**Clients Entering Temporary Institutional Placements**

Clients entering institutions for a period of 90 days or less may remain active on the list if it is determined that they will still need housing upon exit from that institution. The client will retain existing vulnerability score on the BNL, unless new circumstances or developments warrant an updated VI-SPDAT and/or vulnerability score. If possible, Sending Agency staff should maintain contact with and/or on behalf of the client during their stay. If it is not possible or advisable for staff to engage with a client or determine client’s status, the client can be rated “inactive” until they again present or are encountered for engagement.

**Policy for when clients state that they don’t wish to be housed**

Participant choice is a core value of the Coordinated Entry System, and clients may choose not to participate in a housing plan. Staff should make clear to the client that they can change their mind at any time and decide they want to work toward housing. Clients may turn down a housing offer without penalty. Additionally, in
rare instances, case managers may determine that it is clinically in the client’s best interest to delay a match offer. These situations will be discussed at case conferencing.

Staff will indicate the client’s intention to be housed in Part 4 of the CE Assessment and in the VI-SPDAT section of the HMIS profile. The Entry Point team will document client’s situation on the BNL. In the meantime, robust Harm Reduction engagement should be continued, and documentation will be deemphasized.
Referrals

The individual or family who is most vulnerable will be at the top of the list and will be prioritized for housing openings as they become available.

Housing Vacancies

Agencies with CoC or ESG funded housing programs will notify the Entry Point Lead Team of all vacancies in their housing programs. Agencies are encouraged to contact the Entry Point Referral Manager as soon as they know there will be a program vacancy. The Receiving Agency will identify one individual to communicate vacancies to the Entry Point Referral Manager. Agencies with non-CoC or ESG funded housing programs may also request referrals from Entry Point.

The Receiving Agency will request referrals to fill vacancies at http://myentrypoint.org/secure-sign-in/. Contact Referral Manager for password; referrals@myentrypoint.org.

Matching

The Entry Point Lead Team will match the highest vulnerability individuals from the BNL/Prioritized List who meet the eligibility requirements for vacancies and whose locational preference matches the vacancy. Wherever possible, veterans who qualify for VA Veteran specific resources will be matched first to available VA Veteran specific vacancies. In those rare instances where a special eligibility requirement exists, the Entry Point Lead Team will locate the highest vulnerability individual who meets that requirement.

Match Notification and Offer Acceptance

The Entry Point Lead Team will notify the Sending Navigator when a match has been secured for the client. The Sending Navigator is encouraged to respond as quickly as possible to verify that the client is interested in pursuing and is eligible for the match. If the Sending Navigator fails to respond to the match notification within the established timeframe, the Entry Point Lead Team may opt to bypass that client and pursue another match for that vacancy. The passed-by client would remain on the list with their same vulnerability score and be considered for a future prospective vacancy for which they are eligible. If the client does not accept the offer, the client remains on the list with their same vulnerability score and be considered for a future prospective vacancy for which they are eligible.

After verifying that the client is willing to accept the match, the Sending Navigator should as quickly as possible verify that all requested documentation, including relevant sections of the Entry Point Phased Assessment, has been provided to the Entry Point Lead Team so that eligibility can be verified and the match process continued. If documentation has not been provided and the Navigation Team is unable to locate the client and/or secure the assessment and verification documents within the established timeframe, the Entry Point Lead Team may opt to bypass that client and pursue another potential match for that vacancy. The passed-by client would remain on the list with their same vulnerability score and be considered for a future prospective vacancy for which they are eligible.

Referral process

Once the Entry Point Lead Team refers a client to a Receiving Agency and makes the relevant documents available, the Receiving Agency contact the Sending Housing Navigator who will facilitate a warm handoff between the Sending and Receiving Agencies and arrange for the first client meeting with the Receiving
Agency staff. If necessary, Receiving Agency staff should work with the Sending Agency staff and client to rectify any outstanding document needs before or at the first in-person meeting. It is the responsibility of the Receiving Agency to confirm that required eligibility documents have been provided for the client.

Receiving Agency staff are expected to move immediately thereafter into housing location (for scattered sites or units not identified) and complete the final phase of Phased Assessment or any other paperwork while in process of locating housing, so that the client can be housed as quickly as possible. The goal is to house an individual within 30 days of receiving the housing referral.

See Appendix J for Housing Assessment, Matching & Referral Process and Timelines

Returned or Appealed Referrals

Returned Referral Request: Receiving programs will have the opportunity to return referrals only when the eligibility screening was not accurate, the agency cannot locate the participant, or the participant declines admission to the program. The Receiving Agency should in good faith attempt a successful referral for 30 days but then notify the Entry Point Referral Coordinator of the need to return a referral and upload a Return Referral Request to the client’s HMIS record. The return referral request will document why the client is not eligible or will detail the agency’s attempt to locate the client or explain why the client declined admission to the program. The Entry Point Referral Coordinator will accept, reject, or ask for more information within two business days of confirming receipt of request. See Appendix K for Returned Referral Request.

Appealed Referral: In extremely rare cases, receiving programs can appeal referrals to the Coordinated Entry Oversight Committee. The receiving program may appeal a referral if they do not agree with the Entry Point Lead Team’s decision to reject a request to return a referral or if they believe the participant does not seem to be clinically appropriate for the program. The receiving program must contact the Entry Point Referral Coordinator or the CoC Program Director and provide clear evidence on their request to decline admission. The Referral Coordinator or CoC Program Director will coordinate with Chairs of the oversight committee. The oversight committee will adjudicate appealed referrals on a case-by-case basis. See Appendix L for Appealed Referral Request.

Exiting Clients from Coordinated Entry Housing Placements – Policy Pending

Case Conferencing

An integral factor in quickly matching and referring individuals to housing interventions is a robust, collaborative case conferencing process. Entry Point and Sub Cook Zero will lead participating agencies in regular case conferencing meetings and phone calls regarding all clients in the prioritized tier of the By Name List as well as all clients who are matched or in an active referral. Sending Agencies with clients on the prioritized tier of the By Name List are required to attend monthly Sub Cook Zero meetings. Sending Agencies and Receiving Agencies with clients in a match or active referral are required to participate in monthly case conferencing meetings and weekly phone conference calls. The Entry Point Lead Team will communicate regularly with Sending and Receiving Agencies about participation.

Pending: Policies for termination of housing placements
Special Populations

People fleeing domestic violence, dating violence, sexual assault, or stalking

When a homeless household is identified by Entry Point needing domestic violence services, that household is referred to the domestic violence hotline immediately. If the household does not wish to seek DV specific services, the household will have full access to the Entry Point, in accordance with all protocols described in this manual.

**Mandated VAWA Emergency Transfer Plan**

The Alliance to End Homelessness Suburban Cook County (Alliance) is concerned about the safety of the tenants of the housing programs that are funded by CoC Program grant funds, and such concern extends to tenants who are victims of domestic violence, dating violence, sexual assault, or stalking. Every care should be made to ensure that these tenants are treated with dignity and respect when they step forward to disclose intimate details of their traumatic experience(s).

In accordance with the Violence Against Women Act (VAWA), CoC-funded programs providing permanent housing (PSh/RRH) or transitional housing must allow tenants who are victims of domestic violence, dating violence, sexual assault, or stalking to request an emergency transfer from the tenant’s current unit to another unit. The ability to request a transfer is available regardless of sex, gender identity, or sexual orientation. The ability of a housing program to honor such a request for tenants currently receiving assistance, however, may depend upon a preliminary determination that the tenant is or has been a victim of domestic violence, dating violence, sexual assault, or stalking, and on whether the housing program has another dwelling unit that is available and is safe to offer the tenant for temporary or more permanent occupancy.

This plan identifies tenants who are eligible for an emergency transfer, the documentation needed to request an emergency transfer, confidentiality protections, how an emergency transfer may occur, Entry Point’s role in facilitating transfers and guidance to tenants on safety and security. This plan is based on a model emergency transfer plan published by the U.S. Department of Housing and Urban Development (HUD), the Federal agency that oversees that the Alliance and CoC-funded providers are in compliance with VAWA. See Appendix 0 for full policy.

*Final protocols DV Parallel system including HMIS anonymous entries into Progress Tracker to support Entry Point placement, pending.*

Veterans

There are a number of access points in Suburban Cook County available to veterans experiencing homelessness and in need of services. There are two categories of access points, which are through the CoC service providers or through the Hines VA. The process for assessing a veteran for eligible services is the same with both the CoC and Hines VA (very veteran status, determine VA service eligibility, complete the VI-SPDAT, and based on eligibility and need refer the veteran to either Hines VA or CoC providers for services).

CoC Veteran Workflow

There are CoC access points within each region of Suburban Cook County (north, west and south). When an individual, who identifies as being a veteran, presents to any of the CoC access points the CoC provider staff...
will obtain the necessary information to verify veteran status* and eligibility for any VA resources. The CoC provider staff will refer the veteran to the Hines VA HCHV Program for services. If the veteran is unable or unwilling to go to the Hines VA, the CoC provider staff will contact the Hines VA HCHV Program to coordinate the HCHV staff meeting with the veteran in the community to be assessed for eligibility of VA services. Veterans eligible for VA resources will be referred to the Hines VA for services. Veterans who are determined ineligible for VA resources will be referred to the CoC providers for services.

**Verifying Veteran Status**

SQUARES (Status Query and Resources Exchange System) is a system allowing CoC providers a very basic, preliminary avenue to verify veteran status without contacting the VA ([www.hmisrepository.va.gov](http://www.hmisrepository.va.gov)). This resource is not completely conclusive. The Department of Veteran’s Affairs requires always securing a DD-214 (document of a veteran’s discharge from service) to enroll an individual in services. SQUARES is intended to assist CoC providers in identifying veterans being served by the CoC in order to target their enrollment in eligible services. After accessing SQUARES and an individual has been confirmed to be a veteran, the ONLY way to obtain what VA services the veteran may be eligible for is to have the veteran connect with the Hines VA HCHV program or the veteran provides the CoC consent to consult with the VA.

Anyone identifying to be a veteran will need to provide a DD214 as verification of military service, regardless of what program the veteran is referred. When a veteran does not have a DD214, one can be requested. A DD214 may be obtained by accessing the National Archives website, [https://www.archives.gov/veterans/military-service-records](https://www.archives.gov/veterans/military-service-records). One can also be requested with the support of Hines VA or CoC provider staff.

The most effective way for CoC providers to verify the veteran status of an individual is to refer the individual to the Hines VA HCHV program. This allows, not only for the individual’s veteran status to be verified but also for the individual to be assessed for eligibility of VA services with the potential of an immediate referral to a VA program to which the veteran is eligible. It is very important for all CoC providers to inform all individuals identifying to be veterans of their ability to be served much more quickly by connecting to the VA directly for services.

**Hines VA Veteran Workflow**

In Suburban Cook County, there are three VA-related points of entry for veterans experiencing homelessness to access assistance. Those points include Hines VA, the National Call Center for Homeless Veterans (877-4AID-VET), and Supportive Services for Veteran Families (SSVF) Programs.

Veterans presenting to Hines VA in need of housing assistance services can access these services by presenting to the HCHV Program’s Resources and Referral (R & R) Office. The R & R program is accessible by presenting in person to Hines VA or, for veterans who are unable to present in-person, by calling the R & R Program phone (708-202-4961) and the veteran will be able to speak with a Program staff member. Internal referrals to the HCHV Program can also be made by various departments within the Hines VA Hospital (such as in-patient, substance use, medical units, etc.).

There are five programs available for veterans in need of housing assistance to which a veteran can be referred based on need and program availability. These programs include Contracted Emergency Residential Services (CERS), Low Demand Safe Haven, Grant and Per Diem (GPD) programs*, Supportive Services for Veteran Families (SSVF)*, and HUD-VA Supportive Housing (HUD VASH).

**CERS Programs**

The CERS programs are emergency shelters/housing specifically for veterans. The length of stay in a CERS funded program is for a maximum of 120 days per fiscal year. Veterans receive 3 meals a day while in a CERS
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CERS programs are site-based, meaning veterans are able to remain in one location for their entire length of stay and veterans have their own bed.

There are three CERS-funded programs that serve Suburban Cook County to which veterans may be referred. These programs include Way Back Inn, Opportunity House, and a Safe Haven. The Way Back Inn (WBI) program is a recovery program to which veterans with substance-use disorders and gambling addictions may be referred.

**LOW DEMAND SAFE HAVEN**
Hope Hall is dedicated to veterans who are experiencing higher vulnerability and have not been successful in other VA funded programs. Hope Hall allows for an initial stay of up to 90 days with the opportunity for an extension of up to 90 days (totaling a stay of up to 180 days).

**GPD PROGRAMS**
The GPD funded programs are a type of transitional housing to which veterans may be referred. There are several GPD programs that serve veterans experiencing homelessness in suburban Cook County. There are two GPD programs located outside of Cook County. Those GPD programs include the Friends & Family program and the Midwest Shelter program. The Friends & Family GPD program is a site-based program located in Joliet, IL. The Midwest Shelter GPD program is also a site-based program and is located in Wheaton, IL. The remaining GPD programs are located in the city of Chicago. The GPD programs located in the city of Chicago include Featherfist, Hope Manor, Interfaith/The Boulevard, Veteran Suites, and Eddie Beard House. When a veteran is placed outside of Suburban Cook County (in the city of Chicago or outside of Cook County) and wants to be permanently housed in that area, the veteran will be exited from the Suburban Cook County BNL once confirmed the veteran has been added to the BNL of the area in which the veteran has been placed and wishes to be permanently housed.

There is one additional type of Transitional Housing program located in Suburban Cook County that accepts referrals from both Hines VA and Jesse Brown VA (located in Chicago). The CEDA Bloom Rich Transitional Housing program is a site-based program located in Chicago Heights.

**SUPPORTIVE SERVICES for VETERAN FAMILIES**
In Suburban Cook County there is one SSVF program available to veterans. This is the SSVF Rapid Re-Housing program (SSVF RRH). The SSVF RRH program is a rental assistance program in which the veteran locates a unit and receives rental assistance for a specified amount of time. The SSVF RRH program is offered by several agencies, only one is located in Suburban Cook County; the others are located in Chicago. Veterans may present directly to Catholic Charities for assistance (the agency located in Suburban Cook County), or be referred to Hines VA HCHV Program to access SSVF RRH services by any of the providers. The housing location is based upon the veteran’s choice.

**HUD VASH**
The final type of housing assistance available for veterans is HUD-VA Supportive Housing (HUD VASH). HUD VASH is a form of Permanent Supportive Housing (PSH), which targets veterans experiencing chronic homelessness. There are three types of HUD VASH programs available to veterans in Suburban Cook County that include one Tenant-Based Voucher (TBV) program and two Project-Based Voucher (PBV) programs. When receiving HUD VASH TBV, veterans can locate their own units in the community. Both HUD VASH PBV are located on the Hines VA Campus, Freedoms Path and Freedoms Path II (expected in fall 2018). A HUD VASH voucher can only be obtained through a VA referral; CoC providers cannot refer anyone to the HUD VASH program.
Eligibility for VA Resources

A Veteran is defined as a person who served in the active military, naval, or air service, regardless of length of service, and who was discharged or released there from, excluding any one who received a dishonorable discharge or was discharged or dismissed by reason of a General court-martial (PL 114-315; 38 USC § 2002(b)).

Criteria for VHA Eligibility: Served 2+ years of Active Duty post-1980 with an Honorable Discharge from Service. Veterans eligible for VHA are eligible for all of the above-named programs (CERS, Low Demand Safe Haven, GPD Programs, SSVF programs, and HUD VASH). Eligibility for anyone discharged from Service prior to 1980 is reviewed individually and the Hines VA staff will need to verify eligibility status.

The SSVF and GPD Program: has updated guidance on Veteran Status and eligibility for the SSVF Program. SSVF now permits enrollment of Veterans who only had service time in Basic Training. Therefore, full time active duty (guard and reserve would still not be eligible) veterans who were discharged from the military while in basic training meet service requirements to be considered for SSVF if they meet all other eligibility criteria. Due to the complexity in the definition of active military service, it’s important to have a strong level of communication with your local VA Medical Center to verify if a potential participant has active military service and verify their type of discharge.

All veterans’ eligibility must be verified through Hines VA.

Veterans Not Eligible for VA Resources

When a veteran presents to Hines VA and is determined ineligible for VA services, Hines VA staff refer the veteran to a CoC provider. Hines VA staff will determine which CoC access point to refer the veteran based upon the veteran’s region of preference to receive services (north, west or south). Upon referring the veteran to CoC services, VA staff will notify the CoC provider to whom the veteran is being referred.

NOTE: All veterans are eligible for CEDA Bloom Rich TH. This program has no Active Duty or Discharge status requirements.

Veterans and the By Name List

Veterans are added to the By Name List after they have been entered into HMIS into a homelessness services project and veteran status has been verified. Once added to the By Name List, veterans are included in regular case conferencing. This case conferencing includes both the VA and CoC provider staff to ensure all veterans experiencing homelessness in Suburban Cook County are known and being served. Case conferencing also allows for consultation throughout the CoC in order to address any challenging situations that may arise while seeking to serve those veterans experiencing homelessness in the Suburban Cook County CoC.

Transition Aged Youth - TAY (18-24)

Cook County CoC is participating in a 100-day challenge to end youth homelessness. The goal of the challenge is to take significant strides toward kicking off a plan to end youth homelessness in your community. During the 100-day challenge, the Alliance Youth Committee and 100-day team, sponsors and system leaders (includes CoC providers, youth services providers, youth with lived experience, IDHS, McKinney Vento school reps, Alliance and Entry Point staff) are designing processes to identify and connect at-risk and literally homeless youth to services and housing. Additionally, the goal is to assess all TAY currently in homeless system projects in the CoC using the Entry Point Phased Assessment and HMIS Progress Tracker. Final TAY protocols pending upon completion of the 100-day challenge in February 2019.
Data Quality and Privacy

HMIS Standards

Except as otherwise specified, data associated with the Coordinated Entry system should be stored in the CoC’s Homeless Management Information System (HMIS). All data entered into or accessed or retrieved from the HMIS must be protected and kept private in accordance with the HMIS Data and Technical Standards as announced by the CoC Interim Rule at 24 CFR 578.7(a)(8).

Before collecting any information as part of the Entry Point, all staff and volunteers must first either (1) obtain the participant’s informed consent to share and store participant information for the purposes of assessing and referring participants through the Coordinated Entry process, or (2) confirm that such consent has already been obtained and is still active. Whenever possible, the participant’s consent should be in written form.

The CoC and Entry Point will not deny services to any participant based on that participant’s refusal to allow their data to be stored or shared unless a Federal statute requires collection, use, storage, and reporting of a participant’s personally identifiable information as a condition of program participation. Where appropriate, non-personally-identifiable information about participants who refuse consent to share personally identifiable data should be logged in an electronic case file that uses pseudonyms, e.g., “Jane Doe,” to preserve as much non-personally-identifiable information as possible for statistical purposes.

The completeness and accuracy of data entered into HMIS should be checked regularly as part of the community’s overall efforts to continuously improve data quality. The CoC will provide training and technical assistance on request to anyone using Entry Point who faces obstacles to inputting complete and accurate data.

What Data Will Be Collected

Data that is required to assess, prioritize, match, and refer a household for housing, homeless services, and/or mainstream resources will be collected by the Coordinated Entry system.

Data needed to assess and evaluate the Coordinated Entry system itself, such as system performance metrics, recidivism data, and client and provider satisfaction surveys, should also be collected by the Coordinated Entry system.

Whenever possible, the Coordinated Entry system should avoid collecting personal data that is not needed for the above purposes.

When Personally Identifiable Data Can Be Shared

It is often useful to share certain kinds of data collected during the Entry Point process.

- Among different homeless service providers
- Between a homeless service provider and a mainstream resource provider such as Medicaid
- Between multiple data systems to reduce duplicative efforts and increase case coordination across providers and funding streams, or
- Aggregate data, with the general community for purposes of education and advocacy
However, in doing so, great care must be taken not to share personally identifiable data outside the context of the systems and purpose(s) covered by the client’s affirmative consent. Therefore, all entities that routinely share data with or receive data from the Coordinated Entry system must sign data-sharing agreements that obligate the entities to follow comparable privacy standards and that restrict the use of the data being shared to uses that are compatible with clients’ consent.

Personally identifiable data must always be used for the benefit of the client to which the data pertains, and not for the general convenience of other government entities. Requests for data made by Child Protective Services, Adult Protective Services, prosecutors, detectives, immigration officials, or by police officers who are not actively cooperating with the CoC should be refused unless the requesting party displays a valid warrant specifically ordering the release of the data, or with the client’s affirmative written consent.

**When Anonymous Data Can Be Shared**

Data that is truly anonymous can be shared for any legitimate purpose of the CoC, but care must be taken to ensure that data has been reliably stripped of all characteristics that could conceivably be used to re-associate the data with an individual or household.

**Additional Safeguards for Survivors of Domestic Violence**

In addition to the safeguards described above, additional safeguards must be taken with any data associated with anyone who is known to be fleeing or suffering from any form of domestic violence, including dating violence, stalking, trafficking, and/or sexual assault, regardless of whether such people are seeking shelter or services from non-victim-specific providers.

*Pending final HMIS policy resolution for tracking DV victims/survivors in Entry Point*
Appendices

Appendix Introduction – www.myentrypoint.org

The Entry Point Website, www.myentrypoint.org, serves three main purposes.

First, to direct individuals and families experiencing or at-risk of homelessness toward Entry Point services and housing resources. Service providers in suburban Cook County can access the website to help their clients navigate the housing assessment process.

Second, to provide the assessment tools, training, instructions, reports and HMIS workflows required for homeless system providers to intake, assess and house clients. Providers can access register for training on the website. Regular updates about Entry Point processes will be posted on the website.

Third, a secure login exists on the Providers Tab for housing programs to request referrals when they have vacancies. To obtain the password, please contact the Entry Point lead team.

Most of the information contained in these Appendices can be found at www.myentrypoint.org.
### Appendix A - Lead Agency and Implementing Partners:

<table>
<thead>
<tr>
<th>Lead Agency and Implementing Partners</th>
<th>Services and Locations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing Forward</td>
<td>West Walk-In Center</td>
</tr>
<tr>
<td>1851 S. 9th Ave</td>
<td>Homeless Prevention</td>
</tr>
<tr>
<td>Maywood, IL 60153</td>
<td>Stability and Diversion Services</td>
</tr>
<tr>
<td><em>Entry Point Lead Agency</em></td>
<td>Shelter/Daytime Support Center</td>
</tr>
<tr>
<td><em><a href="mailto:Info@myentrypoint.org">Info@myentrypoint.org</a></em></td>
<td>Housing Navigation</td>
</tr>
<tr>
<td>708-338-1724</td>
<td>Street Outreach</td>
</tr>
<tr>
<td>Catholic Charities</td>
<td>Suburban Cook Call Center</td>
</tr>
<tr>
<td>1899 N. Hermitage</td>
<td>South Regional Lead</td>
</tr>
<tr>
<td>Chicago, IL 60622</td>
<td>Homeless Prevention</td>
</tr>
<tr>
<td>Ford Heights Community Services Organization</td>
<td>South Walk-In Center</td>
</tr>
<tr>
<td>943 E Lincoln Hwy</td>
<td>Homeless Prevention</td>
</tr>
<tr>
<td>Ford Heights, IL 60411</td>
<td>Stability and Diversion Services</td>
</tr>
<tr>
<td>Respond Now</td>
<td>Street Outreach</td>
</tr>
<tr>
<td>1439 Emerald Ave</td>
<td>South Walk-In Center</td>
</tr>
<tr>
<td>Chicago Heights, IL 60411</td>
<td>Homeless Prevention</td>
</tr>
<tr>
<td>Together We Cope</td>
<td>Stability and Diversion Services</td>
</tr>
<tr>
<td>17010 Oak Park Ave</td>
<td>Street Outreach</td>
</tr>
<tr>
<td>Tinley Park, IL 60477</td>
<td>South Walk-In Center</td>
</tr>
<tr>
<td>South Suburban PADS</td>
<td>Homeless Prevention</td>
</tr>
<tr>
<td>4411 W Gatling Blvd.</td>
<td>Stability and Diversion Services</td>
</tr>
<tr>
<td>Country Club Hills, IL 60478</td>
<td>Shelter/Daytime Support Center</td>
</tr>
<tr>
<td>South Suburban PADS</td>
<td>Housing Navigation</td>
</tr>
<tr>
<td>BEDS Plus Care (serving West and South region)</td>
<td>Street Outreach</td>
</tr>
<tr>
<td>9601 W Ogden Ave</td>
<td>North Regional Lead</td>
</tr>
<tr>
<td>LaGrange, IL 60525</td>
<td>North Walk-In Center</td>
</tr>
<tr>
<td>Connections For The Homeless</td>
<td>Homeless Prevention</td>
</tr>
<tr>
<td>2121 Dewey Ave</td>
<td>Stability and Diversion Services</td>
</tr>
<tr>
<td>Evanston, IL 60201</td>
<td>Shelter/Daytime Support Center</td>
</tr>
<tr>
<td>Northwest Compass</td>
<td>Housing Navigation</td>
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<tr>
<td>1300 W Northwest Hwy</td>
<td>Street Outreach</td>
</tr>
<tr>
<td>Mount Prospect, IL 60056</td>
<td>North Regional Lead</td>
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<td></td>
<td>North Walk-In Center</td>
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<td></td>
<td>Homeless Prevention</td>
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<td></td>
<td>Stability and Diversion Services</td>
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<td>Housing Navigation</td>
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<td>Street Outreach</td>
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</tbody>
</table>
## Appendix B - Entry Point Access Locations

(See also [www.myentrypoint.org](http://www.myentrypoint.org))

<table>
<thead>
<tr>
<th>Suburban Cook Call Center</th>
<th>1.877.426.6515 8:30am-4:30pm M-F</th>
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### Walk-In Centers:

<table>
<thead>
<tr>
<th>North</th>
<th>West</th>
<th>South</th>
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</thead>
<tbody>
<tr>
<td>NORTWEST COMPASS 1300 W. Northwest Hwy, Mt. Prospect, IL 847.392.2344 9a-12p &amp; 1p-4p M, Tu, Th 9a-12p &amp; 1p-6p W 9a-12p F</td>
<td>HOUSING FORWARD 6634 W. Roosevelt Rd., 2nd Floor, Oak Park, IL 708.338.1724 9a-3p M, Th, F 9a-1p &amp; 3p-7p Tu 9a-1p W</td>
<td>TOGETHER WE COPE 17010 Oak Park Ave., Tinley Park, IL 708.633.5040 9a-3p M, Tu, W, F 2p-7p Th</td>
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<thead>
<tr>
<th>North</th>
<th>West</th>
<th>South</th>
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<tbody>
<tr>
<td>RESPOND NOW 1439 Emerald Ave., Chicago Heights, IL 708.755.4357 10a-5p M, F 11a-3p Tu, Th 10a-7p W</td>
<td>BEDS-Plus Care SHELTER: Various locations; see <a href="http://www.beds-plus.org/shelters.html">www.beds-plus.org/shelters.html</a> DAYTIME SUPPORT CENTER: 9601 W. Ogden Ave., La Grange, IL 10a-2p M-F</td>
<td>BEDS-Plus Care SHELTER: Various locations; see <a href="http://www.beds-plus.org/shelters.html">www.beds-plus.org/shelters.html</a> DAYTIME SUPPORT CENTER: St. Mark Evangelical Lutheran Church, Heaney Hall, 11005 S. 76th Ave., Worth, IL 708.448.6162</td>
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<thead>
<tr>
<th>North</th>
<th>West</th>
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<th>North</th>
<th>West</th>
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### Emergency Shelter/Day Centers

<table>
<thead>
<tr>
<th>North</th>
<th>West</th>
<th>South</th>
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</thead>
<tbody>
<tr>
<td>Connections for the Homeless SHELTER: Hilda’s Place, by appointment, 847.475.7070 DAYTIME SUPPORT CENTER: 1458 Chicago Ave., Evanston, IL 1:30p-4p M-Th; 10:30a-1p F</td>
<td>BEDS-Plus Care SHELTER: Various locations, see <a href="http://www.beds-plus.org/shelters.html">www.beds-plus.org/shelters.html</a> DAYTIME SUPPORT CENTER: 9601 W. Ogden Ave., La Grange, IL 10a-2p M-F</td>
<td>BEDS-Plus Care SHELTER: Various locations; see <a href="http://www.beds-plus.org/shelters.html">www.beds-plus.org/shelters.html</a> DAYTIME SUPPORT CENTER: St. Mark Evangelical Lutheran Church, Heaney Hall, 11005 S. 76th Ave., Worth, IL 708.448.6162</td>
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</tbody>
</table>

Entry Point Policies and Procedures  
February 22, 2019
## Street Outreach

<table>
<thead>
<tr>
<th>North</th>
<th>West</th>
<th>South</th>
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</thead>
<tbody>
<tr>
<td>Connections for the Homeless</td>
<td>Beds-Plus Care 708.354.0858</td>
<td>Beds-Plus Care 708.448.6162</td>
</tr>
<tr>
<td>847.475.7070</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Northwest Compass</td>
<td>Housing Forward 708.338.1724</td>
<td>Respond Now 708.755.4357</td>
</tr>
<tr>
<td>847.392.2344</td>
<td></td>
<td>South Suburban PADS 708.332.7700</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Veterans</td>
<td></td>
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<tr>
<td><strong>EDWARD HINES JR. VA HOSPITAL (VETERANS)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5000 S. 5th Ave., Hines, IL Building 228, 4th FL</td>
<td>708.202.4961</td>
<td></td>
</tr>
<tr>
<td></td>
<td><a href="http://www.hines.va.gov/services.homeless">www.hines.va.gov/services.homeless</a></td>
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</table>

## Transition Aged Youth 18-24 (TAY)

<table>
<thead>
<tr>
<th>North</th>
<th>West</th>
<th>South</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Harbour</td>
<td></td>
<td>Aunt Martha’s 24-HOUR CRISIS LINE: 708.679.8100</td>
</tr>
<tr>
<td>CRISIS HOTLINE: 847.297.8541</td>
<td></td>
<td>STREET OUTREACH: 708.790.9392</td>
</tr>
</tbody>
</table>

## Domestic Violence

<table>
<thead>
<tr>
<th>North</th>
<th>West</th>
<th>South</th>
</tr>
</thead>
<tbody>
<tr>
<td>WINGS 24-hour hotline: 847.221.5680</td>
<td>Sarah’s Inn 24-hour hotline: 708.386.4225</td>
<td>Crisis Center 24-hour hotline: 708.429.SAFE (7233)</td>
</tr>
<tr>
<td>Evanston/Northshore YWCA 24-hour hotline: 847.864.8780</td>
<td>Constance Morris House 24-hour hotline: 708.745.5277</td>
<td>South Suburban Family Shelter 24-hour hotline: 708.335.3028</td>
</tr>
</tbody>
</table>

## National Domestic Violence Hotline: 1-800-799-SAFE (7233); 1-800-787-3224; www.thehotline.org
<table>
<thead>
<tr>
<th></th>
<th>Entry Point Assessors¹</th>
<th>Supervisors of Assessors</th>
<th>Program Managers and Directors²</th>
<th>Housing Program Staff³</th>
<th>EDs⁴</th>
</tr>
</thead>
<tbody>
<tr>
<td>BT1 = Entry Point Basic Training, Part 1</td>
<td>*ASAP</td>
<td>&lt;6 months</td>
<td>&lt;6 months</td>
<td>&lt;6 months</td>
<td>&lt;6 months</td>
</tr>
<tr>
<td>BT2 = Entry Point Basic Training, Part 2</td>
<td>*ASAP</td>
<td>&lt;6 months</td>
<td>&lt;6 months</td>
<td>&lt;6 months</td>
<td></td>
</tr>
<tr>
<td>BT3 = DV Screening and Safety Planning</td>
<td>*ASAP⁵</td>
<td>&lt;6 months</td>
<td>&lt;6 months</td>
<td>&lt;6 months</td>
<td></td>
</tr>
<tr>
<td>BTU = Annual Update</td>
<td>yearly</td>
<td>yearly</td>
<td>yearly</td>
<td>yearly</td>
<td>yearly</td>
</tr>
<tr>
<td>CC1 = Cultural and Developmental Competence for TAY</td>
<td>&lt;6 months</td>
<td>&lt;6 months</td>
<td>&lt;6 months</td>
<td>&lt;6 months</td>
<td></td>
</tr>
<tr>
<td>CC2 = Creating Safe and Respectful Space for LGBTQ+ People</td>
<td>&lt;6 months</td>
<td>&lt;6 months</td>
<td>&lt;6 months</td>
<td>&lt;6 months</td>
<td></td>
</tr>
<tr>
<td>CC3 = Developmental and Cultural Competence with Families</td>
<td>&lt;6 months</td>
<td>&lt;6 months</td>
<td>&lt;6 months</td>
<td>&lt;6 months</td>
<td></td>
</tr>
<tr>
<td>EBP1 = Housing First Framework</td>
<td>&lt;18 months</td>
<td>&lt;18 months</td>
<td>&lt;18 months</td>
<td>&lt;18 months</td>
<td></td>
</tr>
<tr>
<td>EBP2 = Trauma and Its Impact</td>
<td>&lt;18 months</td>
<td>&lt;18 months</td>
<td></td>
<td>&lt;18 months</td>
<td></td>
</tr>
<tr>
<td>EBP3 = Trauma Informed Care</td>
<td>&lt;18 months</td>
<td>&lt;18 months</td>
<td></td>
<td>&lt;18 months</td>
<td></td>
</tr>
<tr>
<td>EBP4 = Motivational Interviewing</td>
<td>&lt;18 months</td>
<td>&lt;18 months</td>
<td></td>
<td>&lt;18 months</td>
<td></td>
</tr>
<tr>
<td>EBP 5 = Harm Reduction Philosophy and Application</td>
<td>Footnote 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

¹ “Entry Point Assessors” are any direct-service staff who complete VI-SPDAT and/or Multi-Stage Assessment forms with clients, including Shelter staff, Outreach staff, Day Center staff and Walk-in Center staff. *Assessors must attend these trainings before completing assessments with clients.

² This includes managers of shelters, day programs, outreach programs, housing programs, walk-in programs, or other direct service programs, and agency leaders who are directors of these programs or supervisors of these program managers.

³ This includes housing case managers, housing navigators, housing locators, etc.

⁴ In large agencies with multiple non-homeless services programming, this individual would be the top decision maker involved with homelessness services.

⁵ If a direct supervisor has attended DV Screening and Safety Planning, an assessor can attend that training as soon as possible, but begin completing assessments directly after completing Entry Point Basic Training.
**Key:**

< X months = Existing staff: complete within x months from date of policy implementation.  
New staff: complete within x months after starting role or when offered within 12 mos.

**Entry Point Basic Trainings:**
BT1 = Entry Point Basic Training, Part 1  
BT2 = Entry Point Basic Training, Part 2  
BT3 = DV Screening and Safety Planning  
BTU = Annual Update

**Cultural and Developmental Competence Trainings:**
CC1 = Cultural and Developmental Competence for TAY  
CC2 = Creating Safe and Respectful Space for LGBTQ+ People  
CC3 = Developmental and Cultural Competence with Families

**Evidence-Based Practices:**
EBP1 = Housing First Framework  
EBP2 = Trauma and Its Impact  
EBP3 = Trauma Informed Care  
EBP4 = Motivational Interviewing  
EBP 5 = Harm Reduction Philosophy and Application

**Position Specific:** specialized training may be required for Outreach Staff, STSS staff, Housing Locators / Navigators, and other positions as needed.

**Note:** Agencies may request attendance credit for an Entry Point module if staff attended alternate training during the same timeframe and if the curriculum adequately covered the Entry Point module curriculum. To request the credit an agency must submit an overview of the alternative curriculum and documentation of staff’s attendance to the Entry Point Referral Manager. The Training and Engagement Manager will review the alternative curriculum and authorize or deny the credit.

**Compliance Implications:**
1. Assessors who do not meet training requirements will not be allowed to administer Entry Point assessments  
2. For Entry Point Implementing Partners – failure to meet training requirements could jeopardize funding  
3. For housing programs – failure to participate in Entry Point training could jeopardize NOFA rankings.  
4. The Entry Point Lead team will provide a list of training participants to each agency so the agency can track its training compliance.

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6 Outreach staff are strongly encouraged to attend this training.
Appendix D - Civil Rights and Fair Housing Laws and Requirements

Recipients and sub recipients of CoC Program and ESG Program funded projects must comply with applicable civil rights and fair housing laws and requirements, including the nondiscrimination and equal opportunity provisions of Federal civil rights laws as specified at 24 C.F.R 5.105(a), including, but not limited to the following:

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

- 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; and

- 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.

In addition, HUD’s Equal Access Rule at 24 CFR 5.105(a)(2) 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.

The CoC Program interim rule also contains a fair housing provision at 24 CFR 578.93. For ESG, see 24 CFR 576.407(a) and (b), and for HOPWA, see 24 CFR 574.603.

*In certain circumstances some projects may use disability status or other protected class information to limit enrollment, but only if Federal or State statute explicitly allows the limitation (e.g. HOPWA-funded projects may only serve participants who are HIV+ or have AIDS).*
Appendix E - Entry Point Affirmative Marketing Policy

CoC Program interim rule 24 CFR 578.93(c); 24 CFR 5.105(a)(2) and HUD Coordinated Entry Notice: Section I.C.1, requires Coordinated Entry systems to affirmatively market CoC supportive services and housing to eligible persons least likely to apply in absence of special outreach.

The Entry Point Affirmative Marketing Strategy is designed to ensure all suburban Cook County households have fair and equal access to Entry Point and CoC services and housing regardless of sex, gender identity, age, color, creed, disability status, family status, marital status, sexual orientation, ethnicity, national origin, religion, limited English proficiency or any other attribute or characteristic that could be perceived as a barrier to gaining entry to services and/or housing.

The Alliance and participating agencies will identify subpopulations who are eligible for but have historically not participated, enrolled, and entered in CoC programs regardless of race, color, national origin, religion, sex, age, familial status, disability, actual or perceived sexual orientation, gender identity, marital status, immigration status, limited English proficiency. The Alliance and Entry Point lead team will routinely evaluate the effectiveness of the Affirmative Marketing Strategy by measuring participation by eligible individuals from the identified underserved populations as well as those facing actual or perceived barriers due to sex, gender identity, age, color, creed, disability status, family status, marital status, sexual orientation, ethnicity, national origin or religion or persons with any other attribute or characteristic that could be perceived as a barrier to gaining entry to services and/or housing. The Entry Point Affirmative Marketing Strategy will be modified if determined necessary.

Entry Point Affirmative Marketing Procedures will include the following:

- An outreach program that includes measures designed to attract those groups identified as least likely to apply and other efforts designed to attract persons from the total population;
- Advertising in locations or media that are used by those identified as least likely to enter Entry point or CoC services and housing;
- Marketing Entry Point and CoC services and housing at CoC participating agencies as well as community, religious, support organizations or other groups frequented by those least likely to enter CoC services and housing;
- Developing a brochure or handout that describes the Entry Point processes to be used by persons experiencing a housing crisis to locate, identify, and access Entry Point services;
- Developing a website that describes the Entry Point processes to be used by persons experiencing a housing crisis to locate, identify, and access Entry Point services;
- Ensuring that the Entry Point lead staff, staff at Entry Point access locations, Entry Point assessors and staff at CoC and ESG participating agencies have been trained about the Fair Housing Act, and the purpose and objectives of Entry Point Affirmative Marketing Policy;
- Good faith efforts will be made to ensure that marketing media is accessible by eligible persons in suburban Cook County regardless of sex, gender identity, age, color, creed, disability status, family status, marital status, sexual orientation, ethnicity, national origin, religion, limited English proficiency/literacy or any other attribute or characteristic that could be perceived as a barrier to gaining entry to services and/or housing.
Appendix F – Entry Point Inclusion / Non-discrimination Policy

**Discrimination:** Suburban Cook County Coordinated Entry (Entry Point) and its agencies do not discriminate in the course of assessment, matching, and referral for housing and other services on the sole basis of anyone’s:

- Gender, gender status, or gender expression
- Being LGBTQ+
- Race, color, tribe, or ethnicity
- Immigration, refugee, or citizenship status
- Income level, or source of income
- Ability to read, write, or speak English
- Job status or education level
- Alcohol or drug use or addiction, or other addictions
- Health or mental health status, or having HIV or AIDS
- Age
- Marital, family, or partnership status
- Legal history
- Veteran or military discharge status
- Body size
- Participation in the street economy
- Religion or personal philosophy
- Not following a doctor’s or therapist’s medical treatment suggestions
- Physical, developmental, intellectual, or emotional ability

We seek to serve those who have been marginalized or previously rendered service-ineligible for these or any other reasons. Therefore, we do not tolerate any speech, language, or behavior that is abusive or demoralizing to anyone who might participate in our services. We expect staff, interns, and volunteers to be vigilant in enforcing this standard.

Some programs may be required to prioritize enrollment based on regulations imposed by their funding sources and/or state or federal law. For example, a HOPWA-funded project might be required to serve only participants who have HIV/AIDS. Some programs are dedicated to veterans, youth, or survivors of domestic violence, etc. All such programs will avoid discrimination to the maximum extent allowed by their funding sources and their authorizing legislation.

All aspects of Entry Point will comply with all Federal, State, and local Fair Housing laws and regulations. Participants will not be “steered” toward any particular housing facility or neighborhood based on their race, color, national origin, religion, sex or gender identity, sexual orientation, disability, or the presence of children.

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1 In the case that a client presents at an access point who is the subject of a Protective Order held by another client also being served at that access point, Entry Point will prioritize right of service at that location to the client holding the order. The client prohibited from proximity or contact will be referred to another Entry Point access point for assessment and/or service. If, during the course of housing matching and referral, it comes to the attention of the Entry Point Lead Team that a client has experienced abuse by their partner who would otherwise be housed together with them, the wishes of the abuse survivor regarding cohabitation will be honored. If a perpetrator of abuse cannot then be housed with their partner, they will be housed separately as an individual.
The Entry Point Lead Agency conducts quarterly rotating training of staff on Coordinated Entry basic training, this Anti-Discrimination Policy and procedures, and on a wide array of cultural competency topics.

This Inclusion and Non-Discrimination policy pertains specifically to the client assessment, matching and referral processes, but it is assumed that each agency maintains an Inclusion and Non-Discrimination policy regarding their services and programs that substantially and materially echoes this policy, and this policy is not intended to circumvent or exempt an agency’s own policies.

**Discrimination Complaint Process:** Participants will be shown / read the Inclusion and Non-Discrimination policy as part of the standard assessment, and will sign to indicate that they have had it presented. The policy will also be posted in a visible location at all access points. The policy page will inform participants of their right to file a verbal or written Discrimination Complaint, and will contain all information needed to file the complaint.

When a Discrimination Complaint about the Entry Point process is received in verbal or written form, the Entry Point Lead Agency will complete an investigation of the complaint within 30 calendar days by attempting to contact and interview a reasonable number of persons who are likely to have relevant knowledge about the circumstances surrounding the complaint, and by collecting any documents that are likely to be relevant to the investigation. If a complaint is determined to pertain to matters outside the realm of assessment, prioritization, matching and/or referral, but is related to housing, shelter or other services of a particular agency or program, or involved complaint of mistreatment or discriminatory behavior between clients, grievances will be directed back to the appropriate agency for resolution. Within 30 days after concluding the investigation, the Entry Point Lead Agency will write a report of the investigation’s findings, including a proposed decision about whether inappropriate discrimination occurred, and any action(s) recommended to prevent discrimination from occurring in the future. The findings of the investigation will be shared with the Entry Point Committee at the next scheduled meeting to finalize the decision, and will thereafter be shared with the client as soon as practicable. If necessary, the Entry Point Lead Agency may recommend that the client be re-assessed or re-prioritized for housing or services. The report will be retained on file at the Alliance to End Homelessness in Suburban Cook County (Alliance) for two years. If the complainant or other parties continue to dispute the conclusion of the investigation and wish to appeal the decision, they may file an appeal through the Alliance with the Entry Point Committee within 30 calendar days after notice of the Entry Point Lead Team’s determination. The Entry Point Committee will address the complaint appeal within 30 calendar days of its receipt by reviewing all relevant materials, notes and reports from the Entry Point Lead Team’s investigation, and within 30 calendar days, will notify all parties of their disposition, which will be considered final.

Discrimination complaints can also be directed to the Department of Housing and Urban Development: Chicago Regional Office: (800) 765-9372; or online at: https://www.portal.hud.gov/hudportal/HUD?src= /program_offices/fair_housing_equal_opp/online-complaint

**Equal Access and Inclusion Regardless of Family Composition:** Clients’ designation of their familial relationships will be honored and respected, regardless of marital status, gender identity or expression, sexual or romantic orientation, age, disability, proof of legal guardianship, or any other feature of identity or circumstance. Family members will not be denied access or separated based upon these reasons, and will be accommodated together, when possible, within space limits of available shelter or housing stock.
Equal Access and Inclusion of Transgender ("trans*") and Gender Non-conforming Clients: In accordance with federal guidelines and pursuant to standard best practices, we recognize that trans* and gender non-conforming clients are among the most vulnerable who will enter our service spaces and programs. We respect the gender self-identification of all of our clients, use people’s preferred names and pronouns, and invite trans* clients to consider and indicate what would be the safest arrangement for them for sleeping quarters and bathroom use. We do not consider gender markers on people’s IDs, people’s appearance, the gender assigned to someone at birth, or anything other than or over the person’s self-identity. (In other words, regardless of how a client’s gender features are read by staff or others or what her ID might say, if the client identifies as female, she may use the women’s bathroom and shower and sleep in the women’s section if she feels that is safest for her.) We do not ask intrusive questions about a clients’ anatomy or medical business, or seek “proof” of anyone’s gender status, and do not allow gossip or speculation about these things. We do not single out trans* clients for different treatment, but consider their comfort and safety to be paramount above the comfort level of cisgender (non-trans) clients, staff and volunteers. If a client feels more privacy is needed, we discreetly provide individual private shower or bathroom time for the client as much as possible. We do not, however, prescribe or demand more privacy or modesty from trans* clients than from their cisgender peers.

Access for people with disabilities: Appropriate auxiliary aids and services will be available for individuals with disabilities to ensure effective communication. The Suburban Cook Call Center has a TDD number, and each agency will utilize a TDD service as necessary to serve people who are Deaf or hard of hearing. Large type (and ability to enlarge text) versions of documents will be made available for people with visual impairments. Picture communication cards are available for those who are non-verbal. Staff will offer to assist clients in reading any forms, policies or written correspondence, and will offer to write on forms as needed.

Entry Point will ensure that individuals with disabilities, including individuals who use wheelchairs are able to access the Entry Point Assessment process by providing ADA accessible Access Points or arranging reasonable accommodations for mobility-impaired individuals such as assigning a Street Outreach worker or Housing Navigator to provide mobile assessment services. Marketing materials will clearly convey ADA accessible Access Points and processes.

Access for clients with limited English language literacy or proficiency: Forms and policies are to be made available in Spanish. Translation services are secured when needed to communicate with anyone whose primary language cannot be engaged by staff. Entry Point will take reasonable steps to offer process materials and participant instructions in multiple languages to meet the needs of minority, ethnic, and groups with Limited English Proficiency. Staff will offer to assist clients in reading any forms, policies or written correspondence, and will offer to write on forms as needed. The Inclusion and Non-Discrimination Policy and all other important policies and forms will be screened for literacy level using widely accepted best practices.

Cultural and Linguistic Competence: Staff use identity language chosen by clients, and do not select identity descriptors for clients during assessment. Assessments use culturally and linguistically competent questions for all persons that reduce cultural or linguistic barriers to housing and services for special populations, including LGBTQI people and families, youth, immigrants or refugees, devotees of minority religions, etc.
Appendix G - Entry Point Inclusion Policy for Clients

You belong here! You deserve to be included and served with respect! The Entry Point Coordinated Entry System promises to serve all clients fairly, and without discrimination based on any of these things:

- Your gender, gender status, or gender expression
- Being LGBTQ+
- Your race, color, tribe, or ethnicity
- Your immigration, refugee, or citizenship status
- Your income level, or source of income
- How well you read, write, or speak English
- Your job status or education level
- Your alcohol or drug use or addiction, or other addictions
- Your health or mental health status, or having HIV or AIDS
- Your age
- Your marital, family, or partnership status
- Your legal history
- Your veteran or military discharge status
- Your body size
- Your participation in the street economy
- Your religion or personal philosophy
- Not following a doctor’s or therapist’s medical treatment suggestions
- Your physical, developmental, intellectual, or emotional ability

This means when we assess your service needs and match you to programs you’re eligible for, we will make decisions and provide care and services fairly and with respect.

These are some of the ways we do this:

1. We do not allow any speech, language, or behavior that is hateful or abusive for anyone who might come into our spaces. If you feel other clients or staff have mistreated you or made you feel bad or unsafe because of your identity, please let staff know right away.

2. If you are transgender, genderqueer or gender non-conforming in your identity or experience, you can choose whether or not to discuss this with staff or others. Your gender self-identity will be respected, regardless of whether you express that identity in a way others might expect. It won’t matter whether you have chosen medical interventions, or changed your gender marker on your IDs. What matters is how you identify. Staff will use your chosen name and pronouns and protect your privacy. You can work with staff to decide what is safest for you in gendered spaces.

3. We don’t need to know your immigration, refugee or citizenship status. We will not work together with ICE or any other law enforcement people, or even let them know we are serving you, unless they present an arrest warrant that is signed by a judge and names you.

4. We have these things to help you communicate with us if you need them:
   a. TDD/TTY access
   b. Picture communication cards
   c. Large print forms and policies
   d. Language translation service

5. If you find it hard to read or write, staff will read forms and other written things to you, or help you write on forms. We try hard to make our forms and writing easy to read and understand.
6. If you have mobility difficulties, staff will help you decide which buildings are most accessible for you. We will send an Outreach worker as soon as possible to a mutually agreed upon location if needed.

7. Your family is your family, no matter what the ages and genders of the family members are. It’s up to you to tell us who’s in it, and you can stay together in the same program regardless if you’re legally married, and no matter what your sexual or romantic orientation is, as long as space and housing stock make it possible to accommodate you safely.

8. You can have whatever religion or personal philosophy you want, and we don’t expect you to go along with any religious activity while you’re with us.

9. We really value diversity and want you to be feel safe expressing and celebrating your own culture!

10. Our programs might have rules that you can’t drink alcohol or use illegal drugs on their sites, but as long as you are behaving respectfully and being safe, it’s your business about what you use off site and whether or not you are intoxicated when you come to us. We do not do drug testing or keep people out because of drinking or using outside program spaces.

11. You don’t need to tell us if you have HIV or AIDS, but if you do, we will protect your privacy, and it might help us find you housing faster.

12. If you feel you have been excluded or discriminated against because of your identity as listed above, you can file a complaint with the Entry Point Lead Team. The complaint process is below.

13. We hold everyone accountable to the same standards of inclusion and non-discrimination and anticipate that you will extend the same inclusive and non-discriminatory attitudes and behaviors toward other clients. Entry Point and agency program staff and program volunteers.

**Discrimination Complaint Process:**

**Step 1:** As soon as possible after the discrimination happens, contact the Entry Point Lead Team by filling out and emailing the Entry Point Discrimination Complaint Form. Your worker will get you the form, and help you get the completed form to the Entry Point Lead Team.

**Step 2:** The Entry Point Lead Team will take up to 30 days to investigate your complaint by reviewing documents and talking to people who might know about the complaint. They will make a decision, and then will communicate the decision to you and others in 30 days after that. If the Entry Point Lead Team feels your complaint is about the services of your agency rather than the process of Entry Point assessment, matching and referral, or if it is about discrimination between clients, they will direct the complaint to the specific agency’s grievance process.

**Step 3:** If the Entry Point Lead Team determines that discrimination happened at some point in the Entry Point assessment, matching, or referral process, they will work to make sure the problem is corrected so that it will not happen again. They will also work with you to decide how to put things right for you.

**Step 4:** If you feel the Entry Point Lead Team made the wrong decision, you may appeal your complaint with the Entry Point Committee within 30 days. The Committee will meet within a month and will let you know their decision as soon after that as possible. The Entry Point Committee’s decision is final.

Discrimination complaints can also be directed to the Department of Housing and Urban Development: Chicago Regional Office.
Phone: (800) 765-9372
Website: [https://portal.hud.gov/hudportal/HUD?src=/program_offices/fair_housing_equal_opp/online-complaint](https://portal.hud.gov/hudportal/HUD?src=/program_offices/fair_housing_equal_opp/online-complaint)
Appendix H - Entry Point Discrimination Complaint Form

Client Name: ___________________________  Date filed:  __________________

Agency Involved: ______________________  Best way to contact me:  ________________

I feel that I have been discriminated against during the Entry Point assessment, matching and/or referral process based on:

- My gender, gender status, or gender expression
- My age
- Being LGBTQ+
- My race, color, tribe, or ethnicity
- My immigration, refugee, or citizenship status
- My income level, or source of income
- How well I read, write, or speak English
- My physical, developmental, intellectual, or emotional ability
- My health or mental health status, or having HIV or AIDS

- My marital, family, or partnership status
- My body size
- My job status or education level
- My legal history
- My alcohol or drug use or addiction, or other addictions
- My veteran or military discharge status
- My participation in the street economy
- My not following a doctor’s or therapist’s medical treatment suggestions
- My religion or personal philosophy

Please describe the mistreatment or discrimination in as much detail as you can:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

When did this event happen?    ______/_______/_________

What staff and others were present or aware of the incident?
Were there any other witnesses? (If so, how can we reach them?)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

What are you hoping will happen as a result of filing a complaint?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

I promise that everything I have said is true to the best of my memory:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

For Entry Point Lead Team use only:

Date complaint received: ___/___/____

Findings:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Resolution:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Date client informed of disposition: ___/___/____

Date agency informed of disposition: ___/___/____

Entry Point Lead Team staff signature: ________________________________________

Entry Point Lead Team printed name: ________________________________________

February 22, 2019
# Appendix I – Entry Point Phased Assessment

Go to [http://myentrypoint.org/for-providers/](http://myentrypoint.org/for-providers/) for Entry Point Phased Assessment Documents and Instructions, Report Instructions and HMIS workflow instructions.

## Overview of Phased Assessment:

<table>
<thead>
<tr>
<th>Part</th>
<th>Overview</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Safety Screening</strong> (complete at first point of contact and retain in client’s file.)</td>
</tr>
</tbody>
</table>
| 2    | **HMIS Initial Intake** (complete at first point of contact, enter into HMIS).  
Verify **HMIS ROI Consent** is most recent version, valid and uploaded. |
| 3    | **Child and Family Needs Assessment** (complete ASAP if applicable, and retain in clients’ file.) |
| 4A   | **Determination to Proceed with Housing Assessment** (wait 7-14 stays/service days to complete.  
Complete earlier for families with minor children, TAY, those who are Chronically Homeless and extremely vulnerable individuals.)  
*If client is not interested in housing at this time, indicate in HMIS and STOP process. Revisit housing conversation within a month and resume assessment when client indicates desire to secure housing.* |
| 4B   | **Vulnerability and Severity of Service Needs Assessment.**  
Begin Progress Tracker record in HMIS.  
Entry Point Assessment and VI-SPDAT Consent form signed and uploaded in HMIS.  
Appropriate VI-SPDAT entered into HMIS.  
Vulnerability and Service Needs Assessment completed and uploaded in HMIS. *(Notify Referral Manager if advocating for an estimated score.)*  
Domestic Violence Prioritization Indicator (Complete as part of housing assessment when imminent safety risk exists) |
| 5    | **Eligibility Verifications**  
Cover Sheet – Client and Sending Agency Info  
Homelessness History Verification (Upload forms and supporting documents in HMIS.)  
Disability Verification (If applicable; Upload forms and supporting documents in HMIS.)  
Veteran Status Verification (If applicable; upload DD214 in HMIS.)  
Income Verification (Upload pay stubs, award letters, verification of zero income, etc. in HMIS.)  
Identity Verification (Work to obtain IDs for the client and all household members while it is free!)  
Family Unification Voucher Program  
Other Eligibility Verification (Collect and upload documents as required.) |
| 6    | **Housing Preferences, History, and Other Considerations** (Complete ASAP after Part 5; Upload in HMIS.) |
Overview of the Entry Point phased assessment instructions and other Entry Point documents:

CE Instructions Guidelines

- **PSH – Housing Assessment, Matching & Referral Process and Timelines**
  
  This document is an overview of process and timelines to get a client housed in PSH.

- **RRH – Housing Assessment, Matching & Referral Process and Timelines**
  
  This document is an overview of process and timelines to get a client housed in RRH.

- **TAY Client Need VI-SPDAT report instructions**
  
  This document provides instruction on how to run the Missing VI-SPDAT report for TAY in ART and what information is included on the various report tabs. Users must have an ART (Advanced Reporting Tool) Viewer license to run the report.

- **Clients Need VI-SPDAT Report Instructions**
  
  This provides the instructions for running the Clients Need VI-SPDAT report in ART. Users must have an ART (Advanced Reporting Tool) Viewer license to run the report.

- **Sending Agency Report Instructions**
  
  These are the instructions for finding and using the Sending Agency Report which is a scheduled report that will show up in a user’s ART Inbox. Users must have an ART Viewer license to run these reports.

- **Receiving Agency Report Instructions**
  
  These are the instructions for finding and using the Receiving Agency Report which is a scheduled report that will show up in a user’s ART Inbox. Users must have an ART Viewer license to run these reports.

- **Shelter Stays Report Instructions**
  
  This document provides instruction on how to run the Single Client Enrollment and Services History report. This report can be used to show shelter stays when documenting homelessness. Users must have an ART (Advanced Reporting Tool) Viewer license to run the report.

- **Uploading and Unlocking Entry Point Document Instructions**
  
  This document provides instructions for uploading Entry Point documents, including naming conventions. Instruction on unlocking the documents to the Entry Point team is also included.

- **Instructions for Entry Point Assessment Progress Tracker**
  
  This document provides details on how parts of the Entry Point Phased Assessment should be recorded in HMIS, including the Housing Interest/VI-SPDAT Status and the Entry Point Assessment Progress Tracker.
## Phased Assessment Documents

**Entry Point Assessment Progress Tracker**  
This provides an overview of the Coordinated Entry process for a client and includes a checklist that can be used to track a client through each stage of Coordinated Entry.

**Part 1: Safety Screening**  
This assessment has a built in script to assess a client's safety in their current situation, whether the client feels their immediate priority is safety or housing/shelter. Resources for referrals are also included.

**Part 2: HMIS Client Consent Form** and **SubCook Initial Intake Assessment**  
These are the same forms found elsewhere on suburbancook.org, specifically on our HMIS page.

**Part 3. Child and Family Needs Assessment**  
For households where minor children are present, this assessment includes specific questions about pregnant or parenting clients and their children.

**Part 4A: Housing Interest and Vulnerability Assessment**  
To be completed to initially determine interest in housing. If interested, proceed with CE VI-SPDAT Consent, appropriate VI-SPDAT, and the rest of the Vulnerability Assessment. This assessment includes estimated VI-SPDAT score considerations (higher or lower), Domestic Violence Prioritization Indicator score, as well as noteworthy factors impacting a client’s severity of service needs. Note both staff and supervisor signatures are required.

**Part 4B: Entry Point Assessment and VI-SPDAT Consent**  
Note the VI-SPDAT Consent now also includes acknowledgement of the Inclusion Policy

- **TAY VI-SPDAT v1.0**  
  This is the VI-SPDAT Assessment for Transitional Aged Youth

- **VI-SPDAT for Families v2.0**  
  This is the VI-SPDAT for Families version 2.0

- **VI-SPDAT for Singles v2.0**  
  This is the VI-SPDAT assessment for individuals adults v2.0

**Part 4C: Domestic Violence Prioritization Indicator Assessment Tool**
To be completed for individuals that are actively fleeing domestic violence and requesting housing assistance.

**Part 5: Eligibility Verifications**

This walks Case Managers through verifying a client's eligibility and includes the Chronic Homelessness Documentation checklists and Verification for documenting Disability, Veteran Status, Income and a Client's Identity as well as key contact information for the client and staff.

**Part 6: Housing Preference, History and Other Considerations**

This assesses a client or household's housing needs including where a client prefers to live (by North, West and South regions), type of housing the client will need and barriers to housing specific to the client or household.

**Part 7: Housing Stabilization Plan**

This document is where Housing Case Managers can record emergency contact information and a supportive services assessment looking at a client's health, employment, income and other open ended questions for clients about relationships, etc..

**CE Eligibility Verification Forms**

**Chronic Homeless Verification Tracking Sheet**

Use this form to track each month of individual’s living situation. A minimum of 12 months of homelessness is required to verify length of time for chronicity.

**Disability Verification**

Use this form to document an individual's disability. This form should be completed by a licensed clinician.

**Third Party Certification**

Use this form to gather documentation of homelessness from third parties (i.e., agency outreach, community representatives, family members). The letter should be printed on letterhead of the organization completing the form (social service agency, police department, church) whenever possible. Note: the first two lines are examples and can be removed prior to completing the form.

**Self-Certification of Homelessness**

To be completed when third party verification cannot be obtained. There may be additional project restrictions if more than 3 months of homelessness is self-certified. Record of Due Diligence must also be completed when self-certifying.

**Record of Due Diligence**

To be completed for individuals self-certifying homelessness. The Record of Due Diligence should record the efforts made by direct service provider staff to obtain third party verification of homelessness. Examples do not have to be included.
# CE Policy Documents

**Entry Point Training Standards**

This document gives a full overview of Entry Point trainings, the staff that must participate in them, and the frequency in which participation should occur. Training schedules are released every trimester, and participants must register in advance.

**Civil Rights and Fair Housing Laws and Requirements**

This document gives a list of Federal civil rights laws pertaining to fair housing and non-discrimination.

**Entry Point Affirmative Marketing Policy**

This document ensures that all Sub Cook households have equal access to Entry Point and CoC services and housing, regardless of any attribute or characteristic that could be perceived as a barrier to these services.

**Entry Point Inclusion/Non-Discrimination Policy**

This document states that Entry Point agencies do not discriminate in the course of housing and other services based on any individual’s attributes or characteristics. The document also gives accommodation requirements, including those for disabilities, culture, and linguistics.

**Entry Point Inclusion Policy for Clients**

This document is for clients to review and understand their eligibility rights and the non-discrimination policies of Entry Point.

**Entry Point Discrimination Complaint Form**

To be completed by a client should they feel that they have experienced any kind of discrimination during the Entry Point process.

**Request to Return Housing Referral**

To be completed if the agency wishes to return a client’s housing referral based on eligibility, lack of contact, or if the client declined admission.

**Housing Referral Appeal**

To be completed if the agency staff disagree with a rejected Return Referral Request or if the client is determined to be not clinically appropriate for the program they were referred to.

**Request to Exclude Placement from NOFA Computation**

To be completed if length of time from referral to placement exceeds 60 days or if the receiving agency regularly communicates housing efforts and obstacles to the Entry Point Referral Manager.

**Appeal – Request to Exclude Placement from NOFA Computation**

To be completed if unusual circumstances outside of the receiving agency’s control adversely delayed the process.
Evaluation and Monitoring

This document gives an overview of how Coordinated Entry is evaluated and monitored based on HUD’s requirements and pre-set outcomes.

HUD Sources

List of related HUD sources, as well as Entry Point revision dates and key changes.

Additional Housing Resources

A Guide to Identifying and Referring Clients to the Family Unification Program

This document provides guidance on who may be eligible for the Family Unification Program and how to complete the referral process.

FUP CoC Referral Form

Use this referral form for individuals that appear to be eligible for the Family Unification Program (FUP).
Appendix J - Housing Assessment, Matching & Referral Process and Timelines

Permanent Supportive Housing:

The following guidelines have been established for the assessment, matching, and referral process for PSH:

1. Entry Point Safety Screening should be done in conjunction with HMIS SubCook Initial Intake Assessment (upon entry into program) since the safety of our clients, staff and volunteers is vitally important.

2. **Chronic individual adults, all Vets, all TAY, and all Family with children households need the Entry Point Phased Assessment Part 4 with VI-SPDATs ASAP;** all other households should receive Entry Point Phased Assessment Part 4 with VI-SPDATs as soon as possible after seven days/stays/interactions.
   
   Enter VI-SPDATs data into applicable HMIS assessment and upload remaining Entry Point Part 4 documents into HMIS.

3. **Immediately begin gathering eligibility (length of time homeless, disabling condition, etc.) documents with Entry Point Phased Assessment Part 5 for chronic adults scoring 8+ on VI-SPDAT, and for all vets, TAY or families with children.** Wait for instructions from Entry Point Lead Team for all other clients.

4. Part 6 of the Entry Point Phased Assessment should be completed and uploaded into HMIS as soon as possible after completing Entry Point Phased Assessment Part 4.

5. Sending Agency workers need to maintain weekly contact and the ability to quickly contact anyone in those above categories as well as anyone who is in the housing process.

6. **Match:** When the Entry Point Lead Team notifies the Sending Agency Housing Navigator of a possible match, the Sending Agency Housing Navigator has **five business days** to respond with the client’s answer about whether they accept the match offer. Please keep the Entry Point Lead Team informed about your efforts to contact the client and your progress. If the Sending Agency Housing Navigator is unable to locate the client and reach a decision, the Lead Team may move to the next eligible client for that vacancy. The original client will remain on the BNL and receive the next offer for which they are eligible.

7. **Offer:** After the client has accepted the match, the client and Sending Agency Navigator have **five business days** to complete any additional documentation that might be needed. If the Sending Agency Housing Navigator and client are unable to provide documentation in that timeframe, the Lead Team may move to the next eligible client for that vacancy. The client will remain on the BNL and receive the next offer for which they are eligible. **Please note, contact Entry Point Lead Team ASAP if you are having issues with documentation because we do not want any client to remain homeless due to documentation difficulties.**

**Goal:** **The total time from match to referral should take no longer than 14 calendar days.**

8. **Referral:** After the Receiving Agency is notified of a referral, they have **five business days** to contact the Sending Agency and/or client to arrange a meeting. Housing programs are expected to begin housing location (if applicable) immediately after receiving a referral, and no later than the day after they first meet a client.
9. **Extenuating placement circumstances:** Receiving agencies will be evaluated annually during the NOFA ranking process based upon the timeliness of housing clients. Periodically there will be unusual circumstances outside of the receiving agency’s control that abnormally delays the process. In these circumstances, the length of time placing a client can be excluded from the agency average for NOFA rankings only as follows:

   a. Length of time from referral to placement exceeds 60 days;
   b. The receiving agency regularly participates in case conferencing and communicates all housing efforts and obstacles to the Entry Point Referral Manager;
   c. The receiving agency submits a Request to Exclude Placement from NOFA Computation to the Referral Manager to exclude placement results for a client no later than 60 days after date of referral; and
   d. It is determined by the Entry Point Referral Manager or, if necessary, an appeal of the Referral Manager’s decision by submitting an Appeal of Request to Exclude Placement from NOFA Computation, that unusual circumstances outside of the receiving agency’s control adversely delayed the process.

**Goal:** The total time from referral to housing should take no longer than 30 calendar days.

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**Rapid Re-Housing**

**Prior to Match/Referral**

**Sending Agency**

1. For clients to be considered for RRH placement:
   a. Household must be literally homeless
   b. Sending Agency must initiate HMIS Entry Point Assessment Progress Tracker, upload and unlock CE-VISPDAT consent form, complete and unlock appropriate VI-SPDAT and upload and unlock completed Parts 4, 5 & 6 of the Entry Point Phased Assessment. 
      - For a reminder of procedures, please see attached Progress Tracker Instructions, which can also be found on the Alliance Website along with other forms and instructions.
      - If agency staff have not been trained or need a refresher training, please contact Jake Bradley at jbradley@housingforward.org
   c. Adult-Only households (including TAY) must have a VI-SPDAT score above 4 to be housed in an RRH project.
   d. Households with minor children must have a VI-SPDAT score above 5 to be housed in an RRH project.
   e. Households must have been engaged in services within the past 30 days.

2. Sending Agencies must be able to verify that non-chronic households are literally homeless (see Phased Assessment Parts 5B & 5C) but will not be required to provide supporting documentation of literal homelessness until requested by Receiving Agency upon enrolling household into RRH project. When Third Party Verification will be required, the Sending Agency should have already had conversations with the party who can verify household’s homelessness so that documentation can be provided promptly when requested.

3. Sending Agencies will need to provide verification for all households experiencing chronic homeless prior to the household being referred to a RRH program. Documentation will need to be uploaded and unlocked...
in HMIS as well. The Entry Point Referral Manager, Jessica Ellenwood jellenwood@housingforward.org, will verify chronic documentation prior to RRH Referrals for chronic households.

**Receiving Agency**

4. When an RRH project has an upcoming opening to fill, request a RRH referral using the [RRH Referral Request Form](#), (click for link), which will provide information about the opening and notify Entry Point to begin the match process.

Note: Please indicate when the project is nearing the end of available funding so Entry Point can discuss and plan future referral options with Receiving Agency to attempt placements that will be commensurate with available funds.

5. All Supplemental ESG funded RRH programs must fill all openings through Entry Point

6. All other ESG and CoC funded RRH programs are expected, until further notice, to:
   a. Use good faith efforts to fill at least half of their openings from Entry Point
   b. Ensure that all households referred to their program outside Entry Point meet the requirements described in 3a, c, d & e above.
      • Notify Entry Point Referral Manager when working with a referral outside Entry Point so that the household will not be matched to another RRH referral.

**Match/Referral**

**Entry Point Team**

7. Entry Point will match referral requests with potentially eligible households from the Prioritized List by region (defined as: experiencing homelessness in the region or requesting to locate in the region)
   a. Households are prioritized based upon approved Entry Point Prioritization Policy.

8. Referrals will be made using the following distribution method:
   a. If RRH project serves only households with minor children, all referrals will be for households with minor children
   b. If RRH project serves adult-only households, referrals will be rotated, on an equal basis, between TAY, Chronic and Non-Chronic adult-only households
   c. If project serves all household types, referrals will be rotated, on an equal basis, between households with minor children and adult-only households (adult-only households divided equally as above).

**NOTE**: When a Receiving Agency indicates that a project is nearing the end of available funding, Entry Point will discuss and plan future referral options with Receiving Agency to attempt placements that will be commensurate with available funds.

9. CE will notify Sending Agency of potential referral.

**Sending Agency**

10. Sending Agency has 2 business days to locate client, confirm eligibility and interest in the placement and notify Referral Manager (jellenwood@housingforward.org) whether to proceed.
**Receiving Agency**

11. **Entry Point** will unlock all Phased Assessment Documents in HMIS so the Receiving Agency can access them. **Entry Point Phased Assessment Documents** are intended to replace individual agency referral forms so additional forms should not be requested from the Sending Agency (other than 13b below). Please contact the Sending Agency if documents are incomplete. Please contact **Entry Point** if additional required contract or grant eligibility information needs to be added to the Phased Assessment Documents.

Note: CE team will verify accuracy or validity of eligibility documents for Chronic Households referred to RRH. For all other households, CE will only verify that documents exist. Receiving Agencies are ultimately responsible for accepting documentation. CE will intervene if necessary where questions/concerns arise between Sending and Receiving Agencies.

12. Receiving Agency will:
   a. Coordinate with the Sending Agency to contact household and communicate with Sending Agency throughout the process.
   b. Work with Sending Agency to obtain documented verification of household’s literal homelessness at the point of intake into the RRH project (not at date housed).
   c. A referral can be returned to Entry Point if eligibility or literal homelessness can’t be documented in 5 business days, or if the participant cannot be located or declines admission. The Receiving agency will detail Sending and Receiving Agency attempts to document eligibility or locate the participant or describe why the participant declined admission in a Request to Return Housing Referral Form submitted to the Entry Point Referral Manager for review.
      ▪ If the return request is approved, the household will be considered for a future placement if they are eligible.
   d. Keep CE informed of progress, including
      ▪ Updating the HMIS Entry Point Assessment Progress Tracker (see number 3 above for instructions), including closing the tracker when the household is housed
      ▪ Inform Referral Manager when the household is housed or if/why the placement did not occur.
Appendix K - Request to Return Housing Referral

Client Name: ______________________________________________________________________  Date: _________________
HMIS ID #: ______________________________________________________________________  Date of Referral: _________________

Housing Program: ____________________________________________________________________

Case Manager Name: ___________________________________________________________________

Email: ___________________________________________________________________________  Phone: _______________

Sending Agency: _____________________________________________________________________

Sending Agency Case Manager: _____________________________________________________________________

Email: ___________________________________________________________________________  Phone: _______________

Reason requesting to return referral (fill in applicable section)

1. Client not eligible for housing program

Please clearly describe eligibility issue:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

2. Cannot locate participant

Please clearly describe sending and receiving agency attempts to locate client:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

3. Participant declined admission to the housing program
Please clearly describe why participant declined admission and sending and receiving agency steps taken to address participant concerns:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Receiving Agency Signature: ____________________________
Date: ____________________________

Submit Form to Entry Point Referral Manager, referrals@myentrypoint.org

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<tr>
<th>Entry Point Resolution</th>
<th>Y / N</th>
<th>Date:</th>
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</table>
Appendix L - Housing Referral Appeal

Client Name: ___________________________ Date: ________________
HMIS ID #: ___________________________ Date of Referral: ________________

Housing Program: ______________________________________________________

Case Manager Name: ____________________________________________________

Email: ___________________________ Phone: ________________

Sending Agency: ______________________________________________________

Sending Agency Case Manager: _________________________________________

Email: ___________________________ Phone: ________________

Reason appealing referral (fill in applicable section)

1. Appealing rejected Return Referral Request
   Date of Return Referral Request: ________________________________

   Describe why agency disagrees with referral return rejection:
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

2. Participant determined not clinically appropriate for program

   Please clearly describe reasons for determination and actions taken by sending and receiving agency staff as well as communication with Entry Point Referral Manager:
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
Receiving Agency Signature: 

Date: 

Submit form to Program Manager at The Alliance to End Homelessness in Suburban Cook County, kurt@suburbancook.org

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<tr>
<td>Members of CE Grievance Committee Votes</td>
<td>Name</td>
<td>Y/N</td>
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Comments
Appendix M - Request to Exclude Placement from NOFA Computation

Client Name: _______________________________ Date: __________________
HMIS ID #: _______________________________ Date of Referral: ________________

Date Housed (Entered in HMIS): ________________________________

Length of Time from Referral to Housed: ________________________________

Housing Program: ________________________________

Case Manager Name: ________________________________

Email: _______________________________ Phone: __________________

Sending Agency: ________________________________

Sending Agency Case Manager: ________________________________

Email: _______________________________ Phone: __________________

1. Time from Referral to Housed exceeds 60 days: Y/N

If HMIS date housed is more than 60 days but interim housing has been arranged for the client, please describe interim arrangement and date interim housing began.

Date interim housing began: ________________________________

Interim housing arrangement: ________________________________

________________________________________________________________________

2. Agency has participated in case conferencing and communicated regularly with Entry Point Referral Manager regarding issues with placement: Y/N

3. Clearly describe unusual circumstances beyond receiving agency’s control adversely delaying the housing process and steps receiving agency is taking to remediate those circumstances:

________________________________________________________________________

________________________________________________________________________

Entry Point Policies and Procedures
February 22, 2019
Receiving Agency Signature: ________________________________

Date: ________________________________

Submit Form to Entry Point Referral Manager, referrals@myentrypoint.org

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Appendix N - Appeal - Request to Exclude Placement from NOFA Computation

Client Name: _______________________________ Date: ________________
HMIS ID #: _______________________________ Date of Referral: ________________

Housing Program: _______________________________________________________
Case Manager Name: _____________________________________________________
Email: _______________________________ Phone: ___________________________

Sending Agency: _________________________________________________________
Sending Agency Case Manager: _____________________________________________
Email: _______________________________ Phone: ___________________________

Please clearly describe reasons for appeal:
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Receiving Agency Signature: ______________________________________________
Date: ________________

Submit form to Program Manager at The Alliance to End Homelessness in Suburban Cook County, kurt@suburbancook.org

<table>
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<td>Name</td>
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Comments
Appendix O – VAWA Emergency Transfer Policy

Alliance to End Homelessness in Suburban Cook County
Emergency Transfer Plan for Victims of Domestic Violence, Dating Violence, Sexual Assault, or Stalking

Emergency Transfers
The Alliance to End Homelessness Suburban Cook County (Alliance) is concerned about the safety of the tenants of the housing programs that are funded by CoC Program grant funds, and such concern extends to tenants who are victims of domestic violence, dating violence, sexual assault, or stalking. Every care should be made to ensure that these tenants are treated with dignity and respect when they step forward to disclose intimate details of their traumatic experience(s). In accordance with the Violence Against Women Act (VAWA), CoC-funded programs providing permanent housing (PSH/RRH) or transitional housing must allow tenants who are victims of domestic violence, dating violence, sexual assault, or stalking to request an emergency transfer from the tenant’s current unit to another unit. The ability to request a transfer is available regardless of sex, gender identity, or sexual orientation. The ability of a housing program to honor such a request for tenants currently receiving assistance, however, may depend upon a preliminary determination that the tenant is or has been a victim of domestic violence, dating violence, sexual assault, or stalking, and on whether the housing program has another dwelling unit that is available and is safe to offer the tenant for temporary or more permanent occupancy.

This plan identifies tenants who are eligible for an emergency transfer, the documentation needed to request an emergency transfer, confidentiality protections, how an emergency transfer may occur, and guidance to tenants on safety and security. This plan is based on a model emergency transfer plan published by the U.S. Department of Housing and Urban Development (HUD), the Federal agency that oversees that the Alliance and CoC-funded providers are in compliance with VAWA.

Eligibility for Emergency Transfers
A tenant who is a victim of domestic violence, dating violence, sexual assault, or stalking, as provided in HUD’s regulations at 24 CFR part 5, subpart L is eligible for an emergency transfer, if: the tenant reasonably believes that there is a threat of imminent harm from further violence if the tenant remains within the same unit. If the tenant is a victim of sexual assault, the tenant may also be eligible to transfer if the sexual assault occurred on the premises within the 90-calendar-day period preceding a request for an emergency transfer. A tenant requesting an emergency transfer must expressly request the transfer in accordance with the procedures described in this plan. Tenants who are not in good standing may still request an emergency transfer if they meet the eligibility requirements in this section.

1 Despite the name of this law, VAWA protection is available to all victims of domestic violence, dating violence, sexual assault, and stalking, regardless of sex, gender identity, or sexual orientation.
2 For purposes of this plan, “CoC-funded programs” include any permanent or transitional housing projects that are supported by CoC Program grant funds.
3 Housing providers cannot discriminate on the basis of any protected characteristic, including race, color, national origin, religion, sex, familial status, disability, or age. HUD-assisted and HUD-insured housing must be made available to all otherwise eligible individuals regardless of actual or perceived sexual orientation, gender identity, or marital status.
Emergency Transfer Request Documentation
To request an emergency transfer, the tenant shall notify the housing program’s administrator and submit a written or verbal request for a transfer. The housing program will provide reasonable accommodations to this policy for individuals with disabilities. The tenant’s written request for an emergency transfer should include either:

1. A statement expressing that the tenant reasonably believes that there is a threat of imminent harm from further violence if the tenant were to remain in the same dwelling unit assisted under the housing program; OR
2. A statement that the tenant was a sexual assault victim and that the sexual assault occurred on the premises during the 90-calendar-day period preceding the tenant’s request for an emergency transfer.

Preliminary Determination Documentation
The tenant has 14 business days from the date of their notice to provide documentation supporting their claim if requested by the housing program. The housing program may use the HUD forms 5382 and 5383 (attached) to document requests for an emergency transfer and to document incidents of domestic violence. The housing program may also accept third-party documentation that demonstrates why the tenant is eligible for an emergency transfer. This may include, but is not limited to: a letter or other documentation from a victim service provider, social worker, legal assistance provider, pastoral counselor, mental health provider, or other professional from whom the tenant sought assistance; a current restraining order or order of protection; a recent court order or other court records; or a law enforcement report or records. In order to protect the safety and confidentiality of the tenant, the determination as to which third-party documentation is submitted should be at the discretion of the tenant. Care should be taken when using HUD forms 5382 and 5383 so the least amount of information necessary is obtained from the tenant.

Confidentiality
The housing program will keep confidential any information that the tenant submits in requesting an emergency transfer, and information about the emergency transfer, unless the tenant gives the housing program written permission to release the information on a time limited basis (VAWA recommends no more than 30 days), or disclosure of the information is required by law or required for use in an eviction proceeding or hearing regarding termination of assistance from the covered program. This includes keeping confidential the new location of the dwelling unit of the tenant, if one is provided, from the person(s) that committed an act(s) of domestic violence, dating violence, sexual assault, or stalking against the tenant especially if that person was housed with the tenant seeking the emergency transfer. See the Notice of Occupancy Rights under the Violence Against Women Act for more information about the housing program’s responsibility to maintain the confidentiality of information related to incidents of domestic violence, dating violence, sexual assault, or stalking.

Emergency Transfer Timing and Availability
The housing program cannot guarantee that a transfer request will be approved or how long it will take to process a transfer request. However, the housing program, will act as quickly as possible to move a tenant who is a victim of domestic violence, dating violence, sexual assault, or stalking to another unit, subject to availability and safety of a unit. If a tenant feels they are in imminent danger from the person(s) that committed an act(s) of domestic violence, dating violence, sexual assault or stalking against the tenant, then they should be given the option to seek emergency shelter with a domestic violence agency or appropriate shelter. If a tenant reasonably believes the proposed transfer would not be safe, the tenant may request a transfer to a different unit. If a unit is available, the transferred tenant must agree to abide by the terms and conditions that govern occupancy in the unit to which the tenant has been transferred. The housing program may be unable to transfer a tenant to a particular unit if the tenant has not or
cannot establish eligibility for that unit. If the housing program has no safe and available units for which a tenant who needs an emergency transfer is eligible, the housing program and participant will collaborate with Entry Point to identify safe and available units to which the tenant could move. At the tenant’s request, the housing program will also assist tenants in contacting the local organizations offering assistance to victims of domestic violence, dating violence, sexual assault, or stalking that are attached to this plan.

For households living in assisted units who qualify for an emergency transfer but a safe unit is not immediately available for an internal emergency transfer, the individual or family shall have priority over all other applicants for rental assistance, transitional housing, and permanent supportive housing projects funded under this part, provided that:

1. the individual or family meets all eligibility criteria required by Federal law or regulation or HUD NOFA; and
2. the individual or family meets any additional criteria or preferences established in accordance with 24 CFR 578.93(b)(1),(4),(6), or (7).

The individual or family shall retain their original homeless or chronically homeless status for the purposes of the transfer.

In cases where a household receiving tenant-based rental assistance separates in order to affect an emergency transfer, the housing program, in consultation with the Alliance, will determine the appropriate actions with respect to the non-transferring family member(s). Clarifying documentation may be required from the tenant(s) if the household needs to be served in separate units.

Safety and Security of Tenants
Pending processing of the transfer and the actual transfer, if it is approved and occurs, the tenant is urged to take all reasonable precautions to be safe.

Tenants who are or have been victims of domestic violence are encouraged to contact the Illinois Domestic Violence Hotline 1-877-863-6338 (Voice), 1-877-863-6339 (TTY); or the National Domestic Violence Hotline at 1-800-799-7233 (Voice), 1-800-787-3224 (TTY); or a local domestic violence agency, see Attachment C, for assistance in creating a safety plan.

Tenants who have been victims of sexual assault may call the Rape, Abuse & Incest National Network’s National Sexual Assault Hotline at 800-656-HOPE, or visit the online hotline at https://ohl.rainn.org/online/.

Tenants who are or have been victims of stalking seeking help may visit the National Center for Victims of Crime’s Stalking Resource Center at https://www.victimsofcrime.org/our-programs/stalking-resource-center.

Attachment A: HUD Form 5383
Attachment B: HUD Form 5382
Attachment C: Local organizations offering assistance to victims of domestic violence, dating violence, sexual assault, or stalking.
Purpose of Form: If you are a victim of domestic violence, dating violence, sexual assault, or stalking, and you are seeking an emergency transfer, you may use this form to request an emergency transfer and certify that you meet the requirements of eligibility for an emergency transfer under the Violence Against Women Act (VAWA). Although the statutory name references women, VAWA rights and protections apply to all victims of domestic violence, dating violence, sexual assault or stalking. Using this form does not necessarily mean that you will receive an emergency transfer. See your housing provider’s emergency transfer plan for more information about the availability of emergency transfers.

The requirements you must meet are:

(1) You are a victim of domestic violence, dating violence, sexual assault, or stalking. If your housing provider does not already have documentation that you are a victim of domestic violence, dating violence, sexual assault, or stalking, your housing provider may ask you for such documentation. In response, you may submit Form HUD-5382, or any one of the other types of documentation listed on that Form.

(2) You expressly request the emergency transfer. Submission of this form confirms that you have expressly requested a transfer. Your housing provider may choose to require that you submit this form, or may accept another written or oral request. Please see your housing provider’s emergency transfer plan for more details.

(3) You reasonably believe you are threatened with imminent harm from further violence if you remain in your current unit. This means you have a reason to fear that if you do not receive a transfer you would suffer violence in the very near future.

OR

You are a victim of sexual assault and the assault occurred on the premises during the 90-calendar-day period before you request a transfer. If you are a victim of sexual assault, then in addition to qualifying for an emergency transfer because you reasonably believe you are threatened with imminent harm from further violence if you remain in your unit, you may qualify for an emergency transfer if the sexual assault occurred on the premises of the property from which you are seeking your transfer, and that assault happened within the 90-calendar-day period before you submit this form or otherwise expressly request the transfer.

Submission of Documentation: If you have third-party documentation that demonstrates why you are eligible for an emergency transfer, you should submit that documentation to your housing provider if it is safe for you to do so. Examples of third party documentation include, but are not limited to: a letter or other documentation from a victim service provider, social worker, legal assistance provider, pastoral counselor, mental health provider, or other professional from whom you have sought assistance; a current restraining order; a recent court order or other court records; a law enforcement report or records; communication records from the perpetrator of the violence or family members or friends of the perpetrator of the violence, including emails, voicemails, text messages, and social media posts.
**Confidentiality:** All information provided to your housing provider concerning the incident(s) of domestic violence, dating violence, sexual assault, or stalking, and concerning your request for an emergency transfer shall be kept confidential. Such details shall not be entered into any shared database. Employees of your housing provider are not to have access to these details unless to grant or deny VAWA protections or an emergency transfer to you. Such employees may not disclose this information to any other entity or individual, except to the extent that disclosure is: (i) consented to by you in writing in a time-limited release; (ii) required for use in an eviction proceeding or hearing regarding termination of assistance; or (iii) otherwise required by applicable law.
1. Name of victim requesting an emergency transfer: ________________________________

2. Your name (if different from victim’s): ______________________________________

3. Name(s) of other family member(s) listed on the lease: __________________________

4. Name(s) of other family member(s) who would transfer with the victim: ____________

5. Address of location from which the victim seeks to transfer: ______________________

6. Address or phone number for contacting the victim: ____________________________

7. Name of the accused perpetrator (if known and can be safely disclosed): __________

8. Relationship of the accused perpetrator to the victim: ____________________________

9. Date(s), Time(s) and location(s) of incident(s): ________________________________

10. Is the person requesting the transfer a victim of a sexual assault that occurred in the past 90 days on the premises of the property from which the victim is seeking a transfer? If yes, skip question 11. If no, fill out question 11. __________

11. Describe why the victim believes they are threatened with imminent harm from further violence if they remain in their current unit.

12. If voluntarily provided, list any third-party documentation you are providing along with this notice: ________________________________

   This is to certify that the information provided on this form is true and correct to the best of my knowledge, and that the individual named above in Item 1 meets the requirement laid out on this form for an emergency transfer. I acknowledge that submission of false information could jeopardize program eligibility and could be the basis for denial of admission, termination of assistance, or eviction.

   Signature ________________________________ Signed on (Date) _______________________

Form HUD-5383
(12/2016)
CERTIFICATION OF
DOMESTIC VIOLENCE,
DATING VIOLENCE,
SEXUAL ASSAULT, OR STALKING,
AND ALTERNATE DOCUMENTATION

Purpose of Form: The Violence Against Women Act (“VAWA”) protects applicants, tenants, and program participants in certain HUD programs from being evicted, denied housing assistance, or terminated from housing assistance based on acts of domestic violence, dating violence, sexual assault, or stalking against them. Despite the name of this law, VAWA protection is available to victims of domestic violence, dating violence, sexual assault, and stalking, regardless of sex, gender identity, or sexual orientation.

Use of This Optional Form: If you are seeking VAWA protections from your housing provider, your housing provider may give you a written request that asks you to submit documentation about the incident or incidents of domestic violence, dating violence, sexual assault, or stalking.

In response to this request, you or someone on your behalf may complete this optional form and submit it to your housing provider, or you may submit one of the following types of third-party documentation:

1. A document signed by you and an employee, agent, or volunteer of a victim service provider, an attorney, or medical professional, or a mental health professional (collectively, “professional”) from whom you have sought assistance relating to domestic violence, dating violence, sexual assault, or stalking, or the effects of abuse. The document must specify, under penalty of perjury, that the professional believes the incident or incidents of domestic violence, dating violence, sexual assault, or stalking occurred and meet the definition of “domestic violence,” “dating violence,” “sexual assault,” or “stalking” in HUD’s regulations at 24 CFR 5.2003.

2. A record of a Federal, State, tribal, territorial or local law enforcement agency, court, or administrative agency; or

3. At the discretion of the housing provider, a statement or other evidence provided by the applicant or tenant.

Submission of Documentation: The time period to submit documentation is 14 business days from the date that you receive a written request from your housing provider asking that you provide documentation of the occurrence of domestic violence, dating violence, sexual assault, or stalking. Your housing provider may, but is not required to, extend the time period to submit the documentation, if you request an extension of the time period. If the requested information is not received within 14 business days of when you received the request for the documentation, or any extension of the date provided by your housing provider, your housing provider does not need to grant you any of the VAWA protections. Distribution or issuance of this form does not serve as a written request for certification.

Confidentiality: All information provided to your housing provider concerning the incident(s) of domestic violence, dating violence, sexual assault, or stalking shall be kept confidential and such details shall not be entered into any shared database. Employees of your housing provider are not to have access to these details unless to grant or deny VAWA protections to you, and such employees may not disclose this information to any other entity or individual, except to the extent that disclosure is: (i) consented to by you in writing in a time-limited release; (ii) required for use in an eviction proceeding or hearing regarding termination of assistance; or (iii) otherwise required by applicable law.
TO BE COMPLETED BY OR ON BEHALF OF THE VICTIM OF DOMESTIC VIOLENCE, DATING VIOLENCE, SEXUAL ASSAULT, OR STALKING

1. Date the written request is received by victim: ________________________________

2. Name of victim: _________________________________________________________

3. Your name (if different from victim's): ______________________________________

4. Name(s) of other family member(s) listed on the lease: _________________________

5. Residence of victim: _______________________________________________________

6. Name of the accused perpetrator (if known and can be safely disclosed): ________

7. Relationship of the accused perpetrator to the victim: _________________________

8. Date(s) and times(s) of incident(s) (if known): _______________________________

10. Location of incident(s): ___________________________________________________

   In your own words, briefly describe the incident(s):
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

This is to certify that the information provided on this form is true and correct to the best of my knowledge and recollection, and that the individual named above in Item 2 is or has been a victim of domestic violence, dating violence, sexual assault, or stalking. I acknowledge that submission of false information could jeopardize program eligibility and could be the basis for denial of admission, termination of assistance, or eviction.

Signature ___________________________ Signed on (Date) ________________________

Public Reporting Burden: The public reporting burden for this collection of information is estimated to average 1 hour per response. This includes the time for collecting, reviewing, and reporting the data. The information provided is to be used by the housing provider to request certification that the applicant or tenant is a victim of domestic violence, dating violence, sexual assault, or stalking. The information is subject to the confidentiality requirements of VAWA. This agency may not collect this information, and you are not required to complete this form, unless it displays a currently valid Office of Management and Budget control number.

Form HUD-5383
(12/2016)
Attachment C: Local Resources

NORTH

Wings
24 hour hotline 847.221.5680

Evanston/North Shore YWCA
24 hour hotline 847-864-8780

WEST

Sarah’s Inn
24 hour hotline 708.386.4225

Pillars Community Health
24 hour hotline 708.745.5277

SOUTH

Crisis Center
24 hour hotline 708.429.SAFE (7233)

South Suburban Family Shelter
24 hour hotline 708.335.3028

For an additional list of local domestic violence resources, visit: www.domesticshelters.org/il/illinois-domestic-violence-help-statistics
Appendix P - Evaluation and Monitoring

Note: Initial CE measures will generally be used to establish a baseline for CE in Suburban Cook County. Trends will be evaluated throughout the year to help identify gaps in service, effectiveness of processes and opportunities for improvement. Specific performance goals have been identified in some instances but will be re-evaluated throughout.

HUD requirement for evaluating Coordinated Entry – HUD Coordinated Entry Notice: Section ii.B.15

**Core Requirements:** CoC consults with each participating project and project participants at least annually to evaluate the intake, assessment, and referral processes associated with coordinated entry. Solicitations for feedback must address the quality and effectiveness of the entire coordinated entry experience for both participating projects and households.

**Evaluation methods:** CoC ensures through written CE policies and procedures the frequency and method by which the CE evaluation will be conducted, including how project participants will be selected to provide feedback, and must describe a process by which the evaluation is used to implement updates to existing policies and procedures.

**Measures to evaluate the effectiveness of CE:**

Note: measures will be evaluated every three months beginning July 1, 2017 across client demographics at CoC, individual agency and project/service type to help ensure nondiscrimination and low-barrier access and to identify gaps in services. Evaluations will be presented to the Alliance Board twice a year.

- Length of time between: identification, pre-screen, VI-SPDAT, BNL (for prioritized households), match/offer, housing referral, housed.
  - Goal 1 – 75% of individuals or families identified as chronic have been assessed for housing within 14 days of identification (screened for housing/services preference, VISPDAT, housing application)
  - Goal 2 – Establish baseline and ongoing improvement toward HUD’s stated objective of minimizing time until housing resources are offered to every prioritized household (BNL) experiencing homelessness
  - Goal 3 – Work toward housing placement within 30 days of referral, evaluate any ongoing exceptions toward meeting this goal to inform potential gaps in services or areas of improvement.

- Completed housing referrals
  - Goal - establish baseline and observed improvement in number of completed compared with returned referrals. Will track completed referrals, returned referrals and reasons for return.

- CoC and ESG funded project vacancies filled by CE (system, agency, project level)
  - Goal – 100% adult-only PSH filled through CE
  - Goal – Establish baseline for all other PSH demographics, RRH and TH.

**Vacancy time and occupancy rate**

- Goal 1 – Adult-only PSH Vacancies filled within 60 days of vacancy
- Goal 2 – CoC funded adult-only PSH occupancy rate exceeds 95%
- Goal 3 - Establish baseline occupancy goals for all other PSH demographics, RRH and TH.

- Call Center process and outcomes
  - Goal 1 – Continued improvement trend in call/caller ratio (reduced number of calls by individual callers before connecting with call specialist)
• Goal 2 – establish baseline and observed improvement for accuracy of eligibility screening for households receiving referrals for services, completed referrals and outcomes by referral type

• Process surveys:
  o Access, Assessment and Referral process for clients – transparent process, fair and equal access, as few barriers to entry as possible
  o Access, Assessment and Referral process for agencies – consistent, standardized procedures across all CoC and ESG funded projects (Emergency Services, Street Outreach, Prevention, RRH, TH and PSH)
  o Training assessment – are agencies/staff receiving appropriate training

• Compliance with requirements of HUD Coordinated Entry Notice CPD-17-01
  o Goal – Written policies and procedures in place to achieve full compliance by January 23, 2018

Potential CE Impact on HUD CoC System-Wide Outcomes:
  • Reduced average length of time homeless (by household type/demographic)
  • Reduced return to homelessness
  • Reduced rate of first-time homelessness
  • Reduced chronic homelessness, family homelessness and youth homelessness
  • Meet outcome targets for housing stability and increased income

General data measurements – as currently measured by HMIS staff:
  • Household served makeup (size, CH, Vet, demographic)
  • Data Quality – standard Alliance HMIS goals
Appendix Q – HUD Sources

Policy

**Coordinated Entry (CE) Notice:**

**COC Program Interim Rule:**

**Emergency Solutions Grants (ESG) Program Interim Rule:**

**Final Rule defining chronically homeless:**

**HMIS Data and Technical Standards:**

**Prioritization Notice (addressing Permanent Supportive Housing):**

Guides

**Coordinated Entry Self-Assessment:** [https://www.hudexchange.info/resources/documents/coordinated-entry-self-assessment.pdf](https://www.hudexchange.info/resources/documents/coordinated-entry-self-assessment.pdf)

**Coordinated Entry Guidebook:** [https://www.hudexchange.info/resources/documents/Coordinated-Entry-Core-Elements.pdf](https://www.hudexchange.info/resources/documents/Coordinated-Entry-Core-Elements.pdf)

**Entry Point Policy and Procedures Annual Update**

The Coordinated Entry Oversite Committee shall be responsible, at least once annually, for the review, revision and approval of Coordinated Entry Policies and Procedures (CE P&P). Updated CE P&P will be presented to the Alliance Executive Committee to determine which, if any, revisions will require submission to the Alliance Board for approval.

<table>
<thead>
<tr>
<th>Version</th>
<th>Date Adopted</th>
<th>Key Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>2/26/2016</td>
<td>N/A (see link to Original Protocols below)</td>
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<tr>
<td>2.0</td>
<td>2/22/2019</td>
<td>Operationalizing protocols agreed upon in version 1.0 Reflects requirements in HUD Coordinated Entry Notice</td>
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Originally adopted CE Protocols (Version 1):