Salt Lake County, Utah
Coordinated Entry Standards
January 21, 2018

Table of Contents

WRITTEN STANDARDS ADOPTION DATE AND FUNDING STREAM COVERAGE:

ACTIVITY	**FUNDING STREAMS**	**DATE**
Released as a tool for possible adoption	Multiple funding streams	January 2018
Adopted	Continuum of Care and Emergency Solutions Grant	Scheduled for Vote on January 22, 2018
Scheduled for Re-Adoption	Continuum of Care and Emergency Solutions Grant	Scheduled for Vote in 2018

I. INTRODUCTION

A. Purpose/Objectives of CE System

Coordinated Entry (CE) is a standardized process for connecting people experiencing homelessness to the resources available the community. It is an essential element of Salt Lake County's response to homelessness. The objective of CE is to ensure that people who are experiencing homelessness have streamlined access to available assistance and receive timely referrals to the interventions that are most appropriate to meet their needs. CE helps the community meet its goal of ensuring that the experience of homelessness is rare, brief, and one-time.

In addition to meeting local needs, CE is also a requirement established by the U.S. Department of Housing and Urban Development (HUD). The Salt Lake County Continuum of Care (CoC) is required to establish standardized processes and tools to assess and prioritize people for CoC and ESG-funded programs and assistance within the region, including emergency shelter, transitional housing, permanent supportive housing, rapid rehousing, and other interventions.

B. Purpose of the CE Standards

These standards establish the policy framework the Salt Lake County (CE) system. These standards are a working document which were released for community review in January 2018. These standards will be reviewed again in April 2018 and a minimum of annually thereafter.

The standards have been developed in connection with the Collective Impact Steering Committee CES workgroups focused on the Coordinated Entry 2.0 design process. Participants in the process included a wide range of stakeholders inclusive of federal funding streams, local government funding streams, private philanthropy and a wide range of providers covering prevention, diversion, shelter, outreach, housing interventions and connected services such as behavioral health, mainstream benefits, health care etc.

The standards serve several purposes:

- Provides organizations and agencies that work with people experiencing homelessness with general guidance on how CE operates and what they can expect when interacting with CE; and
- Specifies what households experiencing homeless can expect from CES.
- Provides a general set of federally compliant policies that can be adopted by homeless system funders and incorporated into contracts with homeless system providers;

This is not an operational manual and does not lay out procedures for implementation of these standards. Detailed operation procedures will be developed collaboratively by providers in the homeless services system. Providers may be assisted with this task as a service provided. A working group, including providers, will be asked to develop an operations manual draft by April 2018 that includes integration of key safety elements such as trauma informed care and confidentiality that integrate DV best practices as well as VAWA requirements.

In addition, a working group, including providers will be asked to develop a system cost/staffing plan for the costs associated with implementation. The group will also review the written standards and may propose additions to the written standards where further clarification or detail is helpful.

C. Guiding Principles for CE

The Collective Impact Steering Committee on Homelessness has developed the following Guiding Principles for the CE system in Salt Lake County. The CE standards are based upon these principles. A copy of these guiding principles are included below for reference.

1. Interventions
   a) Regarding all instances of homelessness for priority populations, CES will operate with the intention that homelessness be rare, brief, and non-recurring.
   b) The CES system and all programs within it in Salt Lake County will shift from a crisis-based system to a prevention-based and housing stability-focused system. This will be embodied in moving from a shelter-based system to a service-based system.

2. Access
   a) CES will embody the "no wrong-door" approach and will be easily accessible throughout the county, with multiple entry points, including in-person, phone, internet or app, points etc.
   b) CES will include outreach so people least likely to seek services independently have access to the resources of the system.
   c) All providers participating in the CES process will comply with the equal access and non-discrimination provisions of federal civil rights laws. The referral process will be informed by Fair Housing laws and regulations, and ensure that participants are not guided towards any particular housing facility or neighborhood because of race, color, national origin, religion, sex, disability, or the presence of children.

3. Standardized Process
   a) Every CES point will assess vulnerability and needs, and recommend and/or assign appropriate interventions for clients with standardized protocols using standardized tools and processes.
   b) Standardization will be promoted and supported by a non-conflicted third party agency who will oversee the entire CES process.

4. Respect for Clients and Confidentiality
   a) Information will be collected in a respectful, strengths-based and trauma-informed manner: (i) tools and referral/decision processes will require only as much information as is needed to assist or refer clients at that point; (ii) with informed client consent, information will be shared within the system.
   b) Client choice and the client's service and personal network will inform options for services, housing, and referrals.

c) Data will be used according to privacy restrictions and regulations, including those for healthcare and domestic violence and in line with the above-mentioned principles. Where ever possible, data systems should be aligned to promote data sharing in the best interest of the client and providers, so that data will not have to be repeatedly collected.

5. Referral Processes
   a) Referrals will be based on meeting the clients' housing and services needs, rather than on filling the beds or slots of programs.
   b) Client transitions will be supported through clear hand-off protocols, for both the outgoing and incoming service providers.
   c) Programs will only take individuals or families into their program under established CES policies, and not from alternate sources (except in specific, defined circumstances).
   d) As much as possible, wait lists will be avoided. Where necessary, wait lists will be prioritized by set criteria, and regularly revisited on a predetermined timeline.

6. Service Prioritization
   a) Entry into services and housing intended for those who are homeless will prioritize those who are most vulnerable. For those with access to shelter and where safety concerns permit, diversion strategies and services will be utilized to stabilize clients and prevent homelessness from occurring.
   b) Needs will be determined by a common assessment tool determining vulnerability.
   c) CES will match the level of service intervention to the level of client need to resolve their housing crisis. Assessment will be ongoing, and services offered will be adjusted as needed. Clients can opt for less intensive support than what is offered.

7. Housing Problem Solving (Diversion) for those Not Yet Homeless
   a) People not yet homeless will be provided support and problem solving services to avoid an entry into the homeless system whenever safe and appropriate.
   b) Diversion will be offered by a third party, non-shelter based service provider, and will be offered at shelters and at other service provider locations.

8. Links to Domestic Violence Services
   a) Throughout the system, safety screening and links to domestic violence services will be integrated.

9. CES Management, Oversight, & Evaluation
   a) Resources will be allocated to ensure the coordinated entry system is managed, well-coordinated, and continually improving. Data will be used to assess the impacts and outcomes of the system to inform changes and will be accessible via a public Dashboard.
   b) Stakeholders — including service providers, funders, and people with lived experience of homelessness — will have an ongoing role in the oversight and refinement of the CES process.
   c) CES will function as a system where funders support clients, through service providers. A feedback mechanism will be developed by representatives of the homeless, or formerly

homeless, to both ensure accountability of service providers and assist funders in identifying the nature and quality of services rendered.

d) While recognizing specific funding source requirements, CES will function as a system that works to address current gaps among clients. CES will not be *restricted* by any single federal definition of homelessness. When necessary or helpful, it will seek to meet broad definitions of homelessness provided by the Department of Health and Human Services, while recognizing that potential local needs may differ from federal definitions.

D. Overview of CE System Design

This section describes the primary design features of the CE system in Salt Lake County.

1. Geographic Coverage

The CE system covers the entire Salt Lake County geography, which is the same geography as the CoC. Access Points are distributed throughout the County to ensure full geographic coverage. The system may also be accessed by telephone for those households who cannot physically come to an Access Point (see Section II.A for standards regarding Access Points).

2. Populations

The general design of the Salt Lake County CE system is the same for all populations: adults without children, families with children, youth, people experiencing domestic violence and people at-risk of homelessness. All Access Points are useable by all these populations and the same screening and assessment approach is used at all Access Points for all populations. There are some variations in tools and process steps for different populations. These differences are noted in the standards. If no specific population is called out, then the standard policy applies to all populations.

The CE does not include any specialized access points or assessment processes for veterans. Any veteran that connects with CE through an Access Point will go through the same screening and assessment steps as a non-veteran and has equal access to the programs available through the CE system. However, there is a specialized process for veterans to veteran-specific programs funded by the VA for veterans experiencing homelessness (specifically GPD, SSVF and VASH). This process has been developed collaboratively between the CI, CoC and VA. Standards relating to the process for accessing VA funded programs are included in Section II.

3. System Elements

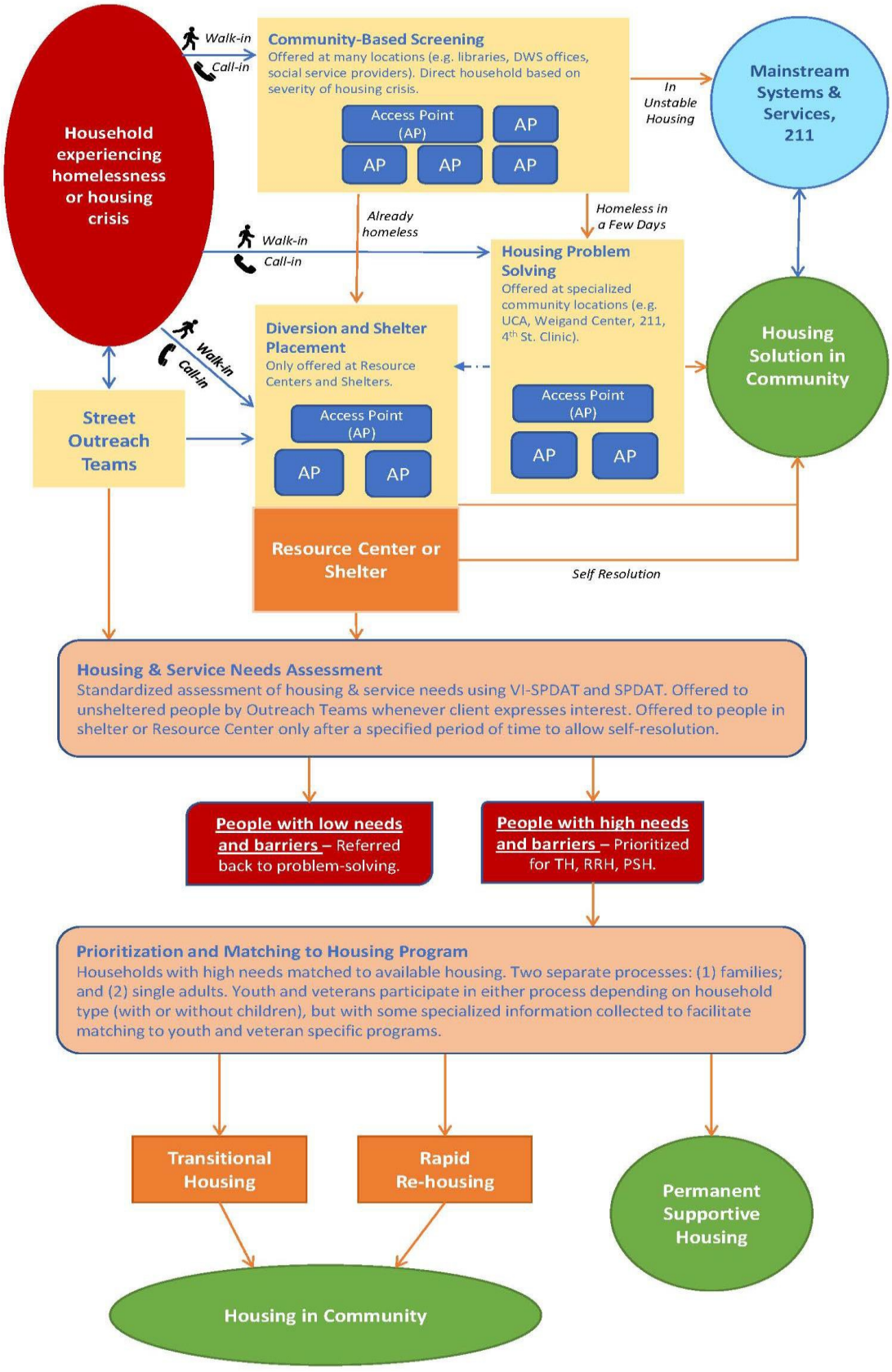
The CE process will integrate a phased assessment approach, with clients moving through a series of steps. Information gathered at each step is used to inform what assistance a household receives and where they are referred.

The graphic on the next page presents an overview of the CES system flow and briefly describes the steps in the CE process:

1. Community-based screening
2. Housing problem-solving
3. Diversion and/or placement into shelter or resource center
4. Housing needs assessment
5. Prioritization and referral to housing program

Standards relating to each of these steps are provided in Section II.

Proposed CE System Flow – Salt Lake County, UT



II. CE CORE COMPONENTS

A. Access Points

1. General Approach to Access

The CE will be structured with multiple Access Points throughout the community. The purpose of the Access Points is to provide clear and well-understood entryway to assistance for households experiencing a housing crisis. The model for access is to have "many right doors" – any household that seeks attention from an Access Point will receive a standardized initial screening and connection to the most appropriate service or system to address their needs.

2. Access Point Locations

Access points will be distributed throughout the community and will provide geographic coverage for all areas of Salt Lake County. Access Points will be locations where people experiencing homelessness tend to seek out assistance, and could include (but are not limited to): resource centers, homeless drop-in centers (e.g. Weigand Center), non-profit social service provider locations (e.g. UCA, Welfare Square), mainstream service system offices (e.g. DWS, VA), health system locations (e.g. 4th Street Clinic), and libraries. Mobile access will be available through street outreach teams and virtual access through 211.

Any service location may become an Access Point provided they have the capacity to implement Community-Based Screening (see Section II.A.5 for standards). Access Points are not required to enter client data into HMIS.

Access Points are designed to maximize accessibility for all populations and particularly for people who have difficulty accessing service systems. See Section IIII for standards relating to equal access and non-discrimination.

3. Access Point Functions

All Access Points will conduct the Community-Based Screening (see Section II.A.5). A subset of Access Points will conduct a further level of assessment and intervention (Housing Problem Solving or Shelter Diversion/Shelter Placement). Access Points will be responsible for the following three initial steps in the CE phased assessment process:

1. Community-Based Screening. The initial screening will be brief and designed to identify whether there is a housing crisis and how much time the household has before becoming homeless (i.e. already unsheltered, will be unsheltered tonight, has a few more days, has more than 3 days, etc.). Households that are unsheltered or at imminent risk will be directed to either Step 2 (Housing Problem Solving) or Step 3 (Shelter Diversion/Shelter Placement), depending on how

acute their crisis is. Those with less immediate housing needs will be directed to other systems and services or 211. See Section II.A.5 for standards.

2. Housing Problem Solving. A subset of Access Points will offer Housing Problem Solving for people who are unstably housed and likely to become homeless within a few days. The goal of problem solving is to identify a no cost or very low-cost housing solution (e.g. reunite with family, share with a friend, resolve conflict with current landlord, etc.). See Section II.A.6 for standards.

3. Shelter Diversion and/or Shelter Placement. A small set of locations, connected with outreach teams, will conduct Shelter Diversion for people who are already homeless or likely to become homeless in the next day. This work will be done only at Resource Centers or shelters and will include a diversion conversation and potential help with diversion resources, or a placement into a resource center or shelter bed for those who cannot be diverted. Diversion specialists will be out-stationed at the Resource Centers to do this work and help manage the flow of people into these beds. Diversion and placement will not necessarily be done by the Resource Center staff. See Section II.A.6 for standards

4. Street Outreach

One goal of mobile outreach is to ensure that CES is available to those unsheltered households who do not actively seek shelter or services, yet have a high need for assistance from the homeless crisis response system. Salt Lake County's homeless outreach teams will serve as mobile Access Points into CE. Outreach teams will be trained to perform the Community-Based Screening and Housing Problem Solving steps, and will connect people to an appropriate Resource Center for diversion or placement into a bed if needed.

Street outreach teams will also be able to conduct a Housing Needs Assessment (VI SPDAT) for people who are unsheltered (see Section II.C. for Assessment standards). When an unsheltered household is matched to an available housing vacancy, the outreach staff will be responsible for locating the household and assisting them to complete the steps needed to enroll in the housing program, if the client choses to do so. Since many unsheltered and chronically homeless people will initially decline an offer of shelter or housing assistance, mobile outreach teams are expected to continue to engage with these clients over an extended period, with the goal of eventually assisting the client to make the transition to permanent housing.

5. Community-Based Screening

The purpose of Community-Based Screening is to have a consistent way to direct people experiencing a housing crisis to the right next step or resource. Questions will be designed to help identify an individual or family's level and urgency of need and direct them as follows:

- Housing problem that requires a response, but household not expected to experience immediate housing loss – direct to mainstream benefits, employment, 211 for other referrals.
- Housing crisis and household is within a few days of losing a place to live – direct to an Access Point offering Housing Problem Solving.

- Already homeless or will lose housing in the next day – direct to appropriate Resource Center or shelter for Diversion and possible placement into shelter bed. People will be directed to Resource Centers based on population/household type (adult men, adult women, families, youth, DV).
- Safety issue – direct to DV system or DV shelter if interested.
- Veteran – connect to Veteran's system.

Questions in the Community-Based Screening will cover the following topics:

- Acuity of housing crisis using time factors (e.g. currently already homeless, nowhere to go tonight, nowhere to go in a few days, can stay in place for 3 days or more, etc.)
- Safety question – both safety regarding relationships with others and also whether the person is a threat to themselves
- Basic household composition (number of people, whether any children in household, whether children are school age)
- Age of head of household and family members
- Veteran status
- Already accessing or need mainstream benefits
- Whether ever experienced homelessness before

6. Housing Problem Solving and Shelter Diversion

Housing Problem Solving and Shelter Diversion are both processes designed to help to identify a solution to a household's housing crisis, including help to remain in their current housing or move directly to alternative housing. The difference between the two activities is the depth to which the Access Point is able to explore solutions with the household and the intensity of assistance available:

- Housing Problem Solving: brief exploration of the household's situation with some moderate assistance available;
- Shelter Diversion: more in-depth exploration and more intensive assistance available. Households that receive Shelter Diversion and do not identify a housing solution will be considered eligible for placement into a shelter or resource center bed.

In the Housing Problem Solving or Shelter Diversion process, trained staff work with clients to identify potential existing resources and housing supports already in place, to help households avoid becoming homeless or help them re-enter housing. These staff will have a strong understanding of the principles of diversion, mediation, strength-based problem-solving, client engagement techniques. They also should be knowledgeable about how to navigate and manage conflict resolution, be familiar with landlord mediation, and be aware of other mainstream resources that may be of assistance to people who are experiencing challenges relating to their housing.

Housing problem solving or shelter diversion is a conversation that utilizes a problem-solving approach. It is not an eligibility interview. Questions asked will focus on the client's current and recent housing history, and their network of supports. Typical questions will include:

- Where did you stay last night?
- What is your relationship with the person/people you are staying with?

- How long have you been there; when do you have to leave?
- Why do you have to leave?
- Are there things that could help you be able to stay where you are currently staying?
- Do you pay anything to stay there?
- If we can't find you somewhere to sleep tonight, where will you stay?
- Where else have you stayed in the past?
- Can you find a place for a few nights?
- Where do you usually stay in emergencies? Where have you stayed in the past if there was an emergency?
- Who do you go to when you need assistance or advice? (including asking about family members, friends, co-workers or friends at work (if employed), mentors, faith-based organizations, etc.)
- Where do you have your belongings?
- How much income do you have?

Some of these might have been asked as part of the Community Based Screening, in which case the information may be repeated and confirmed.

For households that identify a housing solution, the assistance offered will very, and could include:

- Mediation, problem-solving, or conflict resolution (with a landlord, family member, or friend with whom the household is staying or could stay);
- Assistance to return to hometown or other community where a safe housing solution is available;
- Connection to mainstream benefits or services; and/or
- One-time financial assistance

Housing problem solving/diversion assistance is designed to be a brief, "one time" intervention that does not require ongoing case management or other follow up. Staff may be available for a limited amount of follow-up contact to help facilitate resolution of the household's housing crisis.

Households for whom problem-solving or diversion that results in a housing solution that is not successful (i.e. return to family but then asked to leave again) may re-enter the CE process by completing the Community Based Screening step.

7. Safety Planning

In order to ensure safety, confidentiality and access to the domestic violence system as appropriate, the Salt Lake County CE process will connect any household fleeing domestic violence immediately to the appropriate domestic violence provider. The Community-Based Screening includes questions relating to safety and households that indicate a safety issue will be connected to a DV hotline or shelter. The Housing Problem Solving and Shelter Diversion conversations will also explore safety issues and connect households to DV hotline or shelter as needed. Households will not be "diverted" to housing situations that are not safe.

Households fleeing DV have equal access to all resources accessible through CE, and may not be denied assistance on the basis that they are or have been victims of domestic violence, dating violence, sexual assault or stalking.

Households fleeing DV who are being assisted by a victim-services provider (i.e. DV shelter or other type of assistance) may access the housing interventions available through the CE system (transitional housing, rapid re-housing, permanent supportive housing) by completing a Housing Needs Assessment (Section II.C) which provides the information used in the prioritization process for these programs.

Due to confidentiality laws in the Violence Against Women Act(VAWA), domestic violence (DV) service provider agencies are not able to share any identifying information of the people they serve, including names, through HMIS or any other system. Upon operation of the CES 2.0 design, DV service providers will be able to access the coordinated assessment list in UHMIS and, through use of an alias, the survivors they assess with the SPDAT show up in the single community prioritization list to receive services based on acuity. This is consistent with practices in other parts of the State.

Consistent with the Violence Against Women Act, client level data for people fleeing domestic violence is not entered into the HMIS system. It is the responsibility of victim service providers to ensure that any household fleeing domestic violence is also given the option to access the non-DV-specific services offered through CE and to inform the household that non-DV-specific programs do not have the same prohibitions on collecting HMIS data.

8. Access to Mainstream Resources

All Access Points are responsible for ensuring that clients can receive accurate and timely information about mainstream resources for which they may be eligible, including, but not limited to: public benefits, employment and training services, health care, behavioral health, affordable housing and other services. Some Access Points may have staff who are trained to assist clients in accessing these services directly. At a minimum, all Access Points will have the capacity to assist clients to contact 211 (by phone, text or online) to receive assistance with connecting to needed services and resources.

B. Emergency Shelters/Resource Centers

The CE process is designed to manage the placement of households into the community's emergency shelters and resource centers. New Resources Centers currently in the development phase will be integrated into CE as they become operational.

The primary process for managing placement into shelter will be the Shelter Diversion process (see Section II.A.6). Trained Diversion staff will be out-stationed at each participating shelter and Resource Centers. Households that are already homeless (living in a place not meant for human habitation) or who will be homeless within the next day will work with the Diversion staff to identify a housing solution and prevent entry into shelter. Those who do not identify a solution will be considered eligible for shelter and can be placed into an available bed upon completion of the Diversion conversation.

There is a system-wide goal to offer shelter to anyone who cannot be diverted and wants to enter shelter. However, in the event that there are insufficient shelter beds, the CE system will prioritize entry into shelter based on a consistent set of criteria that are reasonably easy to verify and related to the acuity of the household's immediate situation – such as whether they are currently unsheltered, presence of a disability or acute health condition, or other immediate risk factor.

Shelters operated by victim-service providers will make placements using their own DV-specific criteria. During the hours when the CE system is not operating, clients may access shelter by calling 211 or going in-person to a Resource Center. To the extent that shelter beds are available, households may be sheltered and then can complete the CE process the next day. The Police Department may also bring people to shelter directly without going through CE.

C. Housing Needs Assessment

1. Assessment Process

The purpose of the assessment process is to identify the housing and service needs of each household using a standardized tool and process. Information gathered during the assessment is also used to determine what programs a household may be eligible to enter. The assessment is used to determine what assistance the household is offered from the homeless system, and can also be used to facilitate referrals to other resources.

The Housing Needs Assessment will be administered only to those households who are experiencing literal homelessness or who are living in a shelter or resource center bed.

Assessments will be administered:

- By street outreach teams for people who are unsheltered. The assessment(s) will be done for any unsheltered person who expresses they would like to do the assessment.
- At Resource Centers/shelters for those who are staying in shelter beds. Assessments will be done only after a specified time period elapses to allow opportunities for households to self-resolve their homelessness.

Assessments will be conducted by neutral individuals/entities, not by the individuals' case manager or other type of advocate. The goal of having a neutral individual conduct the assessment is to ensure that they are conducted in a consistent and objective manner.

2. Assessment Tools

The community has selected the SPDAT suite of tools for the Housing Needs Assessment:

- VI-SPDAT – conducted as the first step of assessment. The VI-SPDAT assesses a household's history of homelessness, housing barriers and vulnerability.
- SPDAT – a more in-depth assessment of vulnerability
- Additional information may be collected as needed to establish eligibility for particular programs

- HUD HMIS Universal data elements are collected as part of the assessment if they have not previously been collected

Assessment results are entered into HMIS so that a master list of clients may be generated for purposes of prioritization and referral (see Section II.D).

The VA has established a specialized assessment process for veteran-specific homeless programs (GPD, SSVF and VASH). This process includes a clinical assessment and other screening/eligibility determinations as required by the VA. Veterans who wish to be considered for GPD, SSVF or VASH will complete the VA-required assessments. Veterans are not required to complete these assessments to be considered for regular CoC and ESG funded programs.

3. Client-Centered Assessment

The CE process is accessible to all potential program participants regardless of perceived barriers to housing or services, including, but not limited to, too little or no income, active or history of substance abuse, domestic violence history, resistance to receiving services, the type or extent of disability-related services or supports that are needed, history of evictions or of poor credit, lease violations or history of not being a leaseholder, or criminal record.

The CE process allows potential program participants to decide what information they provide during the assessment process. Individuals may refuse to answer any assessment question at any time. However, failure to provide information that is needed to determine eligibility for a particular program may result in the household not receiving a referral. CE staff will clearly articulate to potential program participants that they have the right to refuse to provide information and the consequences of not providing information.

The assessment process does not require any person to disclose specific disabilities or diagnoses. All assessment questions related to a person's disabilities or diagnoses are only used to determine program eligibility, to make appropriate referrals, or establish the need for a reasonable accommodation.

4. Assessor Training

All Access Point staff conducting assessments receive training on the CE process and how to appropriately administer the assessment tools. Training ensures that policies and procedures are fairly and consistently applied. Training opportunities are provided at least once annually to all Access Points and organizations that conduct assessments. The training provides Access Point staff with clear direction on how assessments are to be conducted in accordance with CE policies and procedures, to ensure uniform decision-making. All staff conducting assessments are required to participate in training on the assessment tool and process at least once annually.

All Access Point staff (including those who only conduct Community Based Screening, as well as those who conduct Housing Problem Solving, Diversion and Assessment) must be trained at least once on how

to utilize trauma-informed interview techniques with participants. During this training, special consideration is outlined for survivors of domestic violence and/or sexual assault to reduce the risk of re-traumatization. Further, all Access Point staff must be trained at least once on safety planning and other next-step procedures to be followed in the event that safety issues are identified in the process of conducting an assessment.

D. Prioritization

1. Prioritization Criteria and Policy

The Salt Lake County CE uses the information gathered from the Housing Needs Assessment to determine which households will be prioritized for a housing intervention. Prioritization criteria are:

- Chronicity of homelessness (length of time homeless and/or number of episodes of homelessness)
- Severity of need as reflected by the VI-SPDAT score
- Vulnerability as reflected by the SPDAT score

Clients with extensive histories of homelessness and high scores on the assessment tools will have priority access to available housing resources. Clients with less extensive homelessness and lower scores may continue to access Housing Problem Solving or Diversion services to identify a housing solution.

2. Prioritization Process

Prioritization for housing referrals will be conducted through regularly scheduled "Housing Triage" meetings. There will be separate meetings for adult-only and family households.

On a regular basis (weekly or bi-weekly), the organization responsible for administering the CE prioritization and referral process ("the convener") will generate a list from HMIS of those households that have been assessed and identified as high priority using the criteria listed above. The convener will convene a Housing Triage meeting attended by representatives of the programs that have available housing vacancies. Households on the list will be matched to available vacancies based on their assessed needs and eligibility factors for the programs.

The convener will facilitate a matching and referral process using a case conferencing approach. Each client on the list will be considered by the group and assigned to the most appropriate vacancy for which they are eligible. As a general practice:

- The household with the highest priority on the list will be referred to the first available housing program vacancy, provided the household meets the eligibility criteria for the program.
- If the household does not meet the criteria, the group may skip to the next household on the priority list, and so on, until a household is found to fill the vacancy.
- Only those meeting chronic homeless criteria will be matched to permanent supportive housing (PSH). All others will be matched to a rapid re-housing program (RRH) or other interventions as

available. People who meet the federal chronic homelessness status may be matched to RRH or other interventions if no PSH units are available.

The "Housing Triage" meetings operate using Housing First principles – all clients are understood to be "housing ready" and a placement is sought for each client on the list. The meeting convener is responsible for ensuring that clients who are assessed as having the greatest needs (longest histories of homelessness and highest vulnerability) are not passed over for housing placement due to being difficult to house.

Veterans and transition-age youth will be prioritized for vacancies using the same process as other adults. Only youth will be eligible for youth-specific programs and veterans for veteran-specific programs. For GPD, SSVF and VASH placements, the VA will establish additional prioritization and eligibility criteria. A separate meeting may be convened to prioritize and refer clients to GPD, SSVF and VASH.

E. Referral

1. Programs Filled Through the CE Prioritization and Referral Process

All CoC and ESG funded housing programs are required to accept referrals from CE. In addition, ESG Prevention programs are required to be part of the CE system.

Programs with other funding sources may participate in CE voluntarily. Local funders may elect to require their grantees to participate and will incorporate this requirement into contracts with providers.

The eventual goal is to integrate the following program types into CE:

Population	Funding Source
PSH for CH Individuals	Continuum of Care SLCO General Funds Project Based Section 8 Low Income Housing Tax Credits State Unified Homeless Funds
PSH for CH Families	Continuum of Care Project Based Section 8 Low Income Housing Tax Credits State Unified Homeless Funds
RRH for Families	ESG from State/County/City HOME City/County TANF from State Continuum of Care State Unified Homeless Funds
RRH for Individuals	Continuum of Care Salt Lake County Pay for Success

	State Unified Homeless Funds ESG from State/County/City
PSH, RRH and TH for Youth*	Continuum of Care Low Income Housing Tax Credit State Unified Homeless Funds Family Unification Program
TH, RRH and PSH for Veterans*	VASH, GPD and SSVF

*May have specialized assessment and referral processes

2. Posting Vacancies

All programs receiving referrals through CE are required to provide information about available vacancies to the convener of the Housing Triage meetings in advance of the regularly scheduled meeting dates. Programs will be in regular communication with the convener about available program openings and estimates of future openings for each population type (i.e. families, single adults, youth).

Programs are responsible for communicating to the convener any funder-required eligibility criteria that limit the households that may be referred to fill each vacancy. The meeting convener will maintain regular communication with all participating programs to troubleshoot any problems relating to referrals.

3. Acceptance and Refusal Policy

Acceptance/Refusal by the Program

Once a household has been referred to fill a vacancy, the program is expected to accept the household into the program without further screening or assessment. The program may refuse to enroll the client if it is determined that the households does not meet eligibility criteria or does not have documentation needed to verify eligibility. Any refusal of a referral must be documented by the provider with a specific reason provided. Households who are declined enrollment into a program may go back to the list to be matched to another vacancy at a future Housing Triage meeting.

Acceptance/Refusal by the Client

In the event a household turns down a housing referral, the meeting convener is responsible for communicating with the household about its likelihood of receiving another referral or a specific type of referral. Households may reject up to three housing referrals, but after the third rejection, the household will be removed from the Housing Triage list for six months. After six months, the adult or family may be reassessed at an Access Point and placed back on the list.

4. Client Documentation and Housing Location

The convener is responsible for overseeing a Housing Locator Team that will assist clients in collecting the documentation needed to verify eligibility and enroll in the housing program to which they have been

referred. This team also assists clients to locate housing units. Clients enrolled in programs that provide document readiness and/or housing location assistance will receive assistance through the program to which they have been enrolled.

The general goals of the client documentation process are to:

- Minimize the number of rejected referrals, by ensuring that eligibility factors are documented before a household is referred to a program, whenever possible;
- Minimizing the chances that a household must repeat or duplicate the collection of documents, by ensuring that documentation is gathered close to the time that the referral is made; and
- As much as possible to minimize the paperwork burden upon people experiencing homelessness

5. Program Entry Barriers

To ensure that all programs are available to serve high-need households to the maximum extent possible, providers are expected to reduce eligibility requirements and entry barriers, unless specifically required by a funding source. In particular, programs are expected to eliminate access barriers relating to: too little or no income, active or a history of substance use, domestic violence history, resistance to receiving services, the type or extent of 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 (with exceptions for state or local restrictions that prevent projects from serving people with certain convictions).

III. EQUAL ACCESS AND NON-DISCRIMINATION

A. Affirmative Marketing

The Salt Lake County CE is widely marketed and available to:

- All eligible persons regardless of race, color, national origin, religion, sex, age, familial status, disability, actual or perceived sexual orientation, gender identity, or marital status.
- All populations and subpopulations in the geographic area, including people experiencing chronic homelessness, veterans, families with children, youth, and survivors of domestic violence, have fair and equal access to the coordinated entry process, regardless of the location or method by which they access the system.
- Individuals with disabilities; and
- Persons with Limited English Proficiency (LEP).

Specific steps taken to market the CE system include:

- Regular email updates to the general community, service providers, and City and County Departments, other stakeholders;
- Updates and announcements at CI Steering Committee and CoC meetings, and other meetings routinely attended by provider agency staff
- Posting of CE standards other information on the CI and CoC websites.

B. Non-Discrimination Policy

Housing providers participating in CE must affirmatively market their housing and supportive services to eligible persons regardless of race, color, national origin, religion, sex, age, familial status, or disability who are least likely to apply in the absence of special outreach, and maintain records of those marketing activities. Housing assisted with CoC funds must also be made available to individuals and families without regard to actual or perceived sexual orientation, gender identity, or marital status in accordance with 24 CFR 5.105 (a)(2).

All programs that receive referrals from CE are permitted and expected to comply with all applicable State and Federal civil rights and fair housing laws and requirements, including, but not limited to:

- 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.
- 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.

C. Equal Access

The CE standards ensure that all people experiencing homelessness have fair and equal access to the coordinated entry process, regardless of the location or method by which they access the system. Particular consideration is given to populations that have the greatest barriers to accessing social service systems.

1. Access for Vulnerable Populations

To ensure that the CES is accessible to people who are vulnerable or otherwise disconnected from care, the following measures will be implemented:

- There is a streamlined process to receive assistance. Access Points are located throughout the community and people can also seek out assistance by calling 211 or can receive assistance from a mobile outreach team.
- The CE is designed to prioritize for services those people with the greatest barriers to housing, the longest histories of homelessness, and the highest level of vulnerability. As such, prospective program participants are not screened out or de-prioritized based upon perceived barriers related to housing or services, such as too little income, a history of or active substance use, a history of domestic violence, resistance to receiving services, extent of disability-related services needed, history of eviction, a criminal record, or other similar circumstances.
- Services provided throughout the CE process employ trauma-informed techniques to ensure that clients are not re-traumatized as part of seeking assistance. Access Point staff receive thorough and ongoing training about providing trauma-informed care, domestic violence, and other topics that ensure that they can effectively serve vulnerable populations.

2. Cultural and Linguistic Barriers

To connect people with linguistic or cultural barriers to services, the following measures will be implemented:

- Key written materials, including marketing materials, consent forms, Releases of Information, and others are available in multiple languages, including Spanish. Translation services make the information available in other languages such as Vietnamese, Tagalog, Cantonese, Mandarin, and others.
- The Access Points will actively recruit multi-lingual staff when hiring for positions that will be responsible for CE activities.
- In the event that someone seeking services has limited English proficiency and there is no staff person who is able to communicate with them, the Access Point will seek the services of a phone-based translation line to ensure that they are not denied services due to a linguistic barrier.

3. People with Disabilities

Many of the people seeking assistance through the CE process will be living with physical and/or mental health disabilities. To ensure that people with disabilities have full access to the housing and services offered through CE, the following measures will be taken:

- All Access Points will be fully ADA-compliant and accessible to people with mobility impairments.
- People with other disabilities seeking services will be connected with the auxiliary aids and services needed to ensure clear and effective communication including, but not limited to, materials available in Braille, large type printed materials, assistive listening devices, sign language interpreters, and other tools.
- The assessment process does not require disclosure of specific disability or diagnosis. Such information can only be obtained for the purposes of determining specific program eligibility and making appropriate referrals and matches.
- Access Point staff are trained to provide reasonable accommodations as needed to better serve people with disabilities. Such accommodations could include, but are not limited to: enabling

someone with a mobility impairment to complete an assessment at a location that is easier to access; allowing someone with a mental health disability to be assessed in multiple phases if they become overwhelmed; scheduling appointments at a time of day that will prevent an extended wait; and/or allowing a client to bring someone with them to an appointment for support.

4. Other Special Populations

Some of the community's homeless residents have unique needs with respect to accessing housing assistance. Some elements of the CE process may vary for specific populations to accommodate their needs:

- Veterans can receive services from any CE Access Point, but are also targeted by a veteran-specific outreach team and veteran-specific providers whose shared experiences are designed to build trust.
- Individuals and families who are fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking or human trafficking have equitable access to the services offered through CE. To ensure their safety and connect them to DV-related emergency services, they can select to go through the entire CE process with a victim service-provider and network of services.

D. Client Appeal Process

Any person who believes that they were discriminated against or otherwise treated unfairly during the CE process can file a non-discrimination complaint or an appeal, as appropriate. Each funder with programs participating in CE will establish their own appeal process.

IV. DATA AND EVALUATION

A. Data Management

For projects participating in HMIS, data relating to Coordinated Entry will be stored and managed in the Salt Lake County CoC's HMIS system. Policies relating to data sharing and privacy protections are covered in the HMIS SOP which is available on the utahhmis.org web site. To the extent any additional databases are used, they will be required to develop and adopt standard operating procedures that meet all federal requirements relating to data privacy.

B. Evaluation

The community, including members of the CI Steering Committee, are committed to the ongoing evaluation of CE and its continuous quality improvement. A survey will be conducted at least annually to collect feedback from participating programs and from households that have been CE clients. The survey will be designed to assess the quality and effectiveness of the CE experience for both participating projects and households.

Quantitative measures that will be used to assess the effectiveness of Coordinated Entry include:

- Rate of successful Housing Problem Solving and Diversion activities
- Length of time between assessment and housing placement

- Client referral acceptance rate
- Length of time units remain vacant
- Number of interactions client has with providers before securing housing

The survey feedback and evaluation of these measures will be used to develop refinements and improvements to the CE system.

Funding streams requiring their grantees to participate in CE may establish additional evaluation requirements.

V. GLOSSARY OF TERMS AND DEFINITIONS

[To be added in later revisions]