as of 9/20/19

Salt Lake Valley Coalition
to End Homelessness

Coordinated Entry System Standards

Effectively connecting people to interventions that will rapidly end their homelessness.

END UTAH HOMELESSNESS
Salt Lake Valley

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I. INTRODUCTION

Effectively connecting people to interventions that will rapidly end their homelessness.

A. Purpose/Objectives of a Coordinated Entry System (CES)

A CES is a standardized process for connecting people who are at risk of or experiencing homelessness to the resources available to the community. It is an essential element of Salt Lake County's response to homelessness. The objective of a CES is to ensure that people who are at risk of or experiencing homelessness have streamlined access to available assistance and receive timely referrals to the interventions that are most appropriate to meet their needs. CES helps the community meet its goals of a no-wrong-door approach as well as ensuring that the experience of homelessness is a rare, brief, and one-time occurrence.

In addition to meeting local needs, CES is also a requirement established by the U.S. Department of Housing and Urban Development (HUD) and as such, all Continuum of Care (CoC) and ESG projects are required to participate in the local CES. However, the Salt Lake Valley Coalition to End Homelessness (SLVCEH) aims to have all homeless assistance projects participating in the CES process, and will work with all local projects and funders in its geographic area including emergency shelter, transitional housing, permanent supportive housing, rapid rehousing, and other interventions, to facilitate their participation in the CES.

B. Purpose of the CES Standards

These standards establish the policy framework for the Salt Lake County Coordinated Entry System. These standards will be reviewed annually thereafter.

The standards have been developed in connection with the former Collective Impact (CI) Steering Committee and Salt Lake Continuum of Care (CoC) CES task workgroup, now combined as the Salt Lake Valley Coalition to End Homelessness and the CES Task Group. Historically, these workgroups have focused on the Coordinated Entry System 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:

- Provide organizations and agencies that work with people experiencing homelessness with general guidance on how CES operates and what they can expect when interacting with CES;
- specify what households experiencing homeless can expect from CES;
- provide 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. The CES Task Group will develop an Implementation Guide that includes integration of key safety elements such as Trauma-Informed Care (TIC) and confidentiality that integrate domestic violence best practices as well as Violence Against Women Act (VAWA) requirements.

In addition, the Coordinated Entry Task group will work to assess the system costs associated with implementation and identify gaps as well as recommended priorities for funding. The group will also review the written standards and may propose additions where further clarification or detail is helpful.

C. Guiding Values and Definitions

1. **Harm Reduction:** Harm reduction incorporates a spectrum of strategies from safer use, to managed use to abstinence to meet drug users "where they're at," addressing conditions of use along with the use itself.
2. **Housing First:** An approach to quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to program/housing entry, such as sobriety, treatment or service participation requirements. Supportive services such as housing-focused case management are offered to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to permanent housing entry.
3. **Low Barrier:** Helping all people who seek it meet basic survival needs for shelter, food, clothing, and personal hygiene, while also helping them resolve crises and swiftly secure permanent housing opportunities.
4. **Moving On:** A Moving On strategy enables stable residents of permanent supportive housing who no longer need on-site services to move to a private apartment with rental support and after-care.
5. **No Wrong Door:** Describes the experience of accessing the housing assistance and service system from the client's perspective and is a system that is designed so that the client only has to go one place for a housing referral to the appropriate housing assistance.
6. **Progressive Engagement:** Progressive engagement refers to a strategy of tailoring the amount of assistance to those entering the CES homelessness system based on their level of need. This flexible, individualized approach maximizes resources by only providing the most assistance to households who truly need it.
7. **Trauma-Informed Care:** Recognizes the presence of trauma symptoms and acknowledges the role trauma may play in an individual's life, including service staff.

D. Guiding Principles for CES

The former Collective Impact Steering Committee on Homelessness developed the following Guiding Principles for the Coordinated Entry System in Salt Lake County which the Salt Lake Valley Coalition to End Homelessness supports as well.

1. Intentions

a) Regarding all instances of homelessness 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 community 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. The no wrong door approach ensures that no matter which homeless assistance provider a person goes to for assistance, he/she will have access to the same resources, referrals, and assessment and prioritization processes.

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 Access 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 the Coordinated Entry Task Group, who will establish, evaluate, and review the CES process on behalf of the system/community.

4. Respect for Clients and Confidentiality

a) Information will be collected in a respectful, strength-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 alongside 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 will remain in line with the above-mentioned principles. Wherever 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' needs for housing and services, rather than on filling the beds or slots of programs.

b) Client transitions will be supported through clear warm 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 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 through a number of factors, including a general, agreed-upon assessment tool for determining vulnerability, and others.

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 the level of support they would like.

7. Links to Domestic Violence Services

a) Throughout the system, safety screening and links to Domestic Violence (DV) services will be integrated.

8. CES Management, Oversight, & Evaluation

a) Resources will be allocated to ensure the CES is well-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 created by the State.

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 those experiencing homeless, or formerly experienced 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 U.S. Department of Health and Human Services, while recognizing that potential local needs may differ from federal definitions.

E. Overview of CES Design

This section describes the primary design features of the Coordinated Entry System in Salt Lake County.

1. Geographical Coverage

The CES covers the entirety of Salt Lake County, which is the same area formerly serviced by the Salt Lake County CoC, and now, the Salt Lake Valley Coalition to End Homelessness. Access Points are distributed throughout Salt Lake County to ensure full geographic coverage. The system may also be accessed by telephone or other means 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 CES is the same for all populations: adults without children, families with children, youth, people experiencing domestic violence, and people at-risk for homelessness. All Access Points are useable by all these populations and the same screening and assessment approach is used 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 identified, then the standard policy applies to all populations.

The CES does not include any specialized Access Points or assessment processes for veterans. Any veteran that connects with CES 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 CES. However, there is a specialized process for connecting veterans to programs funded by the Veterans Administration (VA) for veterans experiencing homelessness (specifically Grant Per Diem [GPD], Supportive Services for Veteran Families [SSVF], and Veteran Administration Supportive Housing [VASH]). This process has been previously developed collaboratively between the former Collective Impact Steering Committee on Homelessness, Continuum of Care and Veterans Administration. The Salt Lake Valley Coalition to End Homelessness continues to support this process. Standards relating to the process for accessing VA funded programs are included in Section II.

3. System Elements

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

The graphic on the next page presents an overview of the CES elements and briefly describes the elements in the CES process which are on-going and non-sequential:

- Initial Contact
- Housing Problem Solving and Diversion to Non-Shelter Housing Solutions
- Connection to Shelter or Resource Center
- Housing Needs Assessment
- Ongoing Housing Problem Solving and Rapid Resolution
- Prioritization for Housing
- Housing Assistance Placement
- Progressive Engagement
- Moving On Strategy

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

II. CES CORE ELEMENTS

A. Initial Contact

1. General Approach to Access

The CES will be structured with multiple Access Points throughout the community. The purpose of the Access Points is to provide a clear and well-understood entry path to assistance for households experiencing a housing crisis. The model for access is to have “many right doors” - any household that seeks assistance through 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. Direct access to the Coordinated Entry System will occur through CES providers at authorized locations throughout the community. Other partner agencies serving people experiencing homelessness (including behavioral health, criminal justice, and others) will refer clients to the CES provider through those locations. Mobile access will be available through street outreach teams and virtual access through local community hotline numbers.

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

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

3. Access Point Functions

All Access Points will conduct the Community-Based Assessment). 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 four initial elements in the CES phased assessment process:

a) Initial Contact:

The assessment provided at initial contact 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.

b) Community-Based Assessments

The purpose of Community-Based Assessments are to evaluate the needs and strengths of households experiencing a housing crisis. Questions will be standardized and designed to help identify a household's level and urgency of need and direct them to the most appropriate resource. Special population guidelines will be followed, including VAWA confidentiality guidelines for DV survivors.

c) Housing Problem Solving/Diversion:

Housing problem solving begins at diversion and continues throughout the entire process.

Shelter Diversion is conducted for people who are already homeless or likely to become homeless in the next day. Diversion is a national best practice standard provided by trained staff to help clients identify safe, alternative housing solutions which could include mediation, conflict resolution, and light touch financial supports. Diversion is client-driven and is never a barrier to shelter entry.

The goal of diversion 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.

d) Connection to Shelter:

When necessary, households requiring shelter will be connected to the appropriate resource center, shelter bed, or other community resource. Connection to shelter services will be provided by trained staff. See section C. for standards.

4. Street Outreach

Street Outreach serves clients who do not seek shelter services, and Street Outreach programs will ensure that CES is available to 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 CES. 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 (an assessment tool) for people who are unsheltered (see Section II.C. for Assessment Standards). If unsheltered households 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 in the transition to permanent housing.

5. 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, healthcare, behavioral health services, affordable housing, and other services. Some Access Points may have staff who are trained to assist clients in accessing these resources directly. At a minimum, all Access Points will have the capacity to assist clients to contact the community hotline number (may be by phone, text or online) to receive assistance by connecting them to needed services and resources.

B. Housing Problem Solving and Shelter Diversion

Housing Problem Solving is the brief and frequent exploration of the household's situation with some moderate assistance available.

Shelter Diversion is the in-depth exploration and more intensive assistance. 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.

If problem-Solving or diversion do not result in a successful housing solution (e.g. return to family but then asked to leave), the household may re-enter the CES process by completing the through Community Based Screening.

C. Connection to Shelter or Resource Center

1. Emergency Shelters and Resource Centers

To ensure all those seeking refuge from the streets and to maximize limited shelter bed resources, the Coordinated Entry System (CES) sets standards and implementation guidelines for enrollment of households experiencing homelessness into community Homeless Resource Centers (HRC's). New resource centers added to the existing network will integrate into CES as they become operational. If system-wide bed capacity issues are present, CES will determine prioritization measures to ensure HRC's are used in the most efficient manner possible.

The CES system designates a Diversion and Coordinated Intake agency. Resource center operator's work with Coordinated Intake referred clients to place those households into shelter beds as available and appropriate. HRC's will follow best practices (Diversion, Low Barrier Shelter, Trauma Informed Care, Housing First) for service provision to those within the centers to assist them with their work to end their homelessness as quickly as possible. Operators of the resource centers will design programming so that instances of homelessness will be rare, brief, and non-recurring. HRC operators will work with community stakeholders and partners to provide services that will assist households to move into stable housing quickly and follow all expected benchmarks.

D. Housing-Needs Assessment

1. Client-Centered Focus

The CES process follows the overall values outlined in section 1-C and is accessible to all potential program participants regardless of perceived barriers to housing or services.

The assessment process does not require any person to disclose specific disabilities or diagnoses. However, clients may choose to disclose this information to assist with appropriate interventions. All information obtained that pertains to a person's disabilities or diagnoses is used solely for the purposes of determining program eligibility, making appropriate referrals, and/or establishing the need for a reasonable accommodation.

2. Housing Needs Assessment Process

The purpose of the assessment is to use a standardized tool and process to identify clients' housing and service needs;to determine what assistance may be available, and to facilitate referrals to other resources.

The Coordinated Entry Task Group will provide training and technical assistance to ensure the Housing Needs Assessments are conducted in a consistent and objective manner.

3. Housing Needs Assessment Tools

The CES Task Group determined that the VI-SPDAT and SPDAT are the agreed-upon Housing Needs Assessment tools. 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 Veterans Administration (VA) utilizes the HOMES Clinical Assessment tool for veteran-specific homeless programs including; Grant Per Diem (GPD), and Veterans Affairs Supportive Housing

(VASH).Veterans are not required to complete these assessments to be considered for SSVF, CoC and ESG funded programs, but will need to complete the VI-SPDAT or SPDAT assessment.

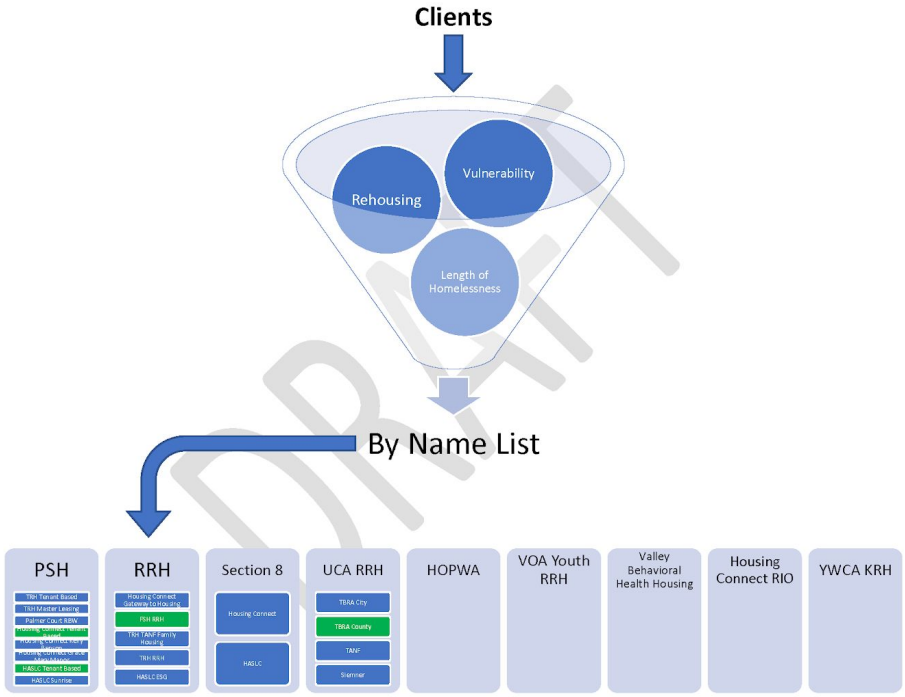
4. Assessor Training

All staff conducting Housing Needs Assessments will receive training on the CES process and how to appropriately administer the assessment tools. Training provides staff with clear direction on how to conduct assessments in accordance with CES policies and procedures to ensure uniform decision making. Regular training opportunities will be provided, and all staff conducting Housing Needs Assessments are required to participate in training at least annually.

E. Ongoing Housing Problem Solving and Rapid Resolution

Case managers working with households experiencing homelessness should maintain regular contact with those households along their path towards self-sufficiency. Households should be encouraged to rapidly resolve their homelessness on their own with relatively few resources provided initially or avoid entering homelessness altogether. As needed and as more barriers are identified, households will work with case management to access additional resources at any point during their episode of homelessness.

E. Prioritization for Housing



1. Prioritization Criteria and Policy

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

- **Maintain housing stability and/or rehousing**
- **Vulnerability as reflected by the assessment tool**
  - **Considerations for special populations will be integrated**
- **Total length of time homeless**

Prioritization based upon this criteria takes precedence. Households are then matched to the most appropriate available housing subsidy within the Progressive Engagement framework.

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

A. Meeting Facilitator process, partner reps, client reps.

Roles and Responsibilities:

- **Meeting Facilitator** – The facilitator is responsible for the general facilitation of meeting discussion and preparing client lists each week for prioritization discussion for available housing placements. The facilitator will generate a list from HMIS of those applicable households who have been assessed based on the criteria set for the group. The facilitator will convene housing triage meetings attended by housing providers and client-referring agencies. The facilitator will be the primary contact point for incoming referrals and completed housing applications from provider agencies to housing providers. The facilitator will coordinate application submission and tracking for all referred housing opportunities.
- **Housing Providers** - Community housing providers will attend triage meetings in order to assist the facilitator and client representatives with coordination of available housing resources. They will provide guidance and best practice information with the application and selection process for all parties. Housing providers are expected to select their representative members based on their familiarity with housing application processes and expected CES practices.
- **Client Representatives** – Homeless service providers attend triage meetings to advocate for their referred clients and assist in system-wide appropriate matching selection of prioritized clients to available housing resources in the community. Providers are expected to select their

representative members based on their familiarity with housing application processes and expected CES practices.

Triage Meeting Facilitator Selection Process

The Coordinated Entry System Task Group will select and approve the Meeting Facilitator from partner agencies referred for consideration. The CES Task Group will base the selection upon the following criteria:

- Objective
- Understanding of CES and Housing processes
- Adherence to Housing First, Trauma-Informed Care, Low-Barrier Housing, Progressive Engagement and other CES best practices

B. Prioritization for housing referrals will be conducted through weekly community triage meetings.

Households on the prioritization lists will be matched to available vacancies based on their Housing Needs Assessment and other eligibility factors for the programs.

The Housing Triage facilitators will organize 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.

The Housing Triage meetings operate using Housing First principles - all households have met eligibility criteria. Housing is sought for prioritized households on the list based upon case management, housing, and subsidy availability.

F. Referrals to Housing

1. Programs Filled Through the CES Prioritization and Referral Process

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

Programs with other funding sources are encouraged to participate in the CES to improve service coordination. Local funders may elect to require their grantees to participate and may incorporate this requirement into contracts with providers.

The following program types should participate in the CES:

Population	Funding Source
PSH	Continuum of Care SLCO General Funds Project Based Section 8 Low Income Housing Tax Credits State Homelessness Fundings
PSH for CH Families	Continuum of Care Project Based Section 8 Low Income Housing Tax Credits State Homelessness Fundings
RRH for Families	ESG from State/County/City HOME City/County TANF from State Continuum of Care State Homelessness Fundings
RRH for Individuals	Continuum of Care Salt Lake County Pay for Success State Unified Homelessness Fundings ESG from State/County/City
PSH, RRH and TH for Youth*	Continuum of Care Low Income Housing Tax Credit State Unified Homelessness Fundings Family Unification Program
TH, RRH and PSH for Veterans*	Veterans Affairs Supportive Housing (VASH) Grant Per Diem (GPD) Supportive Services for Veteran Families (SSVF)

*May have specialized assessment and referral processes

2. Posting Vacancies

All programs receiving referrals through CES are required to provide information about available vacancies to the facilitators of the housing triage meetings in advance of the regularly scheduled meeting dates.

3. Acceptance and Refusal Policy

Acceptance/Refusal by the Program

All prioritized, eligible households are expected to be accepted by the housing provider. Any refusal of a referral must be documented by the provider with a specific reason, and reported to the facilitator of the community triage meetings. Households who are declined will be returned to the prioritization list.

Acceptance/Refusal by the Client

Households may refuse any service and that refusal will not disqualify them from future services. Households who refuse will be returned to the prioritization list.

4. Program Transfers

Program transfers will be utilized as a community tool to support housing stability. Households will be prioritized to be rehoused in cases where they can no longer continue on a particular housing program and can be determined eligible for a transfer.

G. Progressive Engagement

Progressive Engagement is a strategy of tailoring the amount of assistance to those entering the CES homelessness system based on their level of need. This flexible, individualized approach maximizes resources by initially providing a minimal amount of support to stabilize a household and allowing that household the opportunity to rapidly resolve their homelessness. If minimal support strategies in shelter or housing are found to be insufficient, additional supports are offered until the household is stabilized. Regular and ongoing assessment by case managers and administrators determines how much and what level of support is available and necessary to assist the household toward self-sufficiency.

H. Moving On Strategy

A Moving On strategy enables stable households who no longer need services to move to other housing with or without rental support and/or after-care. This allows a housing voucher with more intensive case management services to open up for a higher need household. This strategy promotes the highest level of independence and choice for the Move On household and is consistent with recovery and wellness. It also preserves scarce resources for those who need it and increases supportive housing capacity without new construction.

III. EQUAL ACCESS AND NON-DISCRIMINATION

A. Affirmative Marketing

The Salt Lake County CES 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;
- Individuals with disabilities;
- Persons with Limited English Proficiency (LEP) including refugees.

Specific steps taken to market the CES include:

- Regular email updates to the general community, service providers, City, County, and State Departments, and other stakeholders;
- Updates and announcements at Salt Lake Valley Coalition to End Homelessness and other meetings routinely attended by provider agency staff;
- Posting of CES standards other information on the CoC website;
- Posting of CES training on the CoC website.

B. Non-Discriminatory Policy

Housing providers participating in CES 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, Housing obtained with CoC funds must be made available to households without regard to actual or perceived sexual orientation, gender identity, or marital status in accordance with 24 CFR 5.105 (a)(2).Housing providers must and maintain records of their marketing activities.

All programs that receive referrals from CES 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;

• Title II of the Americans with Disabilities Act: prohibits public entities, including 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). For HOPWA, see 24 CFR 574.603.

C. Equal Access

The CES standards ensure that all people experiencing homelessness have fair and equal access to services, 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:

1.A streamlined process ensures people can receive prompt assistance:

- Access Points are located throughout the community where people can seek services in person;
- 211 is available 24/7;
- Mobile Outreach services can be dispatched to serve remote individuals.
- Law enforcement will coordinate with CES, Access Points, and Mobile Outreach.

2. The CES is designed to prioritize services for those people with the greatest barriers to housing, the longest histories of homelessness, and the highest level of vulnerability. As such, clients are not screened out or de-prioritized based upon perceived barriers 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, registered sex offender, or other similar circumstances.

3. Services provided throughout the CES 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 regarding 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 other forms are available in multiple languages, including Spanish. Referral translation services can make the information available in other languages.
- The Access Points will actively recruit multilingual staff when hiring for CES related positions.
- 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 CES process may 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 CES, 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 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; however, clients may disclose this information at their discretion. Such information shall be kept confidential and can only be used 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 CES process may vary for specific populations to accommodate their needs, including:

- Veterans can receive services from any CES 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, stalking, and/or human trafficking have equitable access to the services offered through CES. To ensure their safety and connect them to DV-related emergency services, they can select to go through the entire CES process with a victim service-provider and network of services.

5. Client Appeal Process

Any person who believes they were discriminated against or otherwise treated unfairly during the CES process can file a non-discrimination complaint or an appeal, as appropriate. Each CES participating service provider may establish their own appeal process. Funders may have and/pr require additional processes. The Coalition has its own process as outlined in the Governance Charter.

IV. DATA AND EVALUATION

A. Data Management

For service providers participating in HMIS, data relating to the CES will be stored and managed in the Utah HMIS system. Policies relating to data sharing and privacy protection covered in the HMIS Standard Operating Procedure (SOP) are available on the Utah HMIS web site (utahhmis.org). To the extent that service providers use other databases, they will be required to develop and adopt standard operating procedures that meet all Federal requirements relating to data privacy.

The Utah HMIS system is available to organizations that provide services to individuals experiencing, at risk of experiencing, or transitioning out of homelessness as defined in the Utah HMIS Standard Operating Procedures. In order to participate in the Utah HMIS system, an organization must provide an Agency Partner Agreement and a Data Sharing Memorandum of Understanding (MOU). In addition, participating organization personnel must receive training by the HMIS team located in the Utah Department of Workforce Services' Housing and Community Development Division and sign an End-User Agreement. Specific training beyond basic end-user training on how to use HMIS for coordinated entry will be available from the HMIS team.

All agency specific databases will be held to the same standards as HMIS.

B. Evaluation

The community, including members of the Coordinated Entry Task Group, under the structure of the SLVCEH, is committed to the ongoing evaluation and process improvement of the CES. Feedback from CES-participating programs and from clients served by the CES is collected and reviewed at least annually and used to assess the quality and effectiveness of the CES system and inform quality and process improvements to benefit service providers and clients.

The CES will be evaluated using a variety of data including:

- Rate of successful Housing Problem Solving and Diversion activities;
- Number of Housing Needs Assessments completed;
- Length of time between Housing Needs Assessment completion and housing placement;
- Client referral acceptance rate;
- Length of time housing units remain vacant;
- Number of interactions clients have with providers before securing housing.

Funding streams that require their grantees to participate in the CES may establish additional evaluation requirements. The Coordinated Entry Task Group will recommend standards for funders to ensure that evaluations are aligned.

V. GLOSSARY OF TERMS AND DEFINITIONS

Case Conferencing: A local process in which CES stakeholders coordinate and discuss ongoing client case management activities including reviewing the Housing Triage prioritization by name list. The goal of case conferencing is to reduce duplication of services and improve the delivery of holistic, coordinated, and integrated services across multiple service providers.

Chronic Homelessness: defined by HUD as:

1. A "homeless individual with a disability" as defined in the McKinney-Vento Homeless Assistance Act who:
    a. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
    b. Has been homeless and living (as described in point a) continuously for at least 12 months or on at least 4 separate occasions in the last 3 years in which the combined occasions amount to at least 12 months
        i. Each occasion is separated by a break of at least seven nights
        ii. Stays in institutional care facilities for fewer than 90 days do not constitute a break in homelessness; OR
2. An individual who has been residing in an institutional care facility (includes jail, substance abuse or mental health treatment facility, hospital, or other similar facility) for fewer than 90 days and has met all of the criteria in paragraph (1) before entering that facility; OR
3. A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Common Assessment Tool (also referred to as a Housing Needs Tool): A comprehensive and standardized assessment tool used for the purposes of housing prioritization and placement within the CES.

Confidentiality/Security/Privacy: Personal Protected Information will remain confidential according to Federal standards. (32 CFR Section 701.115)

Coordinated Entry System (CES): A centralized or coordinated process designed to coordinate program participant intake, assessment, and provision of referrals across a geographic area. The system covers the geographic area (designated by the CoC), is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool." (24 CFR Section 578.7) It is the responsibility of each CoC to implement Coordinated Entry in their geographic area.

Coordinated Intake: Process that provides the best services for households by prioritizing their needs and preferences and minimizing duplication of services. The process ensures the effective use of local resources.

Diversion: A strategy that prevents homelessness for people seeking shelter by helping them identify immediate alternate housing arrangements and, if necessary, connecting them with services and financial assistance to help them return to permanent housing.

Emergency Transfer: In accordance with Violence Against Women Act (VAWA), the transfer from one housing program to another housing program for victims of domestic violence, dating violence, sexual assault, and/or stalking to protect the tenant from a threat of imminent harm from further violence.

HMIS: A Homeless Management Information System (HMIS) is a software application designed to record and store client-level information on the characteristics and service needs of homeless persons. HMIS is typically a web-based software application that homeless assistance providers use to coordinate care, manage their operations, and better serve their clients.

Housing First: Housing First is an approach to quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment, or service participation requirements.

Housing Needs Tool (also referred to as a Common Assessment Tool): A comprehensive and standardized assessment tool used for the purposes of housing prioritization and placement within the CES.

Housing Problem Solving: Housing problem-solving approaches support the effective implementation of **homelessness prevention, diversion, and rapid exit strategies** – strategies that should be a part of every coordinated entry process and are offered as potential housing pathways for all populations.

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

Low Barrier: an adjective used to describe a service or provider that is easily accessible and as user friendly as possible; one that tries to minimize barriers such as paperwork,waiting lists, eligibility requirements as well as physical and staff related characteristics that can stand in the way of people getting their needs met. It is an entry point for a variety of services and approaches.

Mainstream Resources: publicly funded programs that provide services such as health care, mental health care, substance abuse treatment, veteran's assistance, housing support, and income

support to low-income persons whether they are homeless or not. Mainstream resources include Medicaid, Social Security, SNAP (food stamps) and others.

No Wrong Door: An approach that makes it easy for individuals to access homeless services from a variety of Access Point distributed over a broad geographic area as well as via telephone hotlines, law enforcement, and Homeless Resource Centers.

Program Transfer: A case management best practice that eases the transfer of clients from one program to another with the least amount of trauma or difficulty with the clients, including a warm hand off process by case managers.

Rehousing: The prioritization of housing resources for those who have been previously prioritized and housed but have returned to homelessness or cannot maintain housing stability.

Shelter: any facility, the primary purpose of which is to provide a temporary shelter for people experiencing homelessness, including specific sub-populations of homeless individuals, which does not require occupants to sign leases or occupancy agreements.

Trauma Informed: An approach that assumes that an individual is likely to have experienced traumatic events.

Trauma Informed Care: is an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma. Trauma Informed Care also emphasizes physical, psychological and emotional safety for both consumers and providers, and helps survivors rebuild a sense of control and empowerment.

Unsheltered: A term used to describe people who prefer to sleep and reside outdoors in individual or group encampments rather than utilize Shelters or Resource Centers.

Warm Hand-Off: Process in which services providers coordinated with other service providers to connect clients with resources and initiate transfers between programs rather than instructing clients to make their own connections.

VI. Versions of Document

Activity	Date	Key Activities/Changes
Released as a tool for possible adoption	January 2018	Adopted
Adopted	January 22, 2018	Adopted
Revised	September 23, 2019	Approved

VII. ADDENDUM - IMPLEMENTATION GUIDE

This Implementation Guide will be used as a companion to the Coordinated Entry System Standards. This guide contains more detailed procedural information to assist providers in following policies to ensure consistent, system-wide processes.

The Coordinated Entry Task Group is currently working to develop to Implementation Guide.