Hennepin County
Single Adult Coordinated Entry System (CES) Operations Manual

In 2013, the Hennepin County Office to End Homelessness (OEH), on behalf of the Heading Home Hennepin Strategic Plan and the Minneapolis/Hennepin County Continuum of Care, initiated a process to improve the delivery of housing and crisis response services and assistance to families and individuals who are homeless or at imminent risk of homelessness throughout Hennepin County by redesigning the community's process for access, assessment, and referrals within its homeless assistance system.

This process, the Hennepin ***Coordinated Entry System (CES)***, institutes consistent and uniform access, assessment, prioritization and referral processes to determine the most appropriate response to each individual or family's immediate housing needs. This new system of Coordinated Entry is not only mandated by HUD and many other funders, but is recognized nationally as a best practice, can improve efficiency in large systems like Hennepin County, and can help serve more people more quickly and efficiently with assistance targeted to address their housing needs.

This CES Policies and Procedures document is an operational manual, providing guidance and direction for the day to day operation, management, oversight and evaluation of Hennepin County's coordinated entry approach. This manual will be updated and revised on an ongoing basis as the actual application and practical experience of CES design principles are refined and improved. Please refer to www.hennepinca.com to view the most up to date version of this document as well as up to date forms and materials.

CES Policies and Procedures Table of Contents

Introduction and Purpose

The Coordinated Entry System is Hennepin County's approach to organizing and providing services and assistance to persons experiencing a housing crisis throughout Hennepin County. Persons who are seeking homeless or homelessness prevention assistance are directed to defined entry points, assessed in a uniform and consistent manner, prioritized for housing and services and then linked to available interventions in accordance with the intentional service strategy defined by Hennepin County's CoC leadership. Each service participant's acuity level and housing needs are aligned with a set of service and program strategies that represent the appropriate intensity and scope of services needed to resolve the housing crisis.

Hennepin County's CES design is informed by local planning efforts including homeless assistance providers from programs serving families, single adults, youth, and persons fleeing domestic violence. In addition, much of Hennepin County's CES design is derived from statewide CES planning efforts coordinated through the Minnesota Housing Finance Agency.

Guiding Principles

The design, operation and evaluation of CES is informed by a set of Guiding Principles established by the Hennepin County CES Leadership Team and adopted by the Hennepin County/Minneapolis CoC.

Principle 1: Ensure service accessibility

- Allow anyone who needs homeless services to know where to get help and be able to access services as promptly as possible through an assessment process that is consistent and respectful
- Ensure staff conducting assessments are trained and competent in the assessment process

Principle 2: Prioritize swift exit from homelessness

- Facilitate exits from homelessness in the most rapid and appropriate manner possible given available resources; shelter is not housing

Principle 3: Align services to client need

- Ensure a homeless response system that includes a variety of program models targeted to serve a range of subpopulations driven by an analysis of client needs
- Ensure that clients gain access as efficiently and effectively as possible to safe placement options and the type of intervention most appropriate to their immediate and long-term housing needs and preferences
- Ensure that the Coordinated Entry System is sufficiently flexible to enable tailored responses to individual client needs and circumstances

Principle 4: Prioritize services for clients with the greatest need

- Establish uniform, consistent eligibility criteria and prioritization standards
- Limit eligibility criteria to those required by funding sources or other formal external requirements in order to end homelessness for all people as promptly as possible
- Ensure that people who have been homeless the longest and/or are the most vulnerable have priority access to the project model to which they have been matched

Principle 5: Build a system that works efficiently and effectively for clients, referral sources, and receiving programs

- Ensure clarity, transparency, consistency and accountability for homeless clients, referral sources and receiving programs throughout the assessment and referral process
- Incorporate provider and client choice in enrollment decisions, including the ability to opt into a less-intensive intervention
- Promote collaboration, communication, and knowledge sharing regarding resources among providers

Principle 6: Invest in continuously strengthening the system

- Leverage Homeless Management Information System (HMIS) data and infrastructure whenever possible for system evaluation, monitoring, and client care coordination and ensure data quality
- Limit data collection to that which is relevant to the Coordinated Entry process
- Continue to make enhancements to the Coordinated Entry System in response to emerging findings and needs and changes in City, State or Federal policy
- Continuously invest in opportunities to build provider capacity and enable more efficient and effective services

Process for creating and amending the CES Policies and Procedures

CES Policies and Procedures governing the management and oversight of Hennepin Coordinated Entry System shall be documented in the Hennepin County CES Manual. Updates and changes will be periodically reviewed and approved by the CES Leadership Committee.

Provider engagement on the process and procedures will be critical in ensuring this CES works as well as possible. The leadership committee will form a number of groups to gauge feedback and identify choke points in the system, these groups will include:

- Regular provider meetings for referrals
- Regular provider meetings for shelter operations
- Regular provider meetings for HMIS operations
- Peer to peer opportunities

Beyond that, the CES website for Hennepin County will provide a clearinghouse for up to date information, forms, news, and a chance to provide feedback.

Coordinated Entry System Terms

Homeless Definitions

Chronically Homeless (HUD Definition)

HUD defines a chronically homeless person as follows:

An individual who:

1. Is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
    a. Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter **continuously for at least one year or on at least four separate occasions in the last three years, where the cumulative total of the four occasions is at least one year**. Stays in institutions of 90 days or less will not constitute a break in homelessness, but rather such stays are included in the cumulative total; and
    b. Can be **diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability** (as defined in section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000 (42 U.S.C. 15002)), **post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability**;
2. An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
3. A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Disability (HUD Definition)

HUD defines a person with disabilities as a person who:

1. has a disability as defined in Section 223 of the Social Security Act (42 U.S.C.423), or
2. is determined by HUD regulations to have a physical, mental or emotional impairment that:
    a. is expected to be of long, continued, and indefinite duration;
    b. substantially impedes his or her ability to live independently; and
    c. is of such a nature that such ability could be improved by more suitable housing conditions, or
3. has a developmental disability as defined in the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 15002(8)), or
4. has the disease acquired immunodeficiency syndrome (AIDS) or any conditions arising from the etiologic agent for acquired immunodeficiency syndrome (HIV).

For the purpose of qualifying for low income housing under HUD public housing and Section 8 programs, the definition does not include a person whose disability is based solely on any drug or alcohol dependence.

Long-Term Homeless (Minnesota Definition)

Persons including unaccompanied youth, or families with children who lack a permanent place to live continuously for a year or more or at least four times in the past three years. Any period of institutionalization or incarceration shall be excluded when determining the length of time a household has been homeless. Definition includes persons doubled up or "couch hopping" (doubled up or couch hopping is considered an episode of homelessness if a household is doubled up with another household and duration is less than one year or couch hops as a temporary way to avoid living on the streets or an emergency shelter).

Time spent in transitional housing (TH) is a neutral event. Housing history prior to or after transitional housing should be evaluated to determine if it meets the state's LTH definition.

Minnesota's definition does not require that the person have a disabling condition.

Literally Homeless (HUD Homeless Definition Category 1)

An individual or family who lacks a fixed, regular, and adequate nighttime residence

a. An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, camping ground; or
b. An individual or family living in a supervised 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, or local government program for low-income individuals); or
c. An individual who is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

At imminent risk of homelessness (HUD Homeless Definition Category 2)

An individual or family who will imminently lose their housing (within 14 days) and become literally homeless

Homeless under other Federal statutes (HUD Homeless Definition Category 3)

An individual or family defined as 'homeless' by other federal statute (e.g., Dept of HHS, Dept. of Ed.)

Fleeing domestic abuse or violence (HUD Homeless Definition Category 4)

An individual or family fleeing or attempting to flee domestic violence, stalking, dating violence, or sexual assault.

Other Terms

Area Median Income Limits (Hennepin County/Minneapolis Metropolitan Statistical Area)

The Area Median Income (AMI) is the midpoint of a region's income distribution – half of households in a region earn more than the median and half earn less than the median. For housing policy, income thresholds set relative to the area median income—such as 50% of the area median income—identify households eligible to live in income-restricted housing units and the affordability of housing units to low-income households. These are determined and published annually by HUD and can be found at https://www.huduser.gov/portal/datasets/il.html.

HMIS (Homeless Management Information System)

HMIS is a computerized data collection tool designed to capture client-level information over time on the characteristics and service needs of adults and children experiencing homelessness. In Hennepin County and the State of Minnesota we use a platform called ServicePoint to manage our HMIS. ServicePoint and HMIS have become synonymous in MN, but are really separate entities.

VI-SPDAT (Vulnerability Index – Service Prioritization Decision Assistance Tool)

The VI-SPDAT is a triage tool that seeks to assign housing interventions to individuals based on their acuity in several core areas. This tool combines the Vulnerability Index that has been used for morbidity assessment, with the Service Prioritization Decision Assistance Tool that prioritizes housing interventions. There are three versions of the VI-SPDAT in use in Hennepin County; the Family F-VI-SPDAT, the Transition Age Youth TAY-VI-SPDAT, and the original VI-SPDAT which is used with single adults. This tool is not to be confused with the full SPDAT that is used as a longitudinal case management tool and a more comprehensive assessment.

CES Program Component Definitions

Component definitions provide detailed descriptions of each CoC program type available through CES. Performance Measures in RED are meant to serve as examples, and are not community held standards. As the system evolves, these measures will become more solidified. Please check back for future versions of the CES Manual for further detail.

Component Type	Essential Elements	Target Population	Project-level Performance	System-level Performance
Street Outreach & Engagement with the Homeless System				
Emergency services and engagement intended to link unsheltered households who are homeless and in need of shelter, housing and support services.	Low-demand, street-based services that address basic needs (e.g., food, clothing, blankets) and seek to build relationships with the goal of moving people into housing and engaging them in services over time. Multi-disciplinary staff provide or link persons with: case manager, assistance to develop a person-centered case management plan, housing placement, on-site psychiatric and addictions assessment, medication, other immediate and short-term treatment, and assessment to other programs and services.	Homeless persons on the streets, frequently targeting those with mental illness, severe addictions, or dual-diagnosis	**30 days** from initial contact to engagement. **30 days** from engagement to comprehensive assessment. Comprehensive client assessment completed on all clients within **60 days**. **90%** of Street Outreach clients are successfully placed in housing stability program within **90 days**, including: • emergency shelter • transitional housing • permanent housing, including permanent supportive housing	1. Reduction in number of unsheltered (street homeless) households 2. Actively encouraged homeless individuals and families to participate in available homeless assistance services
Prevention (& Diversion)				
A set of strategies to assist people in maintaining permanent housing and/or divert them from entering the homeless system. Service strategies are focused on addressing the immediate housing crisis and can be integrated with other	Flexible funding available wherever households present for services. Funding is used to provide financial assistance to pay for current and back rent, security deposits, current and back utility payments, or "whatever it takes" to prevent people from entering the homeless system and will result in housing stability. Includes direct client support and follow-up case management for up to 90 days following end of assistance to	Households who are at imminent risk of homelessness; without homelessness prevention interventions the client would	• Clients referred are diverted from shelter (i.e., they would have become homeless otherwise) due to prevention assistance. • Clients are relocated to more stable/appropriate housing.	1. Reduction in number of people who become homeless

Component Type	Essential Elements	Target Population	Project-level Performance	System-level Performance
mainstream services to address more long term needs." • Emergency financial assistance to help people avoid imminent homelessness and maintain housing stability. • Supportive services, advocacy and mediation to mitigate factors leading to imminent homelessness.	ensure client maintains stable housing. Essential program elements include housing and needs assessment; shelter diversion through landlord mediation; family outreach and mediation; legal services; assessment to financial prevention assistance; and negotiation and advocacy on behalf of client to avoid homelessness. Initial assistance is often followed by more comprehensive needs assessment and tertiary prevention efforts, such as assessment to supportive services, including life skills and budgeting, and housing counselor.	become literally homeless within 14 days	• Clients do not enter shelter system within **180 days** (6 months) following the provision of prevention assistance.	
Drop-In Centers				
Day space (only open during limited day-time hours) programs providing basic needs assistance and light touch respite care, information/referral and service connection. Provides basic needs, information, and connection to resources for persons experiencing homelessness.	Collaborative partners provide on-site services and assessment for more comprehensive services offered at different sites (e.g. medical, mental health, basic needs.)	Homeless in shelter programs, frequently targeting those with addiction and physical health problems	• Comprehensive client assessment completed on all clients within **60 days**. • Drop-In Center clients are successfully placed in next step housing stability program, including emergency shelter	1. The mean length of episodes of homelessness is less than 21 days. 2. Actively encouraged homeless individuals and families to participate in available homeless assistance services.
Emergency Shelter				
Emergency Shelter programs providing stabilization and assessment; focusing on quickly moving all persons to housing, regardless of disability or background. Short-term shelter that provides a safe, temporary place to stay (for those who	Entry point shelter with: • showers, • laundry, • meals, • other basic services, • and linkage to case manager and housing counselor (co-located on-site), with the goal of helping households move into	Homeless individuals, youth and families. For the purposes of this document, the term homeless is meant to include	• Initial ***shelter intake*** within 24 hours. • All emergency shelter clients residing in shelter for more than 7 days receive t ***next step assessment***, placement score, and successful linkage to the	The mean length of episodes of homelessness is **less than 21 days**; or For individuals and families in similar circumstances in the preceding year, incidence was at least **10 percent less** than in the year before.

Component Type	Essential Elements	Target Population	Project-level Performance	System-level Performance
cannot be diverted from shelter) with focus on initial housing assessment, immediate housing placement and linkage to other services.	stable housing as quickly as possible. Shelters include an array of stabilization options that allow for varying degrees of participation and levels of support based on client needs and engagement at the time they enter the system (i.e., for those with chronic addictions, mental illness, and co-occurring disorders). On-site supportive service staff should conduct ***next step housing assessment*** of repeat clients or clients requesting such assessment within **14 days of entry** to determine housing needs (e.g., unit size, rent levels, location), subsidy needs, and identify housing barriers, provide ongoing case management, and manage ongoing housing support and services that the client will need to remain stably housed. First time homeless clients will receive a next step housing assessment upon or after the 7th day of a continuous shelter stay. Clients should be placed in "next step" housing within **30 to 45 days**.	people who are currently living on the streets	most appropriate housing stability program type. • Emergency shelter clients are placed in housing stability program within an average of **21 days**. Housing placements include: • Rapid Re-housing • Transitional Housing • Permanent (non-subsidized) Housing • Permanent Supportive Housing	
Rapid Re-housing				
Rapid re-housing is an intervention designed to help individuals and families to quickly exit homelessness and return to permanent housing. Rapid re-housing assistance is offered without preconditions (such as employment, income, absence of criminal record, or sobriety) and the resources and services provided are typically tailored to the unique needs of the household. The core components of a rapid re-housing program are below. While a rapid re-housing	**Housing Identification** • Recruit landlords to provide housing opportunities for individuals and families experiencing homelessness. • Address potential barriers to landlord participation such as concern about short term nature of rental assistance and tenant qualifications. • Assist households to find and secure appropriate rental housing. **Rent and Move-In Assistance (Financial)** • Provide assistance to cover move-in costs, deposits, and the rental and/or utility assistance (typically six months or less) necessary to allow individuals and families	Homeless households with temporary barriers to self-sufficiency	• **90%** households are stably housed at 6 months. • **75%** households remain stably housed at 12 months. • **50%** households remain stably housed at 24 months. • **90%** households increase income through employment or benefits. • **90%** households provide improved family environment for children (e.g., improved school attendance).	• The mean length of episodes of homelessness is **less than 21 days**; or • For individuals and families in similar circumstances in the preceding year, incidence was at **least 10 percent less** than in the year before. • **Less than 5 percent recidivism** (individuals and families become homeless again at any time within the next 2 years).

Component Type	Essential Elements	Target Population	Project-level Performance	System-level Performance
program must have all three core components available, it is not required that a single entity provide all three services nor that a household utilize them all.	to move immediately out of homelessness and to stabilize in permanent housing. **Rapid Re-housing Case Management and Services** • Help individuals and families experiencing homelessness identify and select among various permanent housing options based on their unique needs, preferences, and financial resources. • Help individuals and families experiencing homelessness address issues that may impede access to housing (such as credit history, arrears, and legal issues). • Help individuals and families negotiate manageable and appropriate lease agreements with landlords. • Make appropriate and time-limited services and supports available to families and individuals to allow them to stabilize quickly in permanent housing. • Monitor participants' housing stability and be available to resolve crises, at a minimum during the time rapid re-housing assistance is provided. • Provide or assist the household with connections to resources that help them improve their safety and well-being and achieve their long-term goals. This includes providing or ensuring that the household has access to resources related to benefits, employment and community-based services (if needed/appropriate) so that they can sustain rent payments independently when rental assistance ends. • Ensure that services provided are client-directed, respectful of individuals' right to			

Component Type	Essential Elements	Target Population	Project-level Performance	System-level Performance
	self-determination, and voluntary. Unless basic, program-related case management is required by statute or regulation, participation in services should not be required to receive rapid re-housing assistance.			
Transitional Housing				
Safe, temporary apartments located in project-based or scatter-site housing that focuses on housing planning, addictions treatment, stabilization, and recovery for individuals and families with temporary barriers to self-sufficiency.	Safe units located in site-based or scattered site housing that focuses on housing planning, addictions treatment, stabilization, and recovery for individuals and families with temporary barriers to self-sufficiency. Recognizing that a zero tolerance approach does not work for all clients, some transitional housing programs would employ a harm reduction, or tolerant, approach to engage clients and help them maintain housing stability assuming that the project-based environment allows for appropriate observation of the family environment and care of children. Housing assistance may be provided for up to two years, including rental assistance, housing stabilization services, landlord mediation, case management, budgeting, life skills, parenting support, and child welfare preventive services. Housing plan within 2 weeks. Average stay is 6 months. Could stay up to 2 years. All programs provide follow up case management post exit. Expectation of 6 months of post placement tracking to assess success	• Homeless single adults and families contemplating recovery or newly in recovery, • youth, • ex-offenders, • single-parent females younger than 25 with children under 6, • veterans (utilizing GPD)	• **90%** households are stably housed at 6 months. • **75%** households remain stably housed at 12 months post exit. • **50%** households remain stably housed at 24 months post exit. • **90%** households increase income through employment or benefits. • **90%** households provide improved family environment for children (e.g., improved school attendance).	**Less than 5 percent recidivism** (individuals and families become homeless again at any time within the next 2 years).
Permanent Supportive Housing				
Project-based, clustered and	Permanent housing with supports that help	Targeted to	• **90%** of households maintain	**Less than 5 percent recidivism**

Component Type	Essential Elements	Target Population	Project-level Performance	System-level Performance
scattered site permanent housing linked with supportive services that help residents maintain housing.	clients maintain housing and address barriers to self-sufficiency. PSH programs should provide subsidized housing or rental assistance; 24/7 tenant support services; and property management services. Recognizing that relapse is part of the recovery process, PSH programs should hold units open for 30 days while clients are in treatment or in other institutions. If a client returns to a program after 30 days and their unit was given to someone else, staff should work with that client to keep them engaged and place them in a unit when one is available. Some PSH programs should have a tolerant, or harm reduction, approach to engage clients with serious substance abuse issues. While in PSH, clients should receive supportive services appropriate to their needs from their case manager and/or the ACT multidisciplinary team.	persons experiencing long-term homelessness, disabilities, and significant barriers to self-sufficiency.	permanent housing (no exits to non-permanent housing destinations). • **90%** of households who leave the program, obtain more autonomous or independent living arrangements • **50%** Households increase income (earned and/or benefit). • Program maintains greater than **90% occupancy**.	(individuals and families become homeless again at any time within the next 2 years).
Permanent Housing – Market Rate				
Housing where people may stay indefinitely with temporary or long-term rental assistance and/or supportive services.	Broad range of clustered or scattered-site permanent housing options for individuals with temporary barriers to self-sufficiency, including group living arrangements, shared apartments, or scattered-site apartments. Clients can receive rental subsidies (transitional or permanent, deep or shallow) and supportive services. Both length and intensity of housing subsidy and services are defined on a case-by-case basis depending on client's needs. Once clients are placed in housing, a multi-disciplinary case management team (lead by the primary case manager of an assigned PH provider) should conduct a comprehensive assessment and develop a long-term case management plan based on their needs. Clients	Persons who were formerly homeless	• Households maintain housing (no exits to non-permanent housing destination). • **Less than 5%** return to shelter within 6 mos., within 12 mos.	**Less than 5 percent recidivism** (individuals and families become homeless again at any time within the next 2 years).

Component Type	Essential Elements	Target Population	Project-level Performance	System-level Performance
	should maintain the same primary case manager for as long as they are in the homeless system, but members of the multi-disciplinary team may change as the client's needs change.			

Staffing Roles and Participation Responsibilities

Single Adult CES Leadership Group

Oversight and monitoring of Coordinated Entry functions is conducted by the Leadership Group of Hennepin County stakeholders to ensure consistent application of CES policies and procedures and high quality service delivery for persons and families experiencing a housing crisis.

Membership is comprised of up to ten Hennepin County stakeholders originally selected via an application process facilitated by the Office to End Homelessness. Members serve two year terms and are not eligible for re-nomination. Initially, this turnover will be staggered in order to ensure continuity in planning. As the openings in the Group occur, the process of filling those spaces will be facilitated by the Group itself with support from Hennepin County staff.

Membership is drawn from the following provider and population concerns:

- Shelter/Outreach Providers
- Housing Providers
- Domestic Violence Providers
- Hennepin County staffing (advisory, non-voting)

The Leadership Group shall meet monthly to monitor progress, hear appeals, assess progress, and implement changes and updates to CES operations. Meeting minutes will be published publically on the Hennepin CES website.

Subcommittees shall be defined and created as necessary.

Roles*:*

1. CES Leadership Group reviews CES **operations** on a monthly basis and establishes and/or updates CES Policies and Procedures as necessary and in accordance with Guiding Principles.
2. Establishes an annual CES **evaluation plan** and reviews evaluation results prepared/compiled by OEH. Evaluation findings and results are used by the CES Governing Board to inform updates and changes to CES operational practices.
3. Review and approve all supporting CES **documentation**, including but not limited to: participation agreements among CoC and participating agencies, assessment tools, prioritization criteria and tools, referral cover sheets, case conferencing protocols, etc.

Hennepin County Housing Referral Coordinator (HRC)

The HRC provides coordination of services and referral management for Hennepin County's homeless continuum.

Primary responsibilities include the following:

A. **Oversight of day-to-day operations of Coordinated Entry Referral System**

- Oversees vacancy reporting, priority list management, and referral functions to:
    - facilitate exits from homelessness in the most rapid manner possible given available resources

    - ensure that clients are appropriately matched to the type of intervention most aligned with their immediate and long-term housing needs and preferences
    - ensure that people who have been homeless the longest and/or are the most vulnerable have priority access to the project model to which they have been referred
- Oversees assessment functions to ensure client needs and preferences are promptly, regularly, respectfully, consistently and accurately determined
- Oversees case conferencing functions to review and resolve rejection decisions by receiving programs and refusals by clients to engage in a housing plan;
- Oversees appeals processes to resolve client grievances regarding eligibility decisions in accordance with relevant policies and procedures
- Uses waitlist and other data in Homeless Management Information System (HMIS) to manage client and program level data including assessments, priority lists, vacancy reporting, referrals, and referral outcomes

B. **Coordination with and Support for Partners**

- Assists in the design and provision of ongoing training for County staff and community partners conducting assessments
- Assists in planning and execution of a strategy to regularly obtain provider and consumer input and promote collaboration, communication, and knowledge sharing regarding resources among community stakeholders
- Leads coordination efforts with other local and state-wide Coordinated Entry efforts
- Develops and maintains strong working relationships with referring and receiving agencies including comprehensive knowledge of program types and provider attributes

C. **Compliance**

- Oversees referral functions in a manner that is in accordance with established eligibility criteria and prioritization standards
- Oversees updates to policies and procedures for the Coordinated Entry System

D. **Program Evaluation, Quality Assurance and Quality Improvement**

- Leveraging HMIS data and infrastructure whenever possible, leads regular evaluation efforts to assess the extent to which the Coordinated Entry System is:
    - achieving established performance objectives
    - providing clarity, transparency, consistency and accountability for homeless clients, referral sources and receiving programs
    - sufficiently flexible to enable tailored responses to individual client needs and circumstances
- Identifies opportunities to adjust the Coordinated Entry System to strengthen performance
- Assists in implementation of process improvement adjustments
- Works to ensure that evaluation and adjustment processes are informed by a broad and representative group of stakeholders.

Hennepin County Housing and Homeless Initiatives – Policy and Planning

Hennepin County Housing and Homeless Initiatives office includes all staff associated with community planning, Housing Referral Coordinators, HMIS staff, CoC management staff, as well as the Office to End Homelessness.

1. Provide staff support to the CES Leadership Group
2. Conduct CES analysis, evaluation, monitoring, and review
3. Maintain CES documentation, tools and resources necessary to manage CES access points, ensure consist assessment, prioritize most vulnerable persons and families for assistance, and ensure timely linkage of persons to available housing and services.
4. Provide guidance, training, capacity building support, communication updates, and other project support as needed to ensure all CES participating providers and referral sources have information and resources as necessary to operate and participate in CES successfully.
5. Creating and widely disseminating outreach materials to ensure that information about the services available through the CES and how to access those services is readily available and easily accessible to the public
6. Designing and delivering training for Assessment Entities and homeless assistance providers throughout Hennepin County
7. Regularly review and analyze HMIS data, including reports on system-wide performance measures that will help gauge the success of the Coordinated Entry System, including clients receiving diversion assistance, vacancy reporting and completion of assessments -
8. Participate in CES Leadership Group and Coordinated Entry Management Meetings as appropriate

Hennepin County – HMIS Local System Administrator

1. HMIS Staff maintain HMIS database in accordance with the Local System Administrator (LSA) role as defined by the Minnesota HMIS.
2. OEH HMIS Staff generate standard CES reports on an ongoing basis as defined by the CES Governing Board, and generate ad hoc CES reports and analysis as determined by the CES Governing Board and OEH staff.
3. Ensuring the HMIS can collect the needed data for monitoring and tracking the process of referrals
4. Participate in CES Leadership Group and other planning efforts as appropriate

Hennepin County homeless assistance providers mandated to participate in CES

1. **Adopt and follow CES policies and procedures.** CES participating providers shall maintain and adhere to policies and procedures for CES operations as identified in this CES Manual, and as established by the CES Governing Board for access points, assessment procedures, client prioritization, and referral and placement in available services and housing.

2. **Maintain low barrier to enrollment.** Homeless providers shall limit barriers to enrollment in services and housing. No client may be turned away from crisis response services or homeless designated housing due to lack of income, lack of employment, disability status, or substance use unless the project's primary funder requires the exclusion or a previously existing and documented neighborhood covenant/good neighbor agreement has explicitly limited enrollment to clients with a specific set of attributes or characteristics. Providers maintaining restrictive enrollment practices must maintain documentation from project funders, providing justification for the enrollment policy.

   CoC providers offering Prevention and/or Short-Term Rapid Rehousing assistance (i.e. 0 – 24 months of financial assistance) may choose to apply some income standards for their enrollment determinations.

3. **Maintain Fair and Equal Access**. CES participating providers shall ensure fair and equal access to CES system programs and services for all clients regardless of actual or perceived race, color, religion, national origin, age, gender identity, pregnancy, citizenship, familial status, household composition, disability, Veteran status, or sexual orientation.

   If a program participant's self-identified gender or household composition creates challenging dynamics among residents within a facility, the host program should make every effort to accommodate the individual or assist in locating alternative accommodation that is appropriate and responsive to the individual's needs.

   CES participating providers shall offer universal program access to all subpopulations as appropriate, including chronically homeless individuals and families, Veterans, youth, persons and households fleeing domestic violence, and transgendered persons.

   Population-specific projects and those projects maintaining affinity focus (e.g. women only, tribal nation members only, chronic inebriates, etc.) are permitted to maintain eligibility restrictions as currently defined and will continue to operate and receive prioritized referrals. Any new project wishing to institute exclusionary eligibility criteria will be considered on a case by case basis and receive authorization to operate as such on a limited basis from the Leadership Group and their funders.

4. **Provide appropriate safety planning**. CES participating providers shall provide necessary safety and security protections for persons fleeing or attempting to flee family violence, stalking, dating violence, or other domestic violence situations. Minimum safety planning must include a threshold assessment for presence of participant safety needs and referral to appropriate trauma-informed services if safety needs are identified.

5. **Create and share written eligibility standards**. Provide detailed written guidance for client eligibility and enrollment determinations. Eligibility criteria should be limited to that required by the funder and any requirements beyond those required by the funder will be reviewed and a plan to reduce or eliminate them will be discussed. Include funder specific requirements for eligibility and program-defined requirements such as client characteristics, attributes, behaviors or histories used to determine who is eligible to be enrolled in the program. These standards will be shared with Housing Referral Coordinators as well as funders.

6. **Communicate vacancies**. Homeless providers must communicate project vacancies, either bed, unit, or voucher, to the Housing Referral Coordinator in a manner determined by the CES Leadership Committee and outlined in this Operations Manual.

7. **Limit enrollment to participants referred through the defined CES access point(s)**. Each bed, unit, or voucher that is required to serve someone who is homeless must receive their referrals from the Housing Referral Coordinators. Any agency filling homeless mandated units from alternative sources will be reviewed with funders for compliance. A finite number of boutique programs serving distinct populations may receive a waiver for this clause, but will need to provide CES with detailed engagement and eligibility plans. CES access points will need to be informed of every opening and how and when they were filled.

8. **Participate in CES planning**. CoC projects shall participate in Hennepin County's CES planning and management activities as defined and established by the CES Leadership Committee.

9. **Contribute data to HMIS if mandated per federal, state, county, or other funder requirements.** Each provider with homeless dedicated units will be required to participate in HMIS to some extent. Providers should check with funding sources to determine what forms they will need to complete in HMIS.

10. **Ensure staff who interact with the CES process receive regular training and supervision.** Each provider must notify the HRC to changes in staffing, in order to ensure employees have access to ongoing training and information related to CES.

11. **Ensure client rights are protected and clients are informed of their rights and responsibilities.** Clients shall have rights explained to them verbally and in writing when completing an initial intake. At a minimum client rights will include:

    - The right to be treated with dignity and respect;
    - The right to appeal CES decisions;
    - The right to be treated with cultural sensitivity;
    - The right to have an advocate present during the appeals process;
    - The right to request a reasonable accommodation in accordance with the project's tenant/client selection process;
    - The right to accept housing/services offered or to reject housing/services;
    - The right to confidentiality and information about when confidential information will be disclosed, to whom, and for what purposes, as well as the right to deny disclosure.

CES Workflow and Policies – Single Adult System

Access Policies – Singles

1. **Universal access for all individuals**. Hennepin County access points shall provide directly or make arrangements through other means to ensure universal access to crisis response services for clients seeking emergency assistance at all hours of the day and all days of the year.
2. **Crisis response during non-business hours**. Hennepin County access providers shall document planned after-hours emergency services and publish hours of operation in an easily accessible location or posted publicly on the Internet. After hours crisis response access may include telephone crisis hotline access, coordination with policy, emergency medical care.
3. **Individuals fleeing domestic violence or sexual assault**. Hennepin County access providers shall be trained on the complex dynamics of domestic violence, privacy and confidentiality, and safety planning, including how to handle emergency situations at access points, whether a physical or virtual location. Hennepin County access providers shall partner with local victim service provider agencies to ensure that trainings for relevant staff are provided by informed experts in the field of domestic violence, dating violence, sexual assault, stalking, and human trafficking. Hennepin County access providers shall make safety referrals to victim service providers as determined to be clinically appropriate or at the request of the family.

Access Workflow – Singles

Hennepin County is in the process of redesigning the emergency shelter response system for single adults. New and updated workflow protocols will be developed and instituted at a later date. Refer to the Hennepin CES website for the most up-to-date version of this CES Operations Manual.

1. Adult System Access providers shall provide directly or make arrangements through other means to ensure universal access to crisis response services for single adults seeking emergency assistance at all hours of the day and all days of the year.

2. Adult System Access providers shall document planned after-hours emergency services and publish hours of operation in an easily accessible location or posted publicly on the Internet. After hours crisis response access may include telephone crisis hotline access, coordination with police, emergency medical care. After hours referrals will be made via 211.

3. Single adults experiencing a housing crisis may go to any of the following access points to seek emergency services (with exceptions noted):
    a. Street Outreach Teams
    b. Catholic Charities – Higher Ground
    c. Salvation Army – Harbor Light
    d. St. Stephen's Human Services Shelter
    e. Simpson Housing Services Shelter
    f. Our Saviour's Shelter
    g. Hennepin County Shelter Team/EWS
    h. First Covenant – with referral from Salvation Army (Nov – April)

Note: Hennepin County staff and the CES Leadership Group have the capacity to identify additional access points as needed.

4. All clients shall receive a shelter intake and initial assessment within 24 hours of enrollment.

5. Shelters will take all necessary steps to confirm identity of shelter guests upon request of shelter.

6. All client intake and initial assessment data shall be entered into HMIS (manually or via scan card) within 2 business days.

7. Shelter guests shall receive limited information about basic needs services upon entry to shelter. This includes how to access benefits, clothes, food, medical care, identification, and housing assistance.

Assessment Policies – Singles

Assessment is an iterative process that may take place over a period of several days and involves several points of contact. Assessment shall only involve the collection of information essential to ascertain the immediate crisis and match the client to the appropriate interventions. To the extent that the assessment entity also provides a longer-term case management function, it is possible that later stages of assessment will probe for information beyond that needed for service-matching; however, at every stage, the information collected should only be that which is necessary to complete the function at hand. The Hennepin County assessment tool and process shall include the following:

- **Document client's homelessness history and housing barriers.** Gather sufficient information to allow for appropriate placement and for the creation of an accurate housing and service plan to address a client's needs.
- **Respect client preferences.** Ask direct questions about needs and preferences of the client in order to ensure the best assessment.
- **Capture just enough data to meet project needs and funder requirements.** Design assessment forms to represent the intake data needs for the full continuum of services that is offered within the CoC.
- **Obtain consent for sharing data with providers.** Comply with local, State, and Federal requirements.
- **Draft, or at least initiate, a housing plan.** Work with clients to begin development of a housing plan that can be transferred to the next stage of service.
- **Standardized practice.** Apply standard practices at every point of entry for every client in order to ensure consistent assessments.
- **Training.** All staff completing CES assessments shall receive training and certification prior to conducting CES assessments. CES Leadership Group shall determine the assessment training scope and curriculum.

An electronic link to the Hennepin County Assessment Tool is included in the ***Forms and Resources*** section of this manual.

Assessment Workflow – Singles

CES providers shall administer the Hennepin County Coordinated Entry System (CES) Assessment Tool and Process as defined by the CES Leadership Group. The assessment process must be standardized with uniform

decision-making across all assessment locations and staff. If access points or assessment processes are conducted or managed by providers who do not receive HUD, State of Minnesota, or Hennepin County funds, those providers shall nevertheless abide by assessment standards and protocols defined by the CES Leadership Group. CES will operate using a client-centered approach, allowing clients to freely refuse to answer assessment questions and/or refuse referrals.

1. Access point providers complete the ***Basic Shelter Intake*** and enter client data into HMIS within 4 business days (for all non-County eligible single adults).

2. Clients who have stayed in emergency shelter or on the streets for a cumulative period of 14 days shall be identified to complete the ***VI-SPDAT***. However, clients may request and receive a VI-SPDAT assessment at any time in the client's first 14 days of service connection.

   Additionally, the Housing Referral Coordinators, in coordination with HMIS staff, may generate a regular census report of all active single adults in shelter in order to identify any additional clients who have 14+ days in shelter.

3. Trained assessor staff at all access points administer the VI-SPDAT tool. Assessor staff will use the TAY VI-SPDAT for single adults who are 24 years of age or under. Based on the score, staff will either refer the individual to affordable housing resources (i.e., non-homeless designated options) or proceed to complete the ***Supplemental Form***. The latter serves to collect the demographic and contact information, barriers to housing, homeless history, and housing preferences needed to suitably match an individual with an appropriate supportive housing intervention.

4. Assessor staff will send the VI-SPDAT assessment and Supplemental Form for each screened individual to the HRC, via a secure method, who will compile the information into a prioritized list.

Assessment Cheatsheet

Initial Intake – Completed by all shelters on the first night of their stay. This includes basic demographic information, and some basic services information. This also includes a request for state ID, or information on how to get one. Completed in the first 24 hours of an individual presenting for shelter.

Full Intake – This completes the intake that was gathered on the first night, with more in-depth information and HUD required data elements. This complete intake will be entered into HMIS within 4 business days.

Note: If a client is accessing Salvation Army Emergency Housing beds, they need to do so via the Hennepin County Shelter team. This team will complete a preliminary eligibility for those beds, which is analogous to the eligibility for GRH. If they are eligible, the Harbor Light Center will then complete the full intake within the first week.

VI-SPDAT or TAY-VI-SPDAT – This assessment tool is completed at 14 cumulative days, or on request by a shelter guest. It is a self-report tool that measures an individual's level of acuity around vulnerability.

Supplemental Form – This is completed at the end of the VI-SPDAT if the shelter guest scores for a supportive housing intervention. It compiles basic demographics, contact information, housing barriers, disability status, homeless history, and housing program preferences.

Note: Organizations serving special populations and/or screening individuals outside of the shelter system, may utilize different forms for initial screening.

Referral Criteria – Singles

The matching process and eventual referral linkage process takes into account a set of prioritization criteria for each CoC project type. These programs and the accompanying VI-SPDAT score may change with availability of units and access to additional data on targeting for each component. The order of client priority on the prioritization list will under no circumstances be determined or adjusted based on disability type or diagnosis.

Prioritization Criteria – Singles

For all programs, within each priority level, those with the highest VI-SPDAT scores are prioritized first (i.e., someone scoring a 17 would be prioritized higher than someone scoring a 14 within the Priority 1 category). Individuals who score 0-3 on the VI-SPDAT will not be prioritized for any housing option described here and should explore non-homeless designated resources.

Rapid Re-Housing Prioritization

Rapid Re-Housing resources are slated to roll into the CES in 2017. In anticipation of this, Hennepin County staff and RRH providers are working to streamline eligibility criteria and funding structures in order to most effectively serve the target population.

Transitional Housing Prioritization

Individuals will be referred to ***Transitional Housing*** according to the following prioritization criteria: at least **75%** of available TH units within Hennepin County must be filled with households that score for TH based on the VI-SPDAT range of 4-7 **AND** meet the criteria of at least one of the priority groups identified below:

- ***Youth –*** All individuals between the ages of 18-24.
- ***Domestic Violence survivors –*** Individuals who identify a domestic violence experience as the primary reason causing their housing crisis.
- ***Persons being released from correctional facilities*** and were homeless before entering prison/jail
- ***Persons in the early stages of alcohol or drug addiction recovery -*** Individuals who recently began receiving services to assist in their recovery from alcohol or other drug addiction. This can include (but is not limited to) people who were recently released from a treatment center or other institution.
- ***Veterans (choosing Grant and Per Diem - GPD)***

Permanent Supportive Housing Prioritization

HUD Chronic Programs

Priority	Description	Length of Time Homeless	VI-SPDAT Acuity	Documented Disability
1	HUD Chronically Homeless	>12 months cumulative or 4 episodes in 3 years totaling one year in an emergency shelter	8 or greater	Yes

2	Most Severe Service Need	High VI-SPDAT Acuity, disability and most severe service need	8 or greater	Yes
3	Long History of Homelessness	Long period of cumulative or episodic homelessness	8 or greater	Yes
4	HUD Homeless	Place not meant for human habitation, safe haven or emergency shelter	8 or greater	Yes
5	Transitional Housing	Homeless families with a disability coming from transitional housing	8 or greater	Yes

MN Long-Term Homeless Programs

Priority	Description	Length of Time Homeless	VI-SPDAT Acuity	Disabling Condition
1	MN Long-Term Homeless	>12 months cumulative or 4 episodes in 3 years (includes institutional & doubled up)	8 or greater	Yes
1.5	MN Long-Term Homeless	>12 months cumulative or 4 episodes in 3 years (includes institutional & doubled up)	8 or greater	No
2	Long History of Homelessness	Up to 12 months cumulative (either continuous or multiple episodes in 3 years) or "Meets Spirit of LTH"	8 or greater	Yes
2.5	Long History of Homelessness	Up to 12 months cumulative (either continuous or multiple episodes in 3 years) or "Meets Spirit of LTH"	8 or greater	No
3	MN Long-Term Homeless	>12 months cumulative or 4 episodes in 3 years (includes institutional & doubled up)	6-7	Yes
3.5	MN Long-Term Homeless	>12 months cumulative or 4 episodes in 3 years (includes institutional & doubled up)	6-7	No

Prioritization and Referral Workflow – Singles

1. Housing and service providers complete ***Vacancy Referral Request Form*** for all vacancies anticipated within 30-60 days, and vacancy form is e-mailed to the HRC. Vacancy form will be completed for available beds, units, or scattered site housing opportunities or vouchers. Programs reporting vacancies must include criteria for the unit, including physical traits of the particular unit. Scattered site programs need to only include the needed client demographics and geographic location of vouchers or program.
2. Vacancies that are unexpected should be reported at the earliest possible time.
3. HRC reviews *Vacancy Referral Request Form* to obtain client eligibility information associated with the housing.

4. HRC generates report (ultimately from ServicePoint when available) to identify eligible individuals who may be appropriate for available housing and service slots.
5. HRC reviews the list of eligible individuals and matches those with the highest vulnerability with the most suitable available housing provider based on known information about client demographics, attributes, and housing preferences. For example, in a given week, if there are 10 available openings, the HRC will identify the individuals with the 10 highest acuity scores and review their attributes, specific barriers, and preferences in order to match them with the program most suited to their needs. If necessary, the HRC can expand the pool beyond 10 individuals in order to meet the eligibility criteria of programs serving specific populations.
6. HRC sends client referral to housing provider via a designated secured method (i.e., fax, cloud, email). This will be done via ServicePoint when available. Included will be the ***CES Referral Cover Sheet.*** This document summarizes the referral and serves as "proof" for the housing provider that the referral was obtained via the CES.
7. Housing service provider reviews client referral and decides whether to accept or decline referral. Referral determinations must be made and communicated back to the HRC within **2 business days.**
8. If the housing provider declines the referral, the decline is noted via the ***Referral Acceptance/Denial Form*** is emailed to the HRC (or in ServicePoint when available).
9. HRC reviews the *Referral Acceptance/Denial Form* and determines if the denial is appropriate and allowable according to CES policies and procedures as established by the CES Leadership Group.
10. If the HRC determines the denial is valid, an alternative referral is provided to the housing provider within **2 business days**.
11. If the HRC determines the denial is **not** valid, the HRC will promptly initiate contact to further discuss the conclusion. This may start with phone contact, but an in-person meeting can be scheduled as necessary with the housing provider, HRC, Property Manager, and Hennepin County staff to identify a solution. Provider will be required to provide justification for denial.
12. If the housing provider accepts the referral, the acceptance is communicated to the HRC via email (and noted in ServicePoint when available).
13. The HRC notifies the Access Point provider/staff via email, who can then inform the client that she/he should anticipate contact in the very near future.
14. The housing provider staff initiate contact with the client and the entity that completed the original assessment forms. As appropriate, the housing provider and referring entity (ie shelter staff) should work together to ensure the referred individual is located and engaged quickly.
15. Once contact is made, the housing provider shall give the client an overview of the housing program and address questions and concerns. The goal of this conversation should be to ensure the individual fully understands the benefits of the particular housing program and can thus make an informed decision about proceeding with participation.
16. If the client accepts the referral, the housing provider must lead/manage the housing/service linkage process by working with shelter staff and client to coordinate further intake procedures, homeless or chronic homeless verification, and eventual move-in or enrollment as needed.
17. Housing provider enters client enrollment details in HMIS and submits the *Referral/Acceptance Denial Form* to the HRC to confirm a successful housing placement by noting the move-in date (firm if site-based and anticipated if scattered site).

Referral Denials - Singles

By Client

Clients may reject up to **three** housing referral placements and continue to maintain their position on the priority list. If client continues to turn down available housing opportunities, a more purposeful engagement strategy will be employed (Access Team, Top 51 type engagement). After first denial, provider staff at access points should engage with client to highlight the fact that they need to take referrals seriously, and they must take one of the next two.

By Housing Provider

Hennepin CoC providers and program participants may deny or reject referrals from the defined CES access point, although service denials should be infrequent and must be documented in HMIS or other comparable system with specific justification as prescribed by the Hennepin County CES Governing Board. The specific allowable criteria for denying a referral shall be published by each project and be reviewed and updated annually. All participating projects and clients shall provide the reason for service denial, and may be subject to a limit on the number of service denials.

Agencies who would like to deny a referral that is incompatible with their programming must include details about the reason for denial. Details should include communication attempts with client, specific criminal or housing history that prevents acceptance of referral, or other similar details. Every denial must be accompanied by a fully completed and detailed *Referral Acceptance/Denial Form*. Some examples of denials that will need significant additional details or documentation include the following:

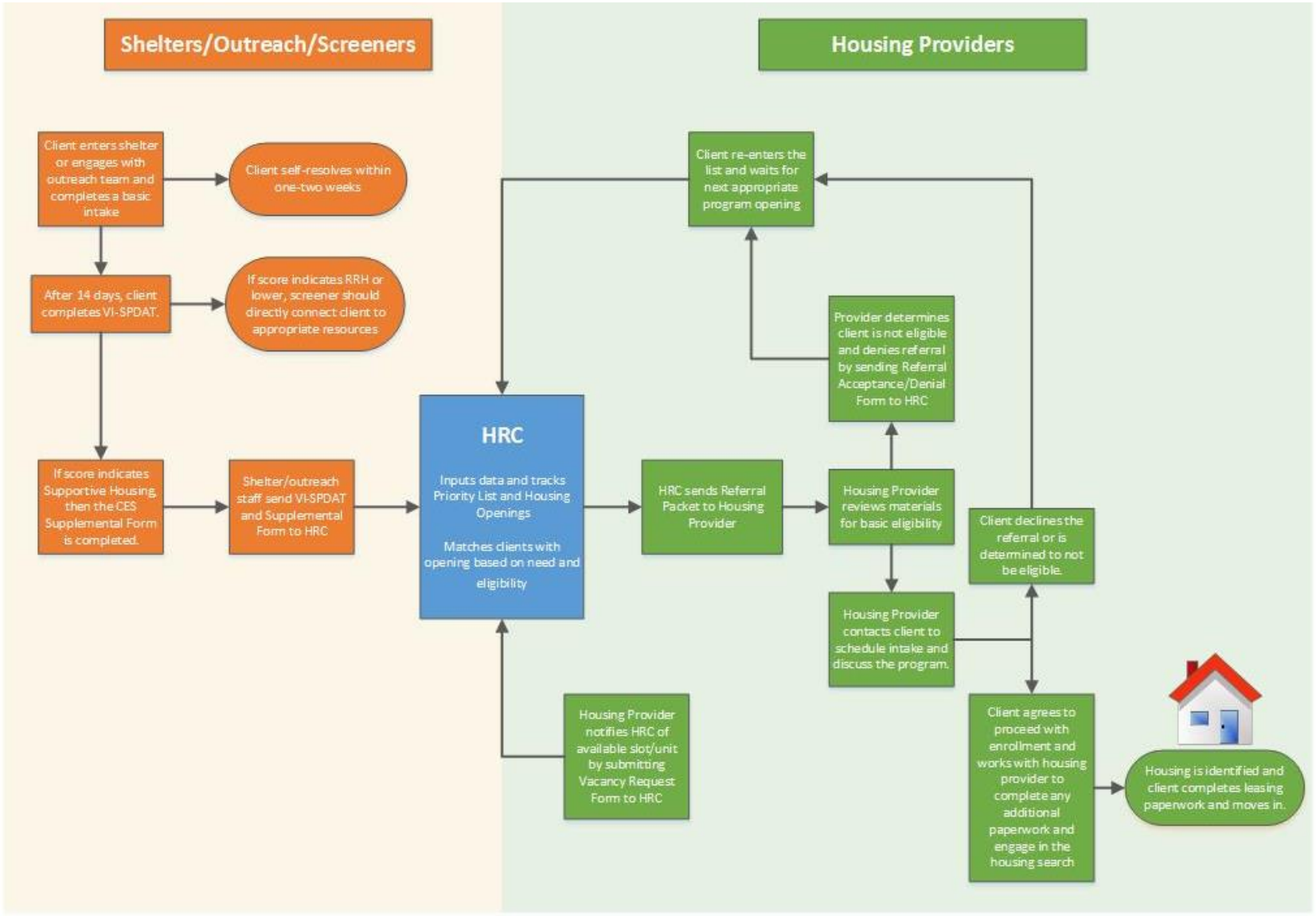
- Client refused further participation (or client moved out of CoC area)
- Client does not meet required criteria for program eligibility
- Client unresponsive to multiple communication attempts
- Client resolved crisis without assistance
- Client safety concerns. The client's/household's health or well-being or the safety of current program participants would be negatively impacted due to staffing, location, or other programmatic issues.
- Client needs cannot be addressed by the program. The program does not offer the services and/or housing supports necessary to successfully serve the household.
- Property management denial (include specific reason cited by property manager)
- Conflict of interest

If a provider denies three referrals in a row, OR if the HRC identifies a pattern of denials over time, the organization will be required to participate in a conferencing meeting with the HRC, and a staff person representing the funding source (e.g., CoC Coordinator, GRH Planning Analyst, etc.).

If the denial is the result of a third party property management/landlord (private or partner of service provider) rejecting the individual's application, the rejection will trigger a case conferencing meeting. If the household chooses to appeal this decision, a new referral will not be provided to the housing program until the appeal process has reached its conclusion.

If a private landlord is unable to be located for use with a voucher or scattered site program after an exhaustive search, the provider may request a new referral. This should be noted in the *Referral Acceptance/Denial Form*, with details about the units applied for, dates applied for, and the reasons for denial of housing.

Visual of Single Adult Work Flow



Transfers

There are circumstances under which a household enrolled with one housing provider may benefit from transferring to another program or provider.

For example,

..1.a. An individual or family has lost several scattered-site housing placements due to problems with visitors.

..1.b. An individual in a site-based setting is unable to comply with rules around sobriety or the environment is not conducive to mental or physical well-being.

The CES seeks to minimize the number of households who are exited back to homelessness, only to have to be re-screened, and re-prioritized, and wait again for supportive housing. If the current housing provider is unable to continue serving a household, staff should contact the appropriate HRC to discuss options besides exiting to homelessness.

If a transfer within the same level of service intervention (i.e., one PSH provider to another PSH provider) is being considered, the referral should come through the CES process. To do so, the current housing provider must contact the HRC in order to determine what other housing providers have available capacity. Housing programs shall not initiate transfers between providers without the involvement and permission of the HRC.

Housing providers are prohibited from transferring a household from one service intervention to another (i.e., TH to PSH, internally or externally) without permission from the HRC. If a provider has an opening in a PSH program, they MUST receive the referral through the CES, and may not fill that opening internally via transfer from a lower service intervention program. Additionally, if it is identified that a household may need a higher intervention than what was determined initially, the housing provider should discuss this with the HRC.

Fair Housing, Tenant Selection and Other Statutory and Regulatory Requirements

All CoC projects in Hennepin's Coordinated Entry System must include a strategy to ensure CoC resources and CES options (referral options) are eligible to all persons regardless of race, color, national origin, religion, sex, age, familial status, disability, actual or perceived sexual orientation, gender identify, or marital status. Special outreach to persons who might be or identify with one or more of these attributes ensures CES is accessible to all persons.

All CoC projects in Hennepin's Coordinated Entry System must ensure that all people in different populations and subpopulations throughout Hennepin County, 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 crisis response system.

All CoC projects in Hennepin's Coordinated Entry System must document steps taken to ensure effective communication with individuals with disabilities. Access points must be accessible to individuals with disabilities, including physical locations for individuals who use wheelchairs, as well as people in Hennepin County who are least likely to access homeless assistance.CES Monitoring and Evaluation

Monitoring and Reporting of CES

Hennepin County shall adhere to Minnesota-defined monitoring and reporting plans for CES. The State-defined monitoring process will report on performance objectives related to CES utilization, efficiency and effectiveness.

Hennepin County CES Reporting Requirements, reflecting State requirements, shall be reported quarterly by the HRCs to the CoC membership and the community at large and include the following elements:

- Narrative description of the status of CES implementation, barriers and challenges experienced, and plans for expansion and improvements in the future
- CES performance indicators may include the following:
    1. Number of persons and individuals receiving CES services
        a. Number seeking assistance/referred to CES
        b. Number completing initial triage/diversion screen
        c. Number completing client intake/assessment
        d. Number completing comprehensive/housing assessment
        2. Demographics and attributes of persons/households receiving CES assistance (from 1d above)
        3. Number of persons and individuals by VI-SPDAT score
        4. Number of persons and individuals receiving CES referrals to the following
        a. Self-Resolve
        b. Rapid Rehousing
        c. Transitional Housing
        d. Permanent Supportive Housing
        e. All other
        5. Destination of persons and individuals to each service strategy as a result of CES referral
        a. Rapid Rehousing
        b. Transitional Housing
        c. Permanent Supportive Housing
        d. All other
        6. Length of time from completion of CES comprehensive/housing assessment to program entry
        a. Average length of time from assessment to referral for each component type
        b. Average length of time waiting on prioritization list for each component type
        7. Number of persons who waited for each CoC component type for greater than 30 days

Evaluation

Hennepin County will conduct a comprehensive system evaluation of CES to ensure that both qualitative and quantitative information are collected and used to identify opportunities for continuous system improvements. Specially, OEH on behalf of the CES Leadership Group is responsible for

- Leading periodic evaluation efforts to ensure that the CES is functioning as intended; such evaluation efforts shall happen at least annually.
- Leading efforts to make periodic adjustments to the CES as determined necessary; such adjustments shall be made at least annually based on findings from evaluation efforts.
- Ensuring that evaluation and adjustment processes are informed by a broad and representative group of stakeholders

- Ensuring that the CES is updated as necessary to maintain compliance with all state and federal statutory regulatory requirements.

Evaluation efforts shall be informed by metrics established annually by the CES Leadership Group in consultation with the community and county staff. These metrics will be displayed on dashboards located on the CES website and shall include indicators of the effectiveness of the functioning of CES itself, such as

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

In addition, these metrics shall also include indicators of the impact of CES on system-wide CoC outcomes, such as

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

Sub-Population Specific Protocols

Veterans

Veterans identified through the CES will be strongly encouraged to sign an additional release of information to be added to the Veteran's Registry. Once on the Registry, veterans who are prioritized based on VI-SPDAT score and who meet program eligibility criteria will have access to both homeless designated housing units available through the CES and to veteran-specific units not accessed through CES (i.e., VASH, SSVF, etc.).

The CES will work closely with representatives from MAC-V, the VA, the State, and other relevant stakeholders to ensure veterans are able to access the full spectrum of housing resources designated for that population.

Victims of Domestic Violence

The CES system will work in partnership with advocacy organizations/shelters serving victims of domestic violence in order to ensure considerations are made to address the specific safety and privacy needs of victims. This includes individuals having the ability to decline housing in neighborhoods that would compromise their location, the choice to be entered anonymously into database, and have full access to housing options.

Youth

Youth age 18 and over shall have access to the single adult CES. Youth-specific access and assessment points are to be determined.

Termination

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

Forms and Resources

Hennepin County CES Website
www.hennepinca.com

Acceptance/Denial Form
http://www.hennepinca.com/provider-portal-singles (password protected)

Hennepin County CES Assessment Tool (VI-SPDAT)
http://www.hennepinca.com/provider-portal-singles (password protected)

Supplemental Form
http://www.hennepinca.com/provider-portal-singles (password protected)

Transfer Request Form
http://www.hennepinca.com/provider-portal-singles (password protected)

Vacancy Request Form
http://www.hennepinca.com/provider-portal-singles (password protected)