NORTHEAST FLORIDA CONTINNUM OF CARE

COORDINATED ENTRY SYSTEM
POLICIES & PROCEDURES

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INTRODUCTION AND OVERVIEW

A System is more than a Series of Programs and Projects.

A Coordinated Entry System (CES) is designed to coordinate entry, assessment, and provision of referrals for permanent housing services throughout Duval, Clay, and Nassau counties (the geographic coverage area for the Northeast Florida Continuum of Care (CoC), also known as FL-510). It is easily accessed by individuals and families seeking housing and services, is well advertised, and includes a comprehensive and standardized assessment tool.

HUD requires each CoC to establish and operate a "centralized or coordinated assessment system," based on evidence that such systems increase the efficiency of local crisis response systems and improve fairness and ease of access to resources, including mainstream system resources. Participating projects use the coordinated entry process established and operated by the CoC to manage coordinated intake and assessment, standardize the prioritization process, and facilitate referrals to available housing and resources. Coordinated Entry (CE) processes are intended to help communities prioritize assistance to ensure that persons who are most in need of assistance receive it in a timely manner. When appropriate data are collected, CE processes can also provide information to CoCs and other stakeholders about service needs and gaps, which helps communities to strategically allocate their current resources and identify the need for additional resources.

All federal guidance, including policy briefs and notices, are linked and available in Appendix 4.

Participation Expectations

CES Policy: All CoC Program and Emergency Solutions Grants (ESG) Program-funded projects are required to participate in the local CES. The CoC still aims to have all homeless assistance projects participating in its CES process and will work with all local projects and funders in its geographic area to facilitate their participation in the CES.

CES Procedure: As part of the annual CoC and ESG application processes, each project must submit a report that identifies the number of participants its project referred, accepted, rejected, and/or served from the CES process.

The CoC may, at times, identify the need to make modifications to the CES and these Policies and Procedures (P&P) based on community and/or environmental factors. In early 2020, the U.S. began to experience the effects of the novel coronavirus, COVID-19. As a result, FL-510 and the Mayor's Shelter Task Force worked collaboratively to develop the COVID-19 Shelter Protocol, included in Appendix 1.

CoC and ESG Coordination

CES Policy: The CoC is committed to aligning and coordinating CES P&P governing assessment, eligibility determinations, and prioritization with its written standards for administering CoC and ESG Programs funds. A copy of the CoC and ESG written standards are included in Appendix 2 of this document.

CES Procedure: The CoC will include at least one representative from the local ESG recipient in its membership of the CES Committee. Additionally, at least annually, representatives from the CoC and the ESG recipient agencies will identify any changes to their written standards and share those with the CoC's CES Committee so that the changes may be reflected in the CES P&P document.

Guiding Principles

The CoC establishes the following guiding principles:

1. The CES will operate with a person-centered approach to include a strong culture of ongoing problem solving (sometimes referred to Rapid Resolution) at all points throughout the system, and with person-centered outcomes.
2. The CES will ensure that participants quickly receive access to the most appropriate services and housing resources available.
3. The CES will reduce the stress of the experience of being homeless by limiting assessments and interviews to only the most pertinent information necessary to resolve the participant's immediate housing crisis.
4. The CES will incorporate cultural and linguistic competencies in all engagement, assessment, and referral coordination activities.
5. The CES will implement standard assessment tools and practices and will capture only the limited information necessary to determine the severity of the participant's needs and the best referral strategy for him or her.
6. The CES will integrate mainstream service providers into the system, including local Public Housing Authorities and VA medical centers.
7. The CES will utilize a Homeless Management Information System (HMIS) for the purposes of managing participant information and facilitating quick access to available CoC resources.
8. The CES will ensure, to the extent possible, that participants do not wait on the prioritization waiting list for periods in excess of 90 days.
9. The CES will strive for equitable outcomes for all participants.

Program Requirements

All HUD CoC & ESG program participants/organizations will be active members of the Northeast Florida CoC CE system as it is locally implemented via the CE Committee. The HUD CoC & ESG programs will have minimal entry requirements to ensure the most vulnerable of the population

are being served. HUD CoC & ESG programs will ensure active client participation, client-centered practices and informed consent. All HUD CoC & ESG programs will receive referrals from the Prioritization List for housing referral and placement with available HUD CoC & ESG housing resources via Coordinated Entry/Weekly Prioritization Meetings.

1. Many programs have eligibility requirements (HUD-funded ESG and CoC programs have grant-specific requirements, as do state-funded programs). Two universal program requirements include 1) accepting referrals from the Coordinated Entry system and 2) adopting a Housing First approach. All programs and are encouraged to review their program requirements and amend them to align with Housing First principles.
2. All adult program participants must meet the ***program*** eligibility requirements and properly document this eligibility as required (HUD-funded ESG and CoC Programs are required to use the HUD CoC & ESG Toolkits by appropriate program) for housing placement.
3. Programs may deny the referral of a registered sex offender from the program if the location of housing will place the client in violation of Florida statute 775.215 which prohibits registered sex offenders from living near schools, daycare facilities and publicly owned playgrounds.[1]
4. Programs **may not** disqualify an individual or family from program entry for lack of income or employment status.
5. Programs **cannot** disqualify an individual or family because of evictions or poor rental history.
6. The program explains the services that are available and encourages each adult member to participate in program services but does not make service usage a requirement or the denial of services a reason for disqualification, termination, or eviction. Please note it is acceptable to require your program participants to participate in housing-focused case management unless otherwise stated by federal notice, but it is not acceptable to require participation in any other supportive services. It is important to note that the purpose of any required housing-focused case management should be to engage the program participant to assist them in **securing or maintaining** their housing.
7. The program will maintain an annual Release of Information and annual income verification, case notes, and all pertinent demographic and identifying data in HMIS, or a comparable database if the agency is a victim services provider. Paper files can also be kept so long as they are stored in a secure location.

[1] Registered sex offenders are prohibited from living within 1,000 feet of a high school, middle school, elementary school, preschool, publicly owned playground, or licensed day care facility. The measurement is taken in a straight line from the nearest property line of the school to the nearest property line of the registrant's place of residence. Additionally, under 24 CFR 578.93 (b)(4), if the program housing has in residence at least one family with a child under the age of 18, the housing may exclude registered sex offenders and persons with a criminal record that includes a violent crime from the project so long as the child resides in the housing.

Roles and Responsibilities

As a system-level process, CE requires intensive coordination and communication among all the projects and agencies in the CoC and, ideally, all of those otherwise available in the community to serve individuals and families experiencing homelessness, including programs that can serve that population but may not be targeting it.

CoC Governance Board:

- General oversight of the CES, including the approval of the CE Policies & Procedures.
- Plan and conduct an annual CES Evaluation.

CoC Lead Agency, CES Manager, and CES Committee:

- Meet monthly to oversee CES implementation and evaluation.
- Regularly update CE Policy & Procedures to ensure most up to date operational information is available to the community.
- Regularly report CES implementation updates, problems, and/or suggestions to the CoC Governance Board.
- Oversee provision of homeless diversion, prevention and housing services for eligible clients.

Collaborative Applicant (CoC Lead Agency) (Changing Homelessness):

- Entity that must (at the request of the CoC Board) compile a consolidated application and apply for HUD funding for coordinated entry, including planning grants.

CES Lead Agency (Mental Health Resource Center):

- Manage the day-to-day operation of coordinated entry.
- Regularly update and make current all programs eligibility guidelines and program contact information so that Navigators can make the best referrals possible.
- Ensure that when a referral is made, the Navigators confirm within two business days whether the referral is accepted, declined by provider or client, pending (with explanation of pending status), or the provider is unable to contact the client. This detailed information will be put into HMIS Case Notes.
- Bring problems and suggestions to the monthly Coordinated Entry Committee meeting.
- Ensure that all points of entry will use the same screening and assessment tool, data collection forms, eligibility verification policies and referral/information-sharing systems.
- Support Collaborative Applicant with all CES-related funding requests.

HMIS Lead Agency (Changing Homelessness):

- Operates the HMIS on the CoC's behalf.
- Ensures CES providers have access to HMIS software and functionality for the collection, management, and analysis of data on persons served through the system.

- Entity designated by the CoC in accordance with HUD's CoC Program Interim Rule to operate the HMIS on the CoC's behalf.

Homeless Service Providers (Participating Projects):

- Agrees to provide homelessness supports/services on behalf of the CoC. A participating project must execute a CE Participation Agreement with the CoC. The Participation Agreement outlines the standards and expectations for the project's participation in and compliance with the P&P governing CE operations. For a project to receive CoC or ESG Program funding from HUD, it is required to participate in coordinated entry.
- Providers must be live on the HMIS system and must maintain data which is inputted no later than within 24 hours of a service or outcome being achieved or rendered.
- Providers must provide written documentation to both the CE Lead (MHRC) and the CE Manager (Changing Homelessness) within three (3) business days on why an applicant was denied entry into a program.

Housing Provider/Referral Partner:

- A type of participating project.
- Referral partner will receive and consider referrals to its project from the CE system.
- Sign a Referral Partner Agreement with the CE Lead Agency affirming it is aware of and will adhere to all CE expectations.

Mainstream System Provider:

- Agency or entity that can provide necessary services or assistance to persons served by coordinated entry. Examples of mainstream system providers include hospitals, mental health agencies, employment assistance programs, and schools.

U.S. Department of Housing and Urban Development (HUD)

- Federal agency responsible for administering housing and homelessness programs including the CoC and ESG Programs.

U.S. Department of Veteran Affairs (VA)

- Federal agency responsible for providing health care and other services, including assistance to end homelessness, to veterans and their families.

NOTE: *This system acknowledges that the needs of a household fleeing or attempting to flee, domestic violence, dating violence, sexual assault or stalking, may be different than the needs of others. Navigators will be trained on sensitivity regarding survivor assistance, and referrals will be made to domestic violence providers unless otherwise indicated by the household being served. In addition, the data of survivors will continue to be treated with the highest level of confidentiality*

and survivor data will not be shared with other Providers (except those designated as Domestic Violence Providers).

Affirmative Marketing and Outreach

CES Policy: All persons participating in any aspect of CE such as access, assessment, prioritization, or referral shall be afforded equal access to CE services and resources without regard to a person's actual or perceived membership in a federally protected class such as race, color, national origin, religion, sex, age, familial status, sexual orientation, gender identity or disability. Additionally, all people in different populations and subpopulations in the CoC's geographic area, including people experiencing chronic homelessness, veterans, and families with children, youth, and survivors of domestic violence, shall have fair and equal access to the coordinated entry process.

CES Procedure: Each project participating in CE is required to post or otherwise make publicly available a notice (provided by the CoC) that describes the coordinated entry process. This notice should be posted in the agency waiting areas, as well as any areas where participants may congregate or receive services (e.g., dining hall). All staff at each agency are required to know which personnel within their agency can discuss and explain CE to a participant who seeks more information.

Safety Planning and Risk Assessment

CES Policy: All persons who are fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking shall have immediate and confidential access to available crisis services within the defined geographic area of Duval, Clay, and Nassau counties.

CES Procedure: The CE system will include a local domestic violence hotline (see DV Centers listed below), which is staffed 24 hours a day, seven days a week, to ensure that all persons who are fleeing or attempting to flee domestic violence or sexual assault have immediate access to crisis response services. All persons will have access to this hotline regardless of which access point they initially contact for services and assistance through the CoC's CE.

Florida Coalition Against Domestic Violence, Certified Domestic Violence Centers

Clay County - Quigley House
Phone: 904.284.0340
Fax: 904.284.5407
Hotline: 904.284.0061 | 800.339.5017
TDD: 904.284.0424
Website: www.quigleyhouse.org

Duval County - Hubbard House
Phone: 904.354.0076
Fax: 904.354.1342
Hotline: 904.354.3114
TDD: 904.354.3958
Website: www.hubbardhouse.org

Nassau County - Micah's Place
Phone: 904.491.6364
Fax: 904.491.6362
Hotline: 904.225.9979
TDD: 904.225.9979
Website: www.micahsplace.org

CES Policy: All CoC providers shall incorporate a safety risk assessment as part of initial CE triage and intake procedures, evaluating, to the greatest extent possible the physical safety and well-being of participants and prospective participants.

CES Procedure: All CoC-defined access points shall conduct an initial screening of risk or potential harm perpetrated on participants as a result of domestic violence, sexual assault, stalking, or dating violence. In the event defined risk is deemed to be present, the participant shall be referred or linked to available specialized services and housing assistance, using a trauma-informed approach designed to address the particular service needs of survivors of abuse, neglect, and violence.

Nondiscrimination

CES Policy: The CES must adhere to all jurisdictionally relevant civil rights and fair housing laws and regulations.

> **"The City of Jacksonville provides, within the limits of the Constitution of the United States, fair housing for all people within the City. The availability of adequate housing without discrimination on the basis of race, color, religion, national origin, sex, sexual orientation, gender identity, handicap, familial status or marital status is a matter of concern to the people of Jacksonville and more particularly of concern to the City in providing for the health, welfare, safety and morals of the people of Jacksonville."**

CES Procedure: The CoC has designated the Lead Agency as the entity responsible for monitoring agencies on compliance with all CE requirements, including adherence to civil rights and fair housing laws and regulations. Failure to comply with these laws and regulations will result

in a monitoring finding on the project, which may affect its position in the local CoC rating and ranking process.

- Fair Housing Act – prohibits discriminatory housing practices based on race, color, religion, sex, sexual orientation, gender identity, 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, which include 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.

Serving our Neighbors

Homelessness Categories

Category 1: Literally Homeless- An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:

(i) 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, or camping ground;

(ii) 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 programs for low- income individuals);

or (iii) 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;

Category 1, Verification Requirements

(a) Written observation by an outreach worker; or

(b) Written referral by another housing or service provider, which includes all due diligence documentation and/or narrative, including dates to validate homelessness eligibility; or

(c) Certification by the individual or head of household seeking assistance state that (s)he was living on the streets or in shelter, accompanied by an outreach or caseworker's statement of due diligence to establish the client's homeless status;

(d) For individuals exiting from an institution – one of the verification options above, and: i. Discharge paperwork or written/oral referral, or ii. Written record of intake worker's due diligence to obtain above evidence and certification by individual that they exited institution.

Category 2: Imminent Risk of Homelessness- An individual or family who will imminently lose their primary nighttime residence, provided that:
(i) The primary nighttime residence will be lost within 14 days of the date of application for homeless assistance;
(ii) No subsequent residence has been identified; and
(iii) The individual or family lacks the resources or support networks, e.g., family, friends, faith-based or other social networks, needed to obtain other permanent housing;

Category 2, Verification Requirements

(a) A court order resulting from an eviction action notifying the individual or family that they must leave; or
(b) For individuals and families leaving a hotel or motel – evidence that they lack the financial resources to stay; or
(c) A documented and verified oral statement; and
(d) Certification that no subsequent residence has been identified; and
(e) Self-certification or other written documentation that the individual lacks the financial resources and support necessary to obtain permanent housing.

Category 3: Homeless Under Other Statues- Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who:
(i) Are defined as homeless under section 387 of the Runaway and Homeless Youth Act (42 U.S.C. 5732a), section 637 of the Head Start Act (42 U.S.C. 832), section 41403 of the Violence Against Women Act of 1994 (42 U.S.C. 14043e 2), section 330(h) of the Public Health Service Act (42 U.S.C. 254b(h)), section 3 of the Food and Nutrition Act of 2008 (7 U.S.C. 2012), section 17(b) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)), or section 725 of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a);
(ii) Have not had a lease, ownership interest, or occupancy agreement in permanent housing at any time during the 60 days immediately preceding the date of application for homeless assistance;
(iii) Have experienced persistent instability as measured by two moves or more during the 60-day period immediately preceding the date of applying for homeless assistance; and
(iv) Can be expected to continue in such status for an extended period of time because of chronic disabilities; chronic physical health or mental health conditions; substance addiction; histories of domestic violence or childhood abuse (including neglect); the presence of a child or youth with a disability; or two or more barriers to employment, which include the lack of a high school degree

or General Education Development (GED), illiteracy, low English proficiency, a history of incarceration or detention for criminal activity, and a history of unstable employment; or

Category 3, Verification Requirements

(a) Certification by the non-profit or state or local government that the individual or head of household seeking assistance met the criteria of homelessness under another federal statute; and

(b) Certification of no permanent housing (PH) in the last 60 days; and

(c) Certification by the individual or head of household, and any available supporting documentation, that (Ss)he has moved two or more times in the past 60 days; and

(d) Documentation of special needs or 2 or more barriers.

Category 4: Fleeing or Attempting to Flee Domestic Violence- Any individual or family who:
(i) Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence;
(ii) Has no other residence; and
(iii) Lacks the resources or support networks, e.g., family, friends, and faith-based or other social networks, to obtain other permanent housing.

Category 4, Verification Requirements

(a) For victim service providers:

i. An oral statement by the individual or head of household seeking assistance which states; they are fleeing; they have no subsequent residence; and they lack resources. Statement must be documented by a self-certification or a certification by an intake worker.

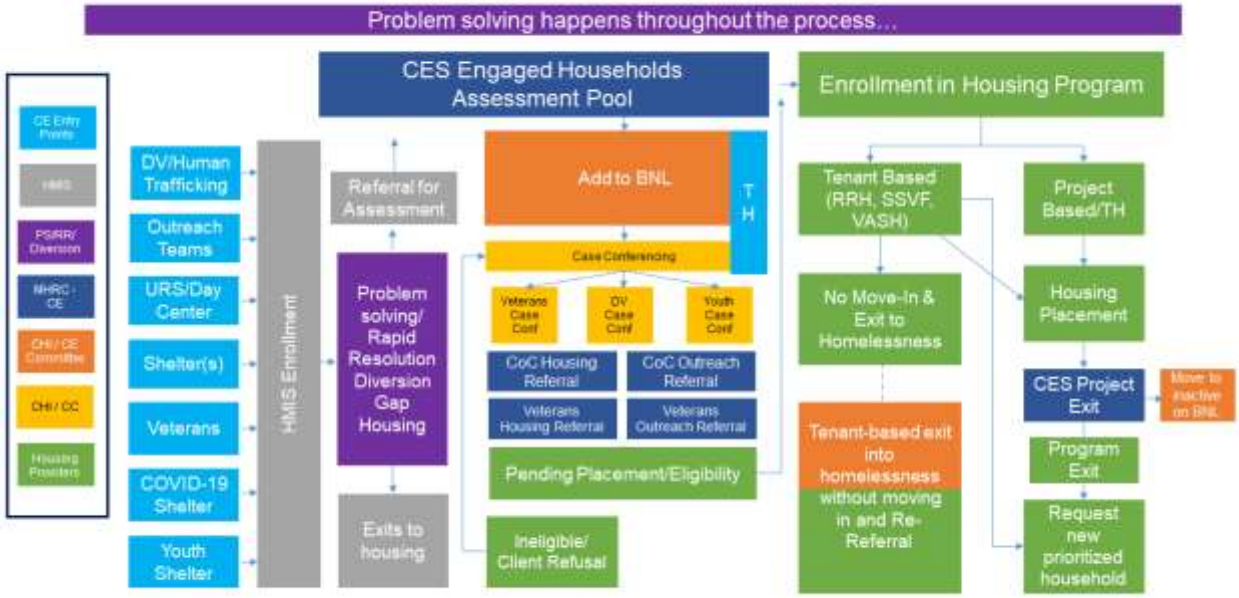
(b) For non-victim service providers:

i. Oral statement by the individual or head of household seeking assistance that they are fleeing. This statement is documented by a self-certification or by a caseworker. Where the safety of the individual or family is not jeopardized, the oral statement must be verified; and

ii. Certification by the individual or head of household that no subsequent residence has been identified; and

iii. Self-certification, or other written documentation, that the individual or family lacks the financial resources and support networks to obtain other permanent housing.

How It Works (CES Process Flow)



Access

Duval, Nassau, and Clay counties are located in Northeast Florida and span over 2,286 square miles of diverse geographic and demographic landscape. Duval County is a populated metropolitan area, Nassau County consists of both rural and beaches community, and Clay County is mostly rural with pockets of suburban neighborhoods.

To meet the needs of our community, we have one centralized site-based access point, with other agencies referring to the centralized access point (Mental Health Resource Center):

- Centralized Access Point
    - Urban Rest Stop, located at the I.M. Sulzbacher Center, 611 E. Adams Street, Jacksonville, FL 32202

CES Policy: The CoC will ensure that CE services are physically accessible to persons with mobility barriers. All CE communications and documentation will be accessible to persons with limited ability to read and understand English.

CES Procedure: The CoC designates the CE coordinating entity to serve as the primary point of contact for ensuring that all CE materials are available in English, Spanish, and [other locally

common language]. In addition, CE participating agencies will, to the greatest extent practicable, provide communication accommodation through translation services to effectively and clearly communicate with persons who have disabilities, as well as with any person with limited English proficiency. The CE coordinating entity will provide visually and audibly accessible CE materials when requested by agencies or participants in CE.

The Mental Health Resource Center (MHRC) QUEST program is designated as the local Coordinated Entry Lead Agency for HUD-funded housing services. To ensure an effective CE process, the QUEST program utilizes the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) which prioritizes individuals based on severity of need. The VI-SPDAT is the local standardized assessment tool. The local CoC has established the following requirements related to CE:

1. **Prioritization.** People with the greatest needs receive priority for any type of housing and homeless assistance available in the CoC for Permanent Supportive Housing (PSH) and Rapid Rehousing (RRH).
2. **Low Barrier.** The QUEST program does not screen people out for assistance because of perceived barriers to housing or services, including, but not limited to, lack of employment or income, drug or alcohol use, or having a criminal record.
3. **Housing First orientation.** The QUEST program promotes Housing First so people are housed quickly without preconditions or service participation requirements.
4. **Person-Centered.** The QUEST program incorporates participant choice. Choice includes location and type of housing, level of services, and other options about which households can participate in decisions.
5. **Fair and Equal Access.** The QUEST program ensures all people in the local CoC geographic area have fair and equal access to the coordinated entry process, regardless of where or how they present for services.
6. **Emergency services.** The QUEST program does not delay access to emergency services such as shelter. The process includes a manner for people to access emergency services at all hours.
7. **Standardized Access and Assessment.** The QUEST program uses the VI-SPDAT assessment with all individuals. A person presenting at a particular location is not steered towards a particular program or provider simply because they presented at that location.
8. **Inclusive.** The CES includes all subpopulations, including people experiencing chronic homelessness, veterans, families, youth and young adults, and domestic violence survivors.
9. **Referral to projects.** The QUEST program makes referrals to all projects receiving CoC and ESG Program funds for RRH and PSH.
10. **Referral protocols.** Programs that participate in the CoC's CES accept all eligible referrals.

11. **Outreach.** The QUEST program provides street outreach efforts so that people sleeping on the streets are prioritized for assistance in the same manner as any other person assessed through the coordinated entry process.
12. **Ongoing planning and stakeholder consultation.** The CoC engages in ongoing planning with all stakeholders participating in the CE process.
13. **Informing local planning.** Information gathered through the CE process is used to guide homeless assistance planning and system change efforts in the community.
14. **Safety planning.** The QUEST program has protocols in place to ensure the safety of the individuals seeking assistance. These protocols ensure that people fleeing domestic violence have safe and confidential access to the coordinated entry process and domestic violence services, and that any data collection adheres to the Violence Against Women Act (VAWA).
15. **Using HMIS and other systems for coordinated entry.** The QUEST program uses HMIS to collect and manage data associated with assessments and referrals.
16. **Full coverage.** The QUEST program covers the local CoC's entire geographic area which includes Duval, Clay, and Nassau counties.

This Northeast Florida CoC is focused on meeting people where they are. When accessing the various points of entry such as the Urban Rest Stop, emergency shelters, or via the Outreach Team, problem solving will begin and continue throughout the CES process flow.

During the first interaction with an Access Point, if the household is eligible, housing problem solving was unable to divert from the homeless response system, and the household wants to complete a housing assessment, QUEST should enroll the household in the Coordinated Entry project in HMIS. If the household does not want to complete a housing assessment but needs other services, QUEST should enroll the household in the Urban Rest Stop Drop In Center program in HMIS.

Assessment

All persons experiencing homelessness who seek out support from an Access Point will be asked a series of triage questions to determine immediate needs, safety concerns, and service referral. The QUEST team will engage in housing problem-solving conversations[2] with all individuals seeking permanent housing; this is to support an individual's ability to resolve their housing crisis before they enter shelter or other homeless-specific service, or to avoid a prolonged stay in emergency shelter or an unsheltered situation. If it is determined that an individual cannot resolve their housing crisis, whether independently or with available financial support, the individual will be offered the next step in the assessment process, which is to complete the VI-SPDAT and some additional questions. The household should also be referred to services they are interested in, including shelter if shelter space is available and appropriate. Individuals determined to be literally

[2] Housing problem solving is also known as rapid resolution, diversion, and rapid exit.

homeless, per HUD's definition of homelessness, are seeking permanent housing services, and willing to be placed on the By Name List (BNL), the master list for prioritization and referral, will be enrolled in the Coordinated Entry project and placed on the list. Individuals will be given a list of documents that will be needed if they are referred to a permanent housing placement.

Housing problem solving services should be available to households at any time during their experience with literal homelessness. If it is not of interest when initially offered or poor timing or for any reason, the household should be informed that they can revisit the conversation/service at any time until they are safely housed.

As the BNL is extensive, the CoC will prioritize the 50 most vulnerable individuals on the list on a weekly basis and actively work with these individuals to complete a SPDAT and assist with document collection so that when a housing referral is made, there is no delay for housing placement.

Currently, the VI-SPDAT is the only standardized assessment tool used to assess individuals. The VI-SPDAT scores will be used to prioritize and refer to the appropriate housing intervention. Other prioritization factors may be used in addition to the VI-SPDAT score, to determine prioritization (ex: length of time homelessness).
NOTE: All assessments conducted on paper must be recorded in HMIS within 48 hours (2 days) of when the information was first collected.

Information gathered and prioritizations made must be consistent with 24 CFR 576.400(e) and 24 CFR 578.7(a)(9). Under no circumstances should a client be told their assessment score or their qualification status based on their assessment score because the assessment tools may not produce a complete body of information necessary to determine household prioritization or program qualification. Case managers may be required to gather additional information relevant to the factors in accordance with CoC prescribed prioritization criteria to make prioritization and qualification decisions.

If a client continues to experience homelessness for 90 or more days, they will be contacted to determine if they would like to remain on the list. The CE Lead Agency has the discretion to offer re-assessments if the client requests it or when a life-changing event occurs such as job loss, household composition change, or major illness.

Participant Autonomy and Privacy Protections
The CE process must allow participants autonomy to freely refuse to answer assessment questions and to refuse housing and service options without retribution or limiting their access to assistance. To strive for participant autonomy, the QUEST team will:
1. Conduct person-centered assessments.

2. Use accessible tools and processes.
3. Ensure sensitivity to lived experiences.
4. Accommodate and encourage participant choice.
5. Provide clear referral expectations.
6. Ensure commitment to referral success.

The NE FL CoC HMIS Privacy Notice describes the privacy policy and outlines that personal information is collected only when appropriate, and no information may be used or disclosed for any purpose other than for that of the program. Information may only be used or disclosed to comply with legal and other obligations. Before conducting an assessment, the Client HMIS Agreement - an informed consent and release of information authorization form - must be verbally accepted or signed, and the client must give consent. All HMIS users are required to sign a user agreement with further instruction related to protecting client's privacy and personally identifying information.

Cultural Competency

Assessments should include culturally and linguistically competent questions for all persons that reduce cultural and linguistic barriers to housing and services for special populations, including immigrants, refugees, and other first-generation populations; youth; individuals with disabilities; and lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual, or other (LGBTQIA+) persons.

Nondiscrimination Complaint and Appeal Process

The NE FL CoC operates the CES in accordance with all federal statutes including, but not limited to: the Fair Housing Act, Title VI of the Civil Rights Act, Section 504 of the Rehabilitation Act, and Title II and Title III of the Americans with Disabilities Act. All service providers, where assistance is provided through Community Planning and Development (CPD) programs, including assistance under the: HOME Investment Partnerships program, Housing Trust Fund program, Community Development Block Grant program, Housing Opportunities for Persons With AIDS program, ESG program, and CoC program, must ensure equal access to the HUD-assisted program in accordance with all general HUD program requirements as specified in 24 CFR Part 5.

The NE FL CoC requires service providers to practice a person-centered model that incorporates participant choice and inclusion of all homeless subpopulations present in Clay, Duval and Nassau counties, including homeless veterans, youth, and families with children, individual adults, seniors, survivors of domestic violence, and LGBTQIA+ individuals and families.

All CoC and ESG funded service providers must ensure that all persons have fair and equal access to the CE process and all forms of assistance regardless of race, ethnicity, national origin, age, sex,

familial status, religious preference, disability type, or amount of disability, gender identity, perceived gender identity, marital status, sexual orientation, or perceived sexual orientation.

Additionally, service providers must maintain compliance with the HEARTH Act's involuntary family separation provision, which ensures that emergency shelters, transitional housing, and permanent housing (PSH and RRH) providers within the CoC do not deny admission to or separate any family members from other members of their family based on age, sex, marital status, gender, gender identity, perceived gender identity, sexual orientation, or disability, when entering shelter or housing.

Submitting a Complaint

Persons who believe they have been discriminated against by the CE Lead Agency can fill out a comment form available at the Urban Rest Stop at 611 E. Adams St. Jacksonville FL 32202 or email ces@changinghomelessness.org. The complaint will go directly to the CE Committee, which meets monthly. The complaint will be reviewed by members of the Committee within 30 days. Any additional investigation of the circumstances of the complaint will occur within 30 days. All complaints will be summarized and submitted to the CoC Governance Board for review, and if necessary final decision.

Prioritization

One of the main purposes of a CES is to ensure that people with the most severe service needs and levels of vulnerability are prioritized for limited housing and homeless assistance. As indicated by HUD guidelines individuals and families experiencing chronic homelessness should be prioritized for PSH. However, during the Spring of 2020, the U.S. began to experience the effects of a global pandemic, COVID-19. As a result, the Mayor's Shelter Task Force partnered with members of the Northeast Florida CoC and created the COVID-19 Shelter Protocol. If an individual is deemed medically vulnerable, exposed or test pending, and/or is COVID+ but medically stable, they will be sent to the Isolation Facility.

The following represents the uniform process to be used across the community for assessing individuals, prioritizing placement into housing, and matching them to an appropriate and available housing intervention.

1. Length of Time Homeless: The first prioritization factor is the length of time an individual has experienced homelessness, giving priority to the person that has experienced homelessness the longest, based on homelessness history present within HMIS and/or the individual's answer to this question on the VI-SPDAT.

2. Unsheltered Sleeping Location: The second prioritization criterion is the location where the individual sleeps based on the HUD universal data element 3.917 Living Situation and/or the

related question of the VI-SPDAT. Unsheltered individuals will be given priority over sheltered individuals.

3. Severity of Needs: The third prioritization criterion will expedite placement into housing for individuals with the most severe medical and service needs who are at greater risk of death. This score would be based on questions 1-27 of the VI-SPDAT version 3, with a maximum score of 15 for single individuals and 20 for families.

In response to community need, the CoC has developed resources to address the needs of people experiencing homelessness in specific conditions.

- An individual or household fleeing domestic violence or human trafficking will be prioritized for a program meeting the specific needs of survivors of domestic violence or trafficking.
- Similarly, veterans are identified early in the assessment process and their housing needs are met through the Supportive Services for Veteran Families (SSVF), a VA-funded program designed to house them. In these cases, the same prioritization factors listed above are applied to determine the most vulnerable veterans and connect them with housing and services.

Prioritization List

All assessed persons and households are added the By Name List (BNL). The HMIS Lead Agency filters the BNL for persons and households based on the prioritization factors listed above as well as conditions of the available housing resource such as domestic violence, age, and veteran status. This list is reviewed and updated weekly to ensure all recent client additions and client housing placements are captured accordingly.

In addition to an active list, the HMIS Lead Agency maintains an inactive list, defined in further detail below.

Active Status on the BNL

People who stay one night or longer at an emergency shelter (ES) or unsheltered situation and are currently enrolled in an ES or an outreach program or have been within the last 90 days will be included on the BNL.

Inactive Policy

The Inactive Policy is a critical component of maintaining a real-time BNL as well as a robust CES. To ensure an efficient assessment and referral process, it is important to ensure that the CES Navigators and Outreach teams can contact and connect with households as soon as a housing opportunity is available, and that households are still actively in need of housing assistance. Without this policy, the CES can experience delays in its referral procedures due to the time spent

searching for households in the community who they have not been able to reach through multiple attempts, often for many months. In some situations, these households may have self-resolved their housing crisis or relocated to another area.

If a household has had no contact with any CE Access Points, System Navigators and/or Community Outreach for 180 days (6 months), AND they have had no services or shelter stays in HMIS for the past 90 days (3 months), the household will be removed from the Active List and placed on the Inactive List.

For our Veteran population, the no contact threshold to remove a client form the active list is 90 days (3 months). We coordinate with our VA team members to access their HOMES and Remote Data Systems to see if the veteran has relocated or has accessed any other VA services locally. If a signed ROI was in place at the time the Veteran was moved to the Inactive List, our local VA team will provide any pertinent information available.

If a household on the inactive list makes contact with the homeless system including outreach workers, drop-in centers, shelters, etc. and they are experiencing literal homelessness, they are moved from inactive to active status and returned to the BNL.

Special Populations

Chronically Homeless

The definition of "chronically homeless" currently in effect for the CoC Program is that which is defined in the CoC Program Interim Rule at 24 CFR 578.3, which states that a chronically homeless person is:

(a) An individual who
a. Is homeless and lives in a place not meant for habitation, a safe haven, or in an emergency shelter
b. 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
c. Currently diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments resulting from brain injury or chronic physical illness
(b) 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 the criteria outlined in section (a)
(c) 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 the criteria in section (a), including a family whose composition has

fluctuated while the head of household has been homeless.

Domestic Violence/Human Trafficking

HUD Definition, Criteria for Defining Homeless, Category 4

(4) Any individual or family who:
(i) Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence;
(ii) Has no other residence; and
(iii) Lacks the resources or support networks, e.g., family, friends, and faith-based or other social networks, to obtain other permanent housing.

See pages 8 and 9 for domestic violence shelter contact info, available 24/7.

People who are currently fleeing domestic violence and human trafficking along with those who have previously experienced domestic violence and/or human trafficking require a path through the CES that promotes and protects their confidentiality and safety. The following procedures are incorporated into the Northeast Florida CES to protect the safety of every person and household impacted by domestic violence.

In Northeast Florida there are two sets of protocols.

DV Provider Protocol

- There are several Domestic Violence (DV) Shelters in Northeast Florida. Survivors of Domestic Violence in current danger who are entering a DV shelter are screened using a tool specific to the single agency providing that service in Clay, Duval or Nassau counties. For the safety of those individuals and/or families who are fleeing or attempting to flee domestic violence, referrals are made to programs identified as victim service providers for assistance whenever those services are immediately available and desired by the household.
- A client fleeing or attempting to flee domestic violence, dating violence, and/or human trafficking must be offered a choice to have their personally identifiable data entered into the comparable database conventionally or have it entered anonymously. Existing entries can be de-identified if a client’s status changes to fleeing and they are already in the HMIS.

Non-DV Provider Protocol

- If a non-victim service provider becomes aware that a household being served is fleeing or attempting to flee violence, the provider should: 1. Offer the household a warm handoff/referral to a victim services provider; and 2. Check HMIS to see if there is an existing record. Follow safety protocols and client choice.
- Non-DV providers may use HMIS and directly enter information while following protocol to lock the Applicant's file and other measures in place for safety and confidentiality. HMIS files of all Applicants presenting as survivors of domestic violence are locked in HMIS so that they can only be seen by the Coordinating Entities for the purpose of matching the household to a housing and/or service intervention.

Veterans

Veterans experiencing literal homelessness in FL-510 CoC will quickly move into permanent housing through a coordinated process that links them with customized interventions based on individual needs.

This system will:

- Provide low-barrier, low-threshold points of entry that take into consideration transit issues, regional preferences, and other barriers to access experienced by the Veteran population.
- Be person-centered, as evidenced by a consistent respect for consumer choice, safety, and cultural preferences.
- Be flexible enough to respond to changing needs and evolve as the system standardizes best practices.
- Utilize a consistent assessment tool across all points of access. The assessment will be made available via multiple methods, such as over-the-phone and in-person.
- Rely on the HMIS as a centralized and accurate database that has real-time availability of resources.
- Reduce barriers by increasing program accessibility, limiting restrictive program criteria and turnaways, and focusing on matching the veteran in need to the right resources.
- Coordinate with other systems of care, locally and regionally, including but not limited to the health care system and the criminal justice system.

Drop-In Centers

The following drop-in centers are available to any person who served in the active military who is experiencing homelessness. Appointments are not needed. Veterans should be encouraged to drop in to complete an assessment so that they can be connected to a permanent housing provider if they have not completed an assessment within the last six months.

Urban Rest Stop (IM Sulzbacher)
611 E. Adams St
Jacksonville, Fl. 32202

Monday-Friday, 7:30 am – 4 pm

Community Resource and Referral Center (CRRC)
605 W. Beaver St.
Jacksonville, Fl. 32202
Monday-Friday, 8:00 am – 4:30 pm

Clara White Mission
613 W. Ashley St.
Jacksonville, Fl. 32202
Monday-Friday, 7am – 11am (closed 11-12) 12 pm – 3 pm

Youth/Young Adults

Unaccompanied Youth and Young Adults are defined as youth (ages 13-17) and young adults (ages 18-24) who are unaccompanied by a parent or guardian and are without shelter where appropriate care and supervision are available, whose parent or guardian is unable or unwilling to provide shelter and care, or who lack a fixed, regular and adequate nighttime residence. Undocumented unaccompanied youth and young adults may also be served under these provisions except where exclusions are noted.

The Department of Health and Human Services Administration for Children, Youth and Families emphasizes that youth who run away from home are often mistakenly portrayed as juvenile delinquents. In contrast, such behaviors often reflect society's failure to develop adequate support, which includes homeless services. Unaccompanied youths are one of the fastest growing and most underserved sub- populations, in our community. In addition, it is important to note that Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex, as well as African American youth and young adults are disproportionately impacted when compared to other groups.

Youth/Young Adults fleeing family violence may qualify for domestic violence (DV) funding programs under the revised DV definition. See Domestic Violence/Human Trafficking definition on pages 21 and 22.

JASMYN (Jacksonville Area Sexual Minority Youth Network)
651 Chelsea ST
Jacksonville, FL 32204
Monday-Friday, 9am – 5pm

Youth Crisis Center (YCC)
3015 Parental Home Rd,
Jacksonville, FL 32216
Monday-Friday ??

Referral

Clients who are assessed and prioritized will be added to the BNL and referred to appropriate resources. To the greatest extent possible, referrals should be person-centric, not program-centric (i.e., the end result will not always be PSH placement, but rather to match a highly vulnerable person to another appropriate housing resource). Individuals and agencies making referrals will make every effort to consider the individuals strengths, goals, risks, lived experiences, and choices in the referral process.

All individuals and families seeking permanent housing resources must be referred through CES. To be connected with these housing resources, an individual or family must:

1. Complete a Housing Needs Assessment at a Coordinated Entry Access Point
2. Connect with outreach or shelter staff to complete the appropriate Assessment:
    a. VI-SPDAT (Individuals)
    b. F-VI-SPDAT (Families)
    c. Y-VI-SPDAT (Youth)
3. Obtain documentation required by housing program.

Weekly Prioritization Team Meetings (formerly known as Case Conferencing Meetings)

The Weekly Prioritization Team meetings are held to connect prioritized individuals and families experiencing homelessness to housing resources and will address the needs of high-risk individuals and those where the assessment process did not reveal the full depth and/or urgency of their situation. The meetings will be attended by representatives from the CoC Lead Agency, the HMIS Lead Agency, and agencies funded with CoC, ESG, TANF, Challenge Grant, and other federal, state, and local funds (this includes all housing and shelter providers). Case managers, housing coordinators, street outreach workers, and shelter staff should attend these meetings to facilitate the housing process. Agencies funded through one of the aforementioned funding programs MUST attend each appropriate Weekly Prioritization Team meeting. In the context of the CE process, determining eligibility is a project-level process governed by written standards as established in 24 CFR 576.400(e) and 24 CFR 578.7(a)(9).

The notes and services for all households will follow the general outline for referrals as described below and will be time-stamped in HMIS:

Housing Agency Requests Referrals

- As housing units become available, agencies with the available housing units are responsible for contacting the CE Lead Agency and the CE Manager and requesting a list of eligible referrals from the BNL. The programs will provide all relevant details to help the CE Lead Agency and CE Manager ensure eligible households are referral appropriately (e.g., housing unit is available for a veteran or a family).

- Based upon the information provided by the Housing Agency, the CE Manager creates a list of eligible referrals from the BNL. This list goes to the CE Lead Agency to contact households for referral. Once a household is contacted and interested in the housing unit, eligibility is confirmed and the household is sent, along with the appropriate documentation, to the Housing Agency with the open unit.

Housing Agency Receives Referral from CE Lead Agency:

- Agency or Program Supervisor receiving the CE referral will review information within 2 business days upon receipt and assign to appropriate Case Manager.
- Case Manager will make contact with the household to schedule a program intake appointment within 2 business days of receiving referral.
- If Case Manager is unable to make contact after 3 documented attempts, they will notify Program Supervisor who will contact Intake Specialists/Navigators within 1 business day.
- Navigators will place referral back at the top of the BNL and contact outreach teams to assist with locating referral. At this point a new referral will be issued to program to fill vacancy.
- Case Manager will meet with the referred household and complete program enrollment to begin services.
- If referral is NOT appropriate for program, Case Manager will notify Program Supervisor immediately and Program Supervisor will notify the Intake Specialist/Navigator within 72 hours (3 days) through HMIS and through an email, including a reason why the referral is not appropriate.
- Case Manager will notify Program Supervisor of program enrollment. Program supervisor will notify, through HMIS and by email, Intake Specialists/Navigators of program enrollment within 72 hours.
- For housing programs, Case Manager will work to house individual and/or family within 30 days upon receipt of referral.
- Once housed, the CE Lead Agency will exit the client from Coordinated Entry in HMIS.

CE processes incorporate mechanisms for determining whether potential participants meet project-specific requirements for which they are prioritized and to which they are referred. The assessment process cannot require disclosure of specific disabilities or diagnosis. Specific diagnosis or disability information may only be obtained for purposes of determining program eligibility to make appropriate referrals. Projects or units may be legally permitted to limit eligibility, e.g., to persons with disabilities, through a federal statute which requires that assistance be utilized for a specific population, e.g., the HOPWA program, through State or local permissions in instances where Federal funding is not used and Federal civil rights laws are not violated.

The CE process must not be used to screen people out due to perceived barriers to housing or services, including, but not limited to:

- Too little or no income
- Active or a history of substance abuse
- Domestic violence history
- Resistance to receiving services
- The type or extent of disability-related services or supports that are needed
- History of evictions, lease violation or lack of leaseholder history
- Criminal records
- Poor credit.

Data Systems

Throughout the CE system, there may be many different types of data and data systems used to collect, manage, and report out on the persons served by CE. Examples of the types of data and data systems that are frequently used are:

- HMIS or comparable database: Often used to collect personally identifiable information (PII) on participants, as well as assessment and referral information.
- Prioritization list: May contain PII on participants and should include information necessary to prioritize and match persons for assistance.
- Housing Inventory Open Units List: Project-level information on the number of beds or units available for referral, as well as project eligibility and location information. Housing Providers/Referral Partners are responsible for weekly updates to ensure this list is accurate and up to date.
- Weekly Prioritization Team notes: Meeting notes from Weekly Prioritization Team meetings will likely include participant names and perhaps other identifying information such as assessment results and referral or location information.

The Northeast Florida CoC uses ClientTrack, web-based software, for its HMIS. ClientTrack collects programmatic information necessary for:

- Tracking client progress through the CES
- Reporting on CES performance
- Planning for CES improvements

Referrals for services are handled in ClientTrack and it facilitates communication between outreach workers, case managers, and CES managers. The foundation for fast and reliable decision-making for the most vulnerable clients lies in timely and useful data entered into ClientTrack.

CES Policy: CE process partners and all participating agencies contributing data must ensure a household's data is secured regardless of the systems or locations where data are collected, stored, or shared, whether on paper or electronically. Additionally, households must be informed how

their data are being collected, stored, managed, and potentially shared, with whom, and for what purpose.

CES Procedure: Households must receive and acknowledge a Client HMIS Agreement (see Appendix 7) form prior to the collection of data for CES. The form identifies what data will be collected, where those data will be stored/managed, how those data will be used for the purposes of helping the participant obtain housing and assistance and for other administrative purposes, and what data will be shared with others (if the participant consents to such data sharing). In addition, the HMIS Agreement should be posted where it can be easily viewed at all access points.

- **COVID-19 Flexibility**: To protect clients during the global pandemic COVID-19 Coordinated Entry phone assessments will secure verbal consent to collection of data for CES. Verbal Consent Form (Client HMIS Agreement) is included in Appendix 7.

CES Policy: Participating agencies must collect all data required for CE as defined by the CoC, including the "universal data elements" (UDEs) listed in HUD's HMIS Data Standards Data Manual.

CES Procedure: All HMIS users must attend training annually. At the training, all attendees will sign an annually updated HMIS User Agreement.

Evaluating Success

CE is one of many processes within our community that addresses the needs of individuals and families at risk of or experiencing homelessness within our communities. The CoC Governance Board, in partnership with the CoC Lead Agency and the Coordinated Entry Committee, will evaluate the effectiveness as well as required HEARTH Act outcomes by utilizing HMIS data.

As recommended by the National Alliance to End Homelessness, the CoC Lead Agency will track progress in the following areas to evaluate the Coordinated Intake and Assessment process:

- ***For purposes of measuring the performance of RRH programs, "enrollment" as recorded in HMIS will begin at "intake," the initial point of engagement with a potential RRH client, not at the final completion of the intake process. "Move-in" will be the date that a client actually begins to live in permanent housing, not when a lease is executed.***
- Length of stay, particularly in shelter: If consumers are referred to the right interventions and those interventions have the necessary capacity, fewer individuals and families should remain in shelter waiting to move elsewhere. Also, if clients are referred immediately to the right provider, over time, clients will likely spend less time jumping from program to program looking for help, which could reduce their overall length and/or repeated episodes of homelessness.
- New entries into homelessness: if every individual and family seeking assistance is coming through the front door to receive it and the front door has prevention and diversion

resources available, more people should be able to access these resources and avoid entering a program unnecessarily.

- Repeat episodes of homelessness: If clients are sent to the intervention the best suited to meet their needs on the first time, families are more likely to remain stably housed.

To track the outcomes summarized above, the CoC Lead Agency will analyze the following Performance Measures annually.

1) Duval, Nassau and Clay County will reduce the number of persons experiencing homelessness.
    a. Reduction in the total number of persons experiencing homelessness
    b. Reduction in the total number of persons experiencing first time homelessness.
2) Duval, Nassau and Clay County will reduce the length of homelessness episodes
    a. Reduction in the mean length of homelessness episode for individuals
    b. Reduction in the mean length of homelessness episode for families with children
    c. Reduction in the mean length of homelessness episode for youth
3) Duval, Nassau and Clay County will reduce the number of persons returning to homelessness.
    a. Reduction in return to homelessness within two years following exit
    b. Increase in exits to permanent housing
    c. Increase in income at exit

Measuring of the success of this system and transparency with the community and providers will be a key to the success of this project. The CoC Lead Agency will summarize the data annually in conjunction with the annual Point in Time homeless census data report.

Moving forward, the CoC Lead Agency will expand the evaluation of outcomes by establishing mechanisms to monitor the quality of service through system-wide monitoring. For example, once a client enters shelter and it is determined that permanent housing is the household's need, an assessment is to be completed within 72 hours. Procedures will be built into the monitoring system to determine how often this goal is met. This will allow for ongoing monitoring of the quality of services and how the program and Providers are able to follow through with this goal.

As part of the evaluation process, as recommended by the National Alliance to End Homelessness, the CoC Lead Agency will set a goal to establish an integrated feedback loop that involves using information gained from these assessments to make any necessary adjustments to the system. For example, if families are being referred to the right program, but the program cannot serve them due to capacity issues while other program types have an increasing number of empty beds, it may

be appropriate to make system-wide shifts in the types of programs and services offered. Additionally, the CoC Lead Agency will continue working to develop data tools to ensure overall system efficiency.

Records and Record Keeping

The purpose of this document is to communicate policy regarding the adherence to records retention requirements as outlined in 2 CFR § 200.333 - Retention requirements for records, 24 CFR § 578.103 - Recordkeeping requirements, The Department of Housing and Urban Development and the General Records Schedule GS1-SL, State of Florida.

24 CFR § 578.103 Recordkeeping requirements state:

- All records pertaining to Continuum of Care funds must be retained for the **greater of 5 years or the period specified below**. Copies made by microfilming, photocopying, or similar methods may be substituted for the original records.
    - Documentation of each program participant's qualification as a family or individual at risk of homelessness or as a homeless family or individual and other program participant records must be retained for 5 years after the expenditure of all funds from the grant under which the program participant was served; and
    - Where Continuum of Care funds are used for the acquisition, new construction, or rehabilitation of a project site, records must be retained until 15 years after the date that the project site is first occupied, or used, by program participants.

All Florida public agencies are eligible to use the GS1-SL, which provides retention periods for the most common administrative records, such as routine correspondence and personnel, payroll, financial and legal records.

- Grant Files, Item #422, This record series documents the activities and administration of grant funded programs, including the application process and expenditure of grant funds. The series may include, but is not limited to, grant applications; notifications to applicants of award or denial of grant funds; contracts; agreements; grant status, narrative and financial reports submitted by recipient agencies; and supporting documentation. For grantor agencies, grant cycle completion has not occurred until all reporting requirements are satisfied and final payments have been received for that grant cycle. For grant recipients, project completion has not occurred until all reporting requirements are satisfied and final payments have been made or received. See also "PROJECT FILES: FEDERAL" and "PROJECT FILES: NON-CAPITAL IMPROVEMENT." These records may have archival value.
- Retention: **5 fiscal years after completion of grant cycle or project, whichever is applicable.** State grantor agencies must contact the State Archives of Florida for archival review before disposition of records. Other grantor agencies should ensure appropriate preservation of records determined to have long-term historical value.

Training

The purpose of the annual CE training is to provide all staff administering assessments with access to materials and training that clearly describe the methods by which assessments are to be conducted with fidelity to the CoC's CE process, including its written policies and procedures.

Data Quality for all HMIS participating agencies will be monitored in accordance with the NE FL CoC Data Quality Plan, which is available on the Changing Homelessness' website. CE training will include:

1. Basic HMIS training including data quality and data security training
2. Advanced HMIS training to include Case Notes and referral process
3. Process for conducting assessments and cultural competency
4. Training in the administration of the VI-SPDAT and Coordinated Assessment for participating agencies
5. A review of the CE Policies and Procedures, which include the requirements for prioritization and referrals

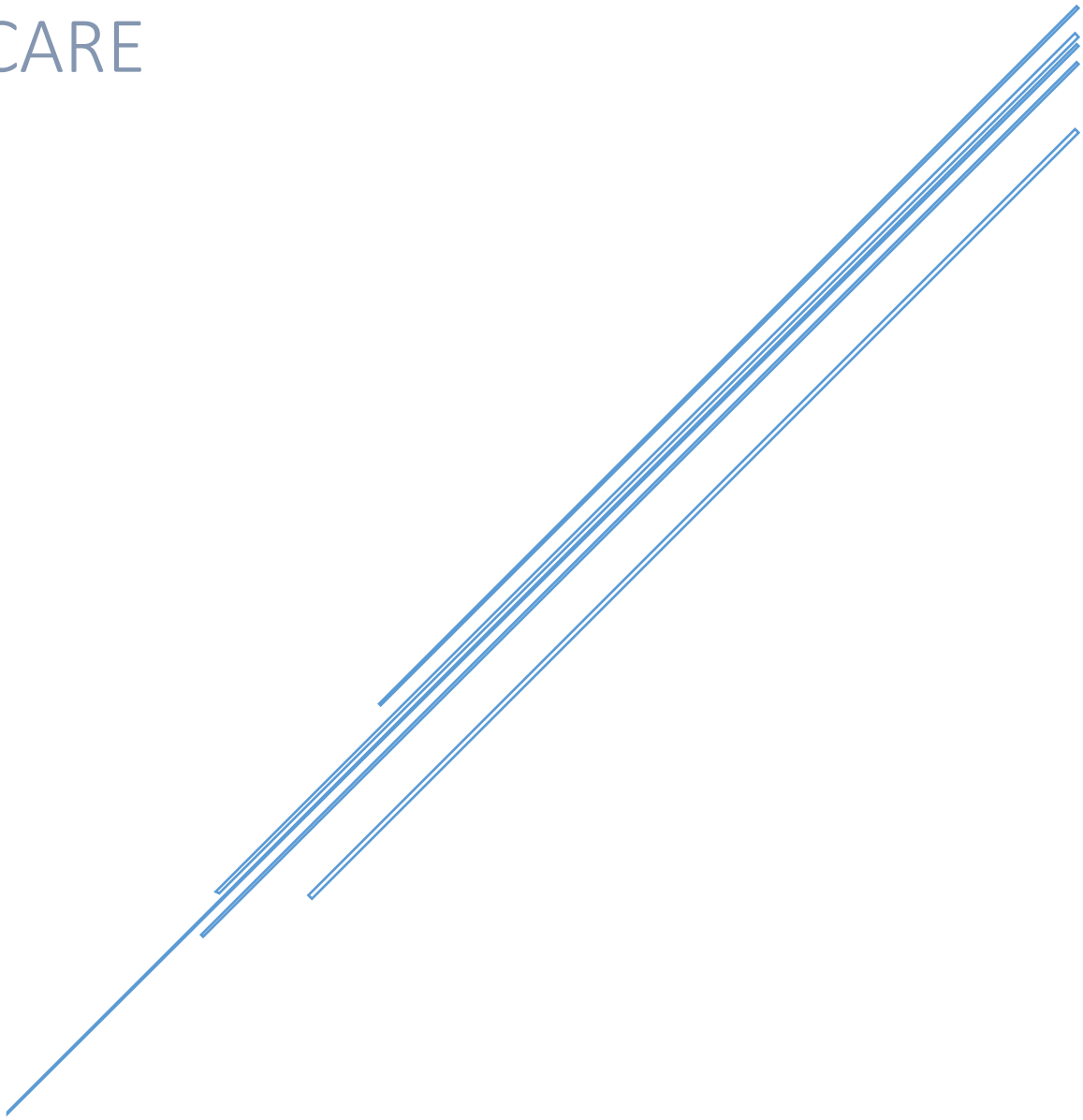
All training is tailored to the individual needs of the service agencies but based primarily on the CES. Training protocols may vary by agency and project type. Each year, the CE Committee will review and update the CES Policies and Procedures, including training programs.

APPENDICES

Appendix 1: COVID-19 Shelter Protocol

As it becomes available, the most recent update of the Protocol will be inserted here.

NORTHEAST FLORIDA CONTINNUM OF CARE



Northeast Florida Continuum of Care, FL-510, COVID-19 Shelter Protocol

Our primary focus is on the health and well-being of the population we serve, our staff members, partner agencies, and stakeholders. As a team, we have developed the protocols below focused on safely continuing essential services to those experiencing homelessness in our community.

Given the fluid nature of this event, our plans are evolving, and will continue to evolve and be modified as needed to best support the community.

1. **Screening to occur as needed. This screening could include staff and volunteers before they enter the shelter/facility.**

Symptoms common to COVID-19 include but are not limited to 1) fever, 2) cough and 3) shortness of breath and can appear 2 to 14 days after exposure.

2. **Person experiencing homelessness has symptoms and is in severe respiratory distress, call 911**

3. **Person experiencing homelessness (sheltered or unsheltered) and is COVID Positive**

Community priority for Person(s) experiencing homelessness is:

i. **COVID-positive/medically stable in hospital**
ii. **COVID-positive/sheltered**
iii. **COVID-positive/unsheltered**

<u>LOCAL HOSPITAL</u>: If a Person/Client presents at a local Hospital and is determined as homeless, the Hospital will provide immediate response to the medical condition.

PLEASE NOTE

- Patient must be homeless (living on the street) prior to hospitalization.
- Patient must test covid positive within the last 72 hours prior to referral.
- Capacity is limited. Please allow up to 24 hours for a reply and confirmation of space availability.
- Complete the Person Under Investigation (PUI) Form and fax to DOH at 904.253.1851

Once stabilized and Patient is deemed MEDICALLY STABLE:

1. Hospital will contact Changing Homelessness via online referral portal.
2. Hospital must confirm proof of positive test within 72 hours of admission and have completed and attached the “Safe to Release” document upon submission. Patients MUST come to facility with 14-day supply of medications in hand
3. If there is space available, you will receive instructions

- For example: "Please transport client to 1234 Main Street no later than 3pm. There will be a staff member waiting to retrieve them from the vehicle. Please review rules with the individual"

4. Coordinate transportation and confirm via email with the shelter coordinator.
   - If a room is not available or person refuses, contact DOH for direction, 904.253.1850.
5. Guidelines outlining the program are stated in the referral. Please review with anyone who is being referred.

If a room is not available or person refuses, contact DOH for direction, 904.253.1850.

<u>COMMUNITY REFERRALS</u> (LOCAL UNSHELTERED OR SHELTERED)

PLEASE NOTE

- Patient must be homeless (living on the street) prior to hospitalization.
- Patient must test covid positive within the last 72 hours prior to referral.
- Capacity is limited. Please allow up to 24 hours for a reply and confirmation of space availability.
- Complete the Person Under Investigation (PUI) Form and fax to DOH at 904.253.1851

1. Community partners will contact Changing Homelessness via online referral portal.
2. Providers must confirm proof of positive test within 72 hours of referral. Tests are to come from the hospital, shelter, or clinic. A link to the suggested testing sites are provided in the referral.
3. If there is space available, you will receive instructions.
   - For example: "Please transport client to 1234 Main Street no later than 3pm. There will be a staff member waiting to retrieve them from the vehicle. Please review rules with the individual"
4. Coordinate transportation and confirm via email with the shelter coordinator.
   - If a room is not available or person refuses, contact DOH for direction, 904.253.1850
5. Guidelines outlining the program are stated in the referral. Please review with anyone who is being referred.

COVID Respite Staff on-site will:

- Input of Patient/Client data into HMIS
- Provide site check-in/welcome kit for Client
- Arrange for food
- Conduct check ins throughout the day
- Escalate emergency transportation request

Emergency Shelter Protocol Agreement

1. _____ _____ _____
   Name Agency Date

2. _____ _____ _____
   Name Agency Date

3. _____ _____ _____
   Name Agency Date

4. _____ _____ _____
   Name Agency Date

5. _____ _____ _____
   Name Agency Date

6. _____ _____ _____
   Name Agency Date

7. _____ _____ _____
   Name Agency Date

8. _____ _____ _____
   Name Agency Date

9. _____ _____ _____
   Name Agency Date

10. _____ _____ _____
    Name Agency Date

NORTHEAST FLORIDA CONTINNUM OF CARE

FL-510 CoC Written Standards
Revised November 2020

PREAMBLE

The Continuum of Care (CoC) is responsible for coordinating and implementing a system to meet the needs of the population and subpopulations experiencing homelessness within the geographic area of Duval, Clay, and Nassau counties. Both the Emergency Solution Grant Rules and Regulations (ESG) and the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Continuum of Care Program Interim Rules state that the Continuum of Care (CoC), in consultation with recipients of Emergency Solutions Grants program funds within the geographic area, (1) establish and consistently follow written standards for providing Continuum of Care assistance, (2) establish performance targets appropriate for population and program type, and (3) monitor recipient and sub-recipient performance.

All programs that receive ESG or CoC funding are required to abide by these written standards. The CoC strongly encourages programs that do not receive either of these sources of funds to accept and utilize these written standards.

The written standards have been established to ensure that persons experiencing homelessness who enter programs throughout the CoC will be given similar information and support to access and maintain permanent housing.

The majority of these standards are based on the ESG and/or the HEARTH Interim Rules. There are some additional standards that have been established by the CoC that will assist programs in meeting and exceeding performance outcomes that will help the CoC reach the goal of ending homelessness.

The Continuum of Care Written Standards will:

- Assist with the coordination of service delivery across the geographic area and will be the foundation of the coordinated entry system
- Assist in assessing individuals and families consistently to determine program eligibility
- Assist in administering programs fairly and methodically
- Establish common performance measurements for all CoC components.
- Provide the basis for the monitoring of all CoC and ESG funded projects

These written standards have been developed to allow for input on standards, performance measures and the process for full implementation of the standards throughout the CoC from the prospective of those organizations that are directly providing homeless housing and services, Emergency Shelter (ES), Transitional Housing (TH), Permanent Supportive Housing (PSH), Rapid Re-Housing (RRH) and Outreach.

The CoC Written Standards have been approved by the CoC and City ESG recipients and providers. The Written Standards will be reviewed and revised as needed at a minimum of once per year. Revisions that would affect the Coordinated Entry process would be made as soon as possible. Agreement to abide by the Written Standards will be a condition of being moved forward for CoC or ESG funding.

COC AND ESG COORDINATION

These written standards have been developed in conjunction with ESG, the CoC Collaborative Applicant and with service providers to allow for input on standards, performance measures and the process for full implementation of the standards throughout the CoC from the prospective of those organization that are directly providing homeless and housing services, Permanent Supportive Housing (PSH), Rapid Re-Housing (RRH), Emergency Shelter (ES), and Transitional Housing (TH). The CoC Written Standards have been approved by the CoC, the County and City ESG recipients. These written standards will be reviewed and revised at least annually. Revisions that would affect the Coordinated Entry process would be made as soon as possible. The Northeast Florida CoC will continue to build upon and refine this document.

HOUSING FIRST MODEL

Irrespective of the program type, all HUD and ESG funded programs are required to utilize a housing first approach to housing assistance. The housing first approach incorporates a model of housing assistance that prioritizes rapid placement and stabilization in permanent housing that does not have service participation requirements or preconditions (such as sobriety or a minimum income threshold). Emergency Shelter, Transitional housing and supportive service only projects may be considered to be using a housing first model if they operate with low-barriers, work to quickly move people into permanent housing, do not require participation in supportive services, and, for transitional housing projects, do not require any preconditions for moving into the transitional housing.

COORDINATED ENTRY SYSTEM

To minimize barriers to housing access and ensure timely placement, all CoC and ESG sub-recipients are required to participate in and receive referrals through Northeast Florida's Coordinated Entry System (CES). Coordinated Entry for Northeast Florida CoC is a hybrid of a decentralized (access points in the three county area), outreach, web-based and telephone based centralized intake model. Initial screening can be conducted for all populations either at one of the intake hot spots, through a Navigator, over the phone or through a web-based component. Coordinated Entry includes the following core components:

- Information so that people will know where or how to access intake for homeless prevention or housing services;
- A screening and assessment process and tools to gather and verify information about the person and his/her housing and service needs and program eligibility and priority;
- Information about programs and agencies that can provide needed housing or services;
- A process and tools for referral of the person to an appropriate programs or agencies; and assistance in making program admissions decisions

While most housing and services are made available through other agencies, a variety of services may be provided on site at the "Access Points" or by a "Navigator". These services typically meet basic client needs and may include diversion services, crisis counseling, landlord/tenant mediation, motel vouchers, JTA bus pass or transportation to an agency and/or access to mainstream resources.

This system ensures that every homeless individual is known by name, provides assistance based on individual's unique needs, and ensure that housing matches are the right fit. Please refer to Northeast Florida CoC Coordinated Entry System (CES) Policies & Procedures for more detailed information.

UNIVERSAL ASSESSMENT

All individuals will be assessed using a comprehensive, universal assessment tool called the Vulnerability Index Service Prioritization Decision Assistance Tool (VI-SPDAT) which is useful for initial triage and entry assessment. This tool guarantees that individuals' levels of need and eligibility determinations are made in an informed and objective manner.

HOMELESS MANAGEMENT INFORMATION SYSTEM

All sub-recipients are required to participate in the Homeless Management Information System (HMIS) per the ESG and CoC Interim Rule (24 CFR 576 and 578). HMIS provides an opportunity to document homelessness and helps to ensure coordination between service providers while avoiding duplication of services and client data.

EQUAL ACCESS TO HOUSING

The Northeast Florida County Continuum of Care non-discriminatory policy, regarding the U.S. Department of Housing and Urban Development (HUD) final rule regarding equal access to Community Planning and Development (CPD) funded programs regardless of sexual orientation, gender identity, and marital status, will ensure that individuals are aware of their rights to equal access to CPD funded programs.

Thus, all CPD funded programs, including Continuum of Care and Emergency Solutions Grant funded programs, must comply with the following requirements:

- Determine client eligibility for housing regardless of sexual orientation, gender identity, or marital status, and must not discriminate against clients who do not conform to gender or sex stereotypes (i.e., because of gender identity).
- Grant equal access to CPD funded programs or facilities consistent with client gender identity, and provide client's family with equal access.
- MUST NOT ask clients to provide anatomical information or documentation (i.e. ID), physical, or medical evidence of gender identity.
- Take non-discriminatory steps when necessary and appropriate to address privacy concerns raised by any residents or occupants.

These requirements are identical to those provided by HUD in a notice for continuums of care to adopt:

https://www.hudexchange.info/resources/documents/Notice-on-EqualAccess-Rights.pdf.

In accordance with the guidance provided by HUD in 24 CFR 5 in the Federal Register, vol. 81, No. 183, all CPD funded programs will

> "Post on bulletin boards and in other public spaces where information is typically made available a notice entitled ''Equal Access regardless of Sexual Orientation, Gender Identity, or Marital Status for HUD's Community Planning and Development Programs."

The post will include the requirements noted above. In addition, all CPD funded programs will adhere to the requirements concerning record keeping in 24 CFR 5, which states that

> "Providers must document and maintain, for a period of 5 years, records of compliance with the requirements of this rule regarding establishing or amending policies and procedures."

PROGRAM REQUIREMENTS FOR ALL PROGAMS

- If programs or agencies do not offer specific services they must coordinate with other targeted homeless services within the CoC that do.
- Program will have to be familiar with the SOAR process and preferably have staff trained in SOAR.
- Programs must coordinate with mainstream resources in the CoC including housing, social services, employment, education and youth programs for which participants may be eligible
- Programs must have written policies and procedures and must consistently apply them to all participants
- Programs that serve households with children:
  - ✓ A staff person must be designated as the educational liaison that will ensure that children are enrolled in school, connected to appropriate services in the community, including early childhood program such as Head Start, Part C of the Individuals with Disabilities Education Act, and the McKinney Vento education services.
  - ✓ The age and gender of a child under age 18 must not be used as a basis for denying any family's admission to a project that provides shelter for families with children.
- Programs receiving ESG and CoC funding must participate in HMIS (Homeless Management Information System), however all homeless programs are strongly encouraged to participate in HMIS.
  - ✓ Programs must meet minimum HMIS data quality standards.
  - ✓ Programs providing Domestic Violence or Legal Services may opt out of HMIS participation but must utilize a comparable database to collect HUD required data elements.
- Programs must participate in the Coordinated Entry System initiative by signing a memorandum of Understanding with the Lead Agency. It will be understood that all housing referrals will be generated through the CE system. If program openings exist programs will be

obligated to accept referrals. Refused referrals with follow the process as indicated in the Coordinated Entry System Policy and Procedures.

- A client is considered enrolled once the service provider engages the client and begins working with them. Regardless of the clients long term outcome a client will be considered in the program and HMIS will indicate the day of engagement as the day enrollment.
- Programs will utilize the Housing First principles regarding the execution of their programs. Although it is expected that each program will have its own variances.
- Program rules and regulations should be designed in the spirit of inclusion rather than as grounds for denial or termination. Programs should exercise judgment and examine all extenuating circumstances in determining when violations are serious enough to warrant termination so that a program participant's assistance is terminated only in the most severe cases.
- Programs must have a formal procedure for terminating assistance to a participant that recognizes the rights of the participant(s) involved. Programs must allow participants the opportunity to dispute termination.
    - ✓ Programs must use judgment and examine all extenuating circumstances in determining that a violation should result in termination
    - ✓ Every effort should be made to allow the participant to remain in the program; termination should only be exercised in the most severe cases.
    - ✓ Termination does not necessarily preclude assistance at a future date
- Programs must make known that use of the facilities and services are available to all on a nondiscriminatory basis
- Programs may not engage in inherently religious activities such as worship, religious instruction or proselytization as part of the programs or services funded under the CoC or ESG. These activities can be conducted but must be separate and voluntary for program participants.

RECORD KEEPING REQUIREMENTS FOR ALL PROGRAMS

- Participant Recordkeeping Requirements include:
    - ✓ All records containing personally identifying information must be kept secure and confidential
        - o Programs must have written confidentiality/privacy notice a copy of which should be made available to participants if requested
    - ✓ Documentation of homelessness (following HUDs guidelines)
    - ✓ A record of services and assistance provided to each participant
    - ✓ Documentation of any applicable requirements for providing services/assistance
    - ✓ Documentation of use of coordinated assessment system
    - ✓ Documentation of use of HMIS
    - ✓ Documentation of Unit inspections
    - ✓ Client leases
    - ✓ Rent calculation worksheets
    - ✓ Rent Reasonableness forms
    - ✓ Records must be retained for the appropriate amount of time as prescribed by HUD
- Financial Recordkeeping Requirements include:

- ✓ Documentation for all costs charged to the grant
- ✓ Documentation that funds were spent on allowable costs
- ✓ Documentation of the receipt and use of program income
- ✓ Documentation of compliance with expenditure limits and deadlines
- ✓ Retain copies of all procurement contracts as applicable
- ✓ Documentation of amount, source and use of resources for each match contribution

OCCUPANCY STANDARDS FOR ALL PROGRAMS

- All housing units, including scattered site programs owned and managed by private landlords, must meet applicable state or local government health and safety codes and have current certificate of occupancy for the current use and meet or exceed the following minimum standards:
  - ✓ Buildings must be structurally sound to protect from the elements and not pose any threat to health and safety of the residents
  - ✓ Must be accessible in accordance with Section 504 of the Rehabilitation Act, the Fair Housing Act and the Americans with Disabilities Act where applicable
  - ✓ Must provide an acceptable place to sleep and adequate space and security for themselves and their belongings
  - ✓ Each room must have a natural or mechanical means of ventilation
  - ✓ Must provide access to sanitary facilities that are in operating condition, private and clean
  - ✓ Water supply must be free of contamination
  - ✓ Heating/cooling equipment must be in working condition
  - ✓ Must have adequate natural or artificial illumination and adequate electrical resources to permit safe use of electrical appliances
  - ✓ Food preparation areas must have suitable space and equipment to store, prepare and serve food in safe and sanitary manner
  - ✓ Building must be maintained in a sanitary condition
  - ✓ Must be at least one smoke detector in each occupied unit of the program; and where possible near sleeping areas. The fire alarm system must be designed for hearing-impaired participants. There must be a second means of exiting the building in case of fire or other emergency.
  - ✓ Environmental Reviews must be conducted on all properties housing permanent supportive housing programs using leasing funds and all rapid rehousing programs.

The Program, Record Keeping and Occupancy Standards as represented above apply to all programs regardless of the type of services/housing that they provide. Below are the minimum standards that apply to each specific component of the homeless system in addition to the above.

PROJECT TYPE DESCRIPTIONS AND OPERATING STANDARDS

EMERGENCY SHELTER PROGRAMS

Emergency shelter programs serve various sub-populations: households with children, individuals male or female, unaccompanied youth, and victims of domestic violence. The level of support services available to participants varies greatly from program to program. The length of stay is generally expected to be less than 30 days (understanding that this the goal/ideal scenario, but may exceed this time); extensions may be granted at some shelters if participants are following through with their case plans.

Access to Emergency Shelter: Information on how to access Emergency Shelter is available 24 hours a day/7 days a week:

Currently, there are multiple entry points into the emergency shelter system. Until full implementation of the Coordinated Entry System individual shelters conduct their own entries

1. **Eligibility criteria:** Participants must meet the HUD definition of homelessness there in lieu of emergency housing. This needs to be taken into consideration in the development of the Coordinated Entry System.

    a. Currently, each individual shelter/program has its own eligibility criteria. At entry, this may be based on the sub-population served, i.e. – age, gender, family composition, severity of behavioral health issues, etc. Once Coordinated Entry System is established all referrals to shelters and assessment for type and level of services will come through that system.
    b. DV programs will be exempt from participating in the coordinated entry system due to issues of confidentiality.
2. **Minimum standards**

    a. Minimum hours of operation 8PM – 7AM
    b. Staff supervision whether paid or volunteer must be provided during hours of operation of program
    c. Provide a minimum of one meal per day
    d. A minimal amount of personal information must be collected to establish a daily client roster to be kept in case of emergency and/or building needs to be evacuated
        i. At intake each participant shall be informed of evacuation procedures.
        ii. Maps/diagrams of exits should be prominently placed throughout the facility

Minimum performance benchmarks for ES projects

- Average length of stay is less than 35 days

- 50 % of participants exit with a successful housing outcome[3]
- And/or 30% of participants exit to permanent housing
- Less than 30% of participants exit to an unknown location
- 60% of participants exit with/linked to cash income
- 60% of participants exit with/linked to non-cash resources

TRANSITIONAL HOUSING PROGAMS

Transitional Housing (TH) facilitates the movement of homeless individuals and families to permanent housing within 24 months of entering TH.

1. **Shared eligibility criteria:** Currently, each individual shelter/program has its own eligibility criteria. At entry, this may be based on the sub-population served, i.e. – age, gender, family composition, severity of behavioral health issues, etc.

    a. Participants must meet the HUD definition of homelessness
    b. Participants will generally have a minimum of 6-9 identified barriers to accessing/retaining permanent housing
    c. Once Coordinated Entry System is established all referrals to shelters and assessment for type and level of services will come through that system.

2. **Minimum standards**

    a. Maximum length of stay cannot exceed 24 months
    b. Assistance in transitioning to permanent housing must be provided
    c. Support services must be provided throughout the duration of stay in transitional housing
    d. Program participants in transitional housing must enter into a lease agreement for a term of at least one month. The lease must be automatically renewable upon expiration, except on prior notice by either party, up to a maximum term of 24 months
    e. Accessing Transitional Housing Programs (until Coordinated Entry System is in place)
    f. TH programs will screen potential participants using the common assessment form
    g. All referrals for TH programs will come through the Coordinated Entry System
    h. Each TH program in the CoC will provide accurate and up-to-date information on eligibility criteria for the program; i.e. – gender specific, individuals/families

Minimum Performance Benchmarks for TH projects

- 80% or more of all participants will exit to a permanent housing situation
- 54% or more of adult participants will have income from sources other than employment
- 56% or more of all participants have mainstream (non-cash) benefits at exit from program

[3] Successful housing outcome for Emergency Shelter participants could be permanent housing or transitional housing for former homeless persons; living with family or friend as permanent tenure; owned or rental by client with or without subsidy; psychiatric facility; substance abuse or detox facility.

- 20% or more of adult participants have employment income
- 20% or more of participants will increase employment income
- 54% or more of adult participants will increase income from all sources

RAPID RE-HOUSING (RRH) PROGRAMS

In North Florida, Rapid Re-Housing is a critical strategy for ending homelessness for individual or families with children due to the extreme shortage of affordable housing. Rapid Re-housing programs in the North Florida continuum should provide housing relocation and stabilization services and short or medium term rental assistance as needed to help a homeless individual or family move as quickly as possible to permanent housing and achieve stability in that housing.

- **Target groups:** Funding should be directed to "Targeted Groups" as determined by the Continuum's gaps analysis, the annual homeless count and data collected through HMIS.

1. **Evaluating eligibility for assistance**

    a. Homeless per federal definition 1 or 4
    b. Income <30% AMI (ESG, SSVF and any other program that requires an income criteria
    c. Produce required documents at intake and assessment :
        i. Two forms of Identification (at least one photo ID, per attached list of acceptable forms of identification). If accepting non-government-issued or other alternate identification, RRH programs will allow 30 days for participants to obtain government-issued photo ID, and will provide support in this process if necessary.
        ii. Documentation of Homelessness per definition 1 or 4 (see "Homeless Definition," attached)
        iii. Income verification
            1. Bank Statements (If income is Direct Deposit—3 months of statements)
            2. If employed, three most recent pay stubs (both spouses if applicable)
            3. Social Security Statements (or Award Letter if SS recently awarded)
            4. VA Award Letter (if applicable)
            5. General Assistance Paperwork & Food Stamp Verification (if applicable)
            6. Student Loan and/or Child Support documentation (if applicable)
            7. Documentation of Legal Cash Income (e.g., letters)
            8. Verification of other regular income
        iv. Credit report (if available)

    d. Eligibility screening: Assess for tier placement on RRH through Intake & Assessment through a certifiable "Navigator"

e. Comprehensive Assessment: Use most recent version of the Service Prioritization Decision Assistance Tool (SPDAT) for case management evaluation and assessment

2. Coordination with other providers

a. Coordinated Entry
    i. Universal prescreening for Rapid Re-Housing with local assessment (under development) & referral through the MHRC Navigators
    ii. All RRH providers will work with MHRC to receive prescreened referrals, and will work with MHRC to best address client needs. CES referrals will be made according to known availability. RRH programs will accept prescreened referrals from CES for further assessment; if a referral is turned away or no slots are available, clients will be offered the attached common grievance procedure.
b. Street Outreach
    i. Outreach workers will refer people on the street into MHRC / Navigators as quickly as possible, prescreen them for RRH as possible, and assist them to make linkage with RRH provider.
c. Prevention & One-time Financial Assistance providers
    i. Assess households seeking assistance for homeless vs. at risk housing status. If homeless, prescreen for RRH with SPDAT screening tool and refer through MHRC to a Rapid Re-Housing program.
    ii. RRH providers will collaborate with agencies providing one-time assistance, for one-time assistance or deposit assistance, (e.g., SNAP Program, ESG, SSVF, etc.).
d. Shelter providers
    i. Prescreen for Rapid Re-Housing with local MHRC screening tool (under development) & refer as appropriate.

3. Determining and prioritizing accepted clients vs. other forms of assistance

a. Each adult referred will be assessed, using most recent version of SPDAT
b. RRH providers will from the viewpoint of screening people *in* rather than out. In doing so they commit to being good stewards of the funds, acting in the best interest of the client, and with transparency regarding the limits of the program.
c. Families and individuals who cannot be assisted within regulatory guidelines will be routed to shelter and permanent supportive housing, or transitional housing

4. Determining what percentage or amount of rent and utilities costs each program participant must pay

a. Each RRH program should have a written standard on how they are going to determine how much rent a participant will be required to pay. The standards should comply with the policy set forth by the funder or should be part of the policy and procedures of the program.

5. **How long a particular program participant will be provided with rental assistance**

    a. Typical length of assistance: 12 months
    b. Extensions may be approved up to 24 months
    c. Each program provider should have a standard for when exit for when a participants can re-enroll or apply for the program once assistance have been given.

6. **Whether and how the amount of assistance will be adjusted over time**

    a. Income assessed quarterly and assistance adjusted up/down so participant pays a% of current household income per HUD guidelines or the program guidelines

7. **Occupancy standards**

    a. All housing units, including scattered site programs owned and managed by private landlords, must meet applicable state or local government health and safety codes and have current certificate of occupancy for the current use and meet or exceed the following minimum standards:
        i. Buildings must be structurally sound to protect from the elements and not pose any threat to health and safety of the residents
        ii. Must be accessible in accordance with Section 504 of the Rehabilitation Act, the Fair Housing Act and the Americans with Disabilities Act where applicable
        iii. Must provide an acceptable place to sleep and adequate space and security for themselves and their belongings
        iv. Each room must have a natural or mechanical means of ventilation
        v. Must provide access to sanitary facilities that are in operating condition, private and clean
        vi. Water supply must be free of contamination
        vii. Heating/cooling equipment must be in working condition
        viii. Must have adequate natural or artificial illumination and adequate electrical resources to permit safe use of electrical appliances
        ix. Food preparation areas must have suitable space and equipment to store, prepare and serve food in safe and sanitary manner
        x. Building must be maintained in a sanitary condition
        xi. Must be at least one smoke detector in each occupied unit of the program; and where possible near sleeping areas. The fire alarm system must be designed for hearing-impaired participants. There must be a second means of exiting the building in case of fire or other emergency.

8. **Limits on the homelessness prevention or rapid re-housing assistance**

    a. Maximum amount of assistance
        i. Determined by Fair Market Rent of appropriate-sized unit for Household
        ii. Fair Market Rent x 24 months lifetime maximum
    b. Maximum number of months the program participant receives assistance

i. Assistance approved in 3-month increments, with reassessment every 90 days.
ii. Average rental assistance to be 12 months.
iii. Extensions can be approved up to 24 months

c. Maximum number of times the program participant may receive assistance
    i. Twice, the original enrollment and no more than one return enrollment.
        1. Reason: Repeated returns to homelessness indicate Tier 4 challenges are impacting participant's life; household should be referred to permanent supportive housing with more services.

Minimum performance benchmarks for RRH projects

- 80% or more of participants will exit to permanent housing
- 35% or more of adult participants will increase income from sources other than employment
- 40% or more of adult participants have employment income
- 40% or more of adult participants increase employment income
- 50% or more of all participants have mainstream (non-cash) benefits at exit from program

PERMANENT SUPPORTIVE HOUSING PROGRAMS

Both the Emergency Solution Grant Rules and Regulations (ESG) and the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Continuum of Care Program Interim Rules state that the Continuum of Care establish and consistently follow written standards for providing Continuum of Care assistance.

Permanent Supportive Housing (PSH) is community-based housing that provides tenants with the rights of tenancy and links to voluntary and flexible supports and services for people with disabilities who are experiencing homelessness without a designated length of stay.

1. PSH Eligibility Criteria

a. Participants must meet the HUD definition of homelessness.
b. PSH can only provide assistance to individuals with disabilities and families in which at least one adult or child has a disability of long duration, verified either by Social Security or a licensed professional that meets the state criteria for diagnosing and treating that condition.

2. Documentation Standards

a. Documentation must be included in the case file, and/or scanned into the HMIS client record that demonstrates PSH eligibility as per HUD program contract and the HEARTH Act.

3. Prioritization Criteria

a. All referrals for PSH must come through the Coordinated Intake System.
b. Referrals for available PSH will be made according to the highest SPDAT scored person on the waiting list for PSH.

4. Occupancy Standards

a. All housing units, including scattered site programs owned and managed by private landlords, must meet applicable state or local government health and safety codes and have current certificate of occupancy for the current use and meet or exceed the following minimum standards:

    i. Buildings must be structurally sound to protect from the elements and not pose any threat to health and safety of the residents
    ii. Must be accessible in accordance with Section 504 of the Rehabilitation Act, the Fair Housing Act and the Americans with Disabilities Act where applicable
    iii. Must provide an acceptable place to sleep and adequate space and security for tenants and their belongings
    iv. Must provide access to sanitary facilities that are in operating condition, private and clean
    v. Water supply must be free of contamination
    vi. Heating/cooling equipment must be in working condition
    vii. Must have adequate natural or artificial illumination and adequate electrical resources to permit safe use of electrical appliances
    viii. preparation areas must have suitable space and equipment to store, prepare and serve food in safe and sanitary manner
        1. Must be at least one smoke detector in each occupied unit of the program; and where possible near sleeping areas. The fire alarm system must be designed for hearing-impaired participants. There must be a second means of exiting the building in case of fire or other emergency.

5. Minimum Standards

a. All PSH programs will utilize a housing first approach; a housing first approach allows eligible homeless individuals and families to enter the project without barriers, such as income or sobriety requirements, or service participation requirements.
b. There can be no predetermined length of stay for a PSH program.
c. Supportive services designed to meet the needs of the program participants must be made available to the program participants throughout the duration of stay in PSH.
d. Program participants in PSH must enter into a lease agreement for an initial term of at least one year. The lease must be automatically renewable upon expiration, except on prior notice by either party.
e. Turnover beds in all PSH projects will be prioritized for the chronically homeless.

f. Each PSH program in the CoC will provide accurate and up-to-date information on eligibility criteria for the program; gender specific, individuals/families, etc.
g. Programs must meet minimum HMIS data quality standards
h. Programs should utilize the SPDAT in development of client Service plans.

6. Written standards for termination of Assistance

a. All programs that offer housing assistance to individuals or families funded by the Continuum of Care must provide a written explanation of a tenant's rights and responsibilities that includes an explanation of program requirements and the consequences and appeal rights should a violation occur. The violation notification must be provided in writing to the participant with an accompanying right to an independent hearing (where the review officer is not directly involved in the program administration) to review the program's decision to terminate assistance to the recipient. Written notification of the outcome of the hearing/final decision will be provided within thirty (30) days of the conclusion of the hearing.

Minimum performance benchmarks for PSH projects

- 80% or more of participants remain stable in PSH for at least one year or exit to permanent housing
- 35% or more of adult participants will increase income from sources other than employment
- 20% or more of adult participants have employment income
- 20% or more of adult participants increase employment income
- 50% or more of all participants have mainstream (non-cash) benefits at exit from program

SUPPORTIVE SERVICES ONLY PROGRAMS

Under the HEARTH Interim Rule Supportive Service Only (SSO) is one of the eligible program components. SSO projects are projects that provide services to persons experiencing homelessness that are not tied to specific housing units.

1. Shared Eligibility Criteria

a. Participants must meet the HUD definition of homelessness

2. Minimum Standards

a. Support services provided must focus on:
   i. Getting participants housed
   ii. Linking participants to mainstream benefits and resources
   iii. Maintaining benefits which the participant is eligible for

b. Street Outreach Programs

i. Engagement (pro-active activities to find and engage persons experiencing homelessness)
ii. Address/provide basic survival items (blankets, gloves, socks, personal care items, etc.)
iii. Provide assistance with navigating system/link to services
iv. Assist with obtaining housing
v. Outreach is a collaborative effort - Must participate in WNY Coalition for the Homeless Outreach Committee
vi. Minimum Safety Measures
    1. A minimum of two outreach workers must be available to go out
    2. Must always have charged cell phone and answer immediately if called
    3. Must sign in/out and include locations that will be visited with approximate times
    4. Try to be aware of possible gang activity for personal safety reasons and to alert homeless contacted (particularly homeless youth) to them

3. Urban Rest Stop: (Should not be used as an emergency shelter)

a. Engagement activities
b. Address/provide basic survival items (blankets, gloves, socks, personal care items, etc.)
c. Provide assistance with navigating system/link to services
d. Assist with obtaining housing
e. Transportation
f. Provide a low demand environment
g. Provision of basic needs (laundry, shower, snacks, clothing, etc.)
h. Provide social supports (informal counseling by staff, peers, etc.)
i. Co-location of other service providers
j. Can be used as jail diversion for small offenses (sleeping in public place, trespassing, etc.)
k. Minimum Safety Measures
    i. A minimum of two staff must be present while open
    ii. Must have a working phone available
    iii. Participants must sign in/out

4. Access to SSO Programs

a. Accessing SSO Programs for legal services may be through Coordinated Entry, direct access at the legal services organization, or through referral from housing/providers.
b. Participants may also access drop-in center or outreach services directly (help with wording)

Minimum Performance Benchmarks for SSO programs

- 80% or more of all participants who are determined eligible will exit to a permanent housing situation
- 54% or more of adult participants will have income from sources other than employment
- 56% or more of all participants have mainstream (non-cash) benefits at exit from program
- 20% or more of adult participants have employment income
- 20% or more of participants will increase employment income
- 54% or more of adult participants will increase income from all sources

PREVENTION AND DIVERSION PROGRAMS

According to the National Alliance to End Homelessness many people seeking homeless assistance still have an opportunity to remain in their current housing situation, whether it's their own housing or the housing of a friend, relative, acquaintance or coworker. In light of this; prevention and shelter diversion are key interventions in the fight to end homelessness.

Immediate screening for these possibilities at entry is an important tactic, and can preserve emergency beds for households that truly have nowhere else to go. Access to rental subsidies and case management at entry is often enough to ensure the household successfully remain housed.

While prevention and diversion are two separate concepts, they are utilized almost interchangeably in this strategy, as they both focus on preventing homelessness. Prevention targets people at imminent risk of homelessness, diversion targets people as they are applying for entry into shelter, and rapid re-housing targets people who are already homeless.

Once households enter into the system, they should be assessed to determine what housing needs they have. The following list includes some, but not all risk factors that may be considered when determining imminent risk of homelessness:

- Three day eviction notice (including housing provided by family and friends).
- Discharge from an institution (including prisons, mental health institutions, hospitals)
- Residency in housing that has been condemned by housing officials and is no longer meant for human habitation.
- Pending foreclosure of rental housing.
- Sudden and significant loss of income.
- Sudden and significant increase in utility cost.
- Mental health and/or substance abuse issues.
- Physical disabilities and other chronic health issues including HIV/AIDS.
- Severe housing cost burden.
- Homeless in last 12 months.
- Young head of household (under 25 with children or pregnant).
- Current or past involvement with child welfare, including foster care.

- Extremely low income (less than 30% of AMI).
- High overcrowding (the number of persons exceeds health and or safety standards for housing unit size).
- Loss of employment.
- Loss or delay of some form of public benefit.
- Victimization by criminal activity.
- Natural disaster.
- Recent traumatic life event, such as death of a spouse or primary care provider or recent health crisis that prevented the household from meeting its financial responsibilities.
- Credit problems that preclude obtaining of housing, or
- Significant amount of medical debt.

Some applicants may not be a good candidate for diversion programs due to a lack of safe and appropriate housing alternative and require immediate admittance to shelter, e.g. client fleeing domestic violence. A client's safety should always be the top consideration when developing an individual/household referral program.

To determine which households are appropriate for prevention/diversion, Navigators can ask applicants a series of questions during the assessment, such as those delineated below:

Prevention Client:

Clients who are being referred for prevention will be asked:

- What emergency has occurred in the last 2-3 months that has caused the client to be unable to pay essential housing expenses?
- Has the client had a recent reduction in household income or unplanned increase in essential living expenses?
- Is the lease or bill in the name of the person applying for assistance?
- If the client owes rent—have they received a three day eviction notice?
- If the clients owes utilities—have they received a disconnection notice or have the utilities been disconnected?
- What assistance does the client need?
    - What is the total amount owed and how many months is the client behind in rent?
    - Utilities: What is the total amount owed and how many months is the client behind?
    - Rent deposit: What is the amount due for a deposit?
    - Utilities: What is the amount due for utilities deposit?
    - Mediation to resolve family issues?

Prevention Providers:

Candidates for referrals for prevention providers will be at imminent risk of homelessness AND meet the following threshold:

- Client must have had an event within the last 2-3 months that has caused the client to be unable to pay essential housing expenses
- Client has a recent reduction in household income or unplanned increase in essential living expenses.
- Client has a double bill; we do not pay current bills.
- The lease/bill is in the name of the person applying for assistance (or other adult living in the household.

Diversion Client:

Clients who are being referred for diversion will be asked:

- Where did you sleep last night? If they slept somewhere safe where they could potentially stay again, this might mean they are good candidates for diversion.
- What other options do you have for the next few days or week? Even if there is an option outside of shelter that is only available for a very short time, it is worth exploring if this housing resource can be used.
- (If staying in someone else's housing) What issues exist with you remaining in your current housing situation? Can those issues be resolved with financial assistance, case management, etc.? If the issues can be solved with case management, mediation, or financial assistance (or all of the above) diversion is a good option.
- (If coming from their own unit) Is it possible and safe to stay in your current housing unit? What resources would you need to do that (financial assistance, case management, mediation, transportation, etc.) If the individual or family could stay in their current housing with some assistance, systems should focus on a quick prevention-oriented solution that will keep the individual or family in their unit.

Diversion Providers:

Candidates for referrals for diversion providers will be at imminent risk of homelessness AND meet the following threshold:

- No appropriate subsequent housing options have been identified.
- The housing lacks the financial resources to obtain immediate housing or remain in its existing housing.
- The household lacks support networks needed to obtain immediate housing or remain in its existing housing.

Minimum performance benchmarks for HP projects

- A reduction in the number of homeless individuals and families seeking emergency shelter services. b. Expected Outcome.
- At least 35% of participants assisted will remain in permanent housing six (6) months after the last assistance.

Appendices

1. ESG-CV Addendum
    a. Per the State of Florida ESG-CV Written Standards, “Given the fluid nature of the COVID-19 pandemic and continuing guidance from HUD regarding ESG-CV funding, there may be a need to develop additional updates to these policies and procedures.”

ESG-CV PROJECT TYPE DESCRIPTIONS AND OPERATING STANDARDS

In April 2020, the community began meeting weekly to develop a response to the COVID-19 crisis. Our primary focus is the health and well-being of the population we serve, our staff members, partner agencies, and stakeholders. As a team, we developed the COVID-19 Shelter Protocol. Given the fluid nature of this event, our plans are evolving, and will continue to evolve and be modified as needed to best support the community in **preventing, preparing and responding to COVID-19.**

ESG-CV Funded Activities:

- **COVID-19 Non-Congregate Shelter, activities provided through January 31, 2022**
- **Street Outreach**
- **Homelessness Prevention**
- **Rapid Rehousing, activities limitations – limited to 3-12 months instead of 3-24**

ESG-CV Provider Agencies and Mainstream Housing and Service Agencies will meet bi-monthly to review progress and identify areas where coordination is not working. If the need increases we would adjust to meeting weekly if necessary.

All ESG-CV funded agencies will enter into an MOU with key goals, commitments and our shared vision documented.

Waivers – "HUD has allowed a range of Waivers, and Alternative Requirements for the Emergency Solutions Grants (ESG) Program Under the CARES Act, as part of the ESG-CV Notice release on September 1, 2020. Written standards will be updated as clarification and guidance is provided by the state.

Eligibility criteria: Homeless Status – Program Entry. In order for a household to receive services through ESG-CV, the household must meet **ONE** of the following conditions:

- Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;

- Is living in the home of another because of economic hardship;

- Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;

- Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by Federal, State, or local government programs for low-income individuals;

- Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 persons reside per room, as defined by the U.S. Census Bureau;

- Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or

- Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the Sub-grantee's approved consolidated plan;

- A child or youth who does not qualify as ''homeless'' under this section, but qualifies as ''homeless'' under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C.5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e–2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C.254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C.2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C.1786(b)(15)); or

(3) A child or youth who does not qualify as ''homeless'' under this section, but qualifies as ''homeless'' under section 725(2) of the McKinney-Vento Homeless Assistance Act (42U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him.

Beyond the COVID-19 eligibility criteria, standard Coordinated Entry eligibility criteria is used.

Assessment, Prioritization, and Reassessment.

Assessment will include a COVID-19 questionnaire.

Prioritization will be given to participants who have COVID-19 symptoms (as defined by CDC), are MEDICALLY VULNERABLE, and/or EXPOSED/TEST PENDING, and/or INFECTED MEDICALLY STABLE.

Community Prioritization Hotel Projects 1—4

1. Homeless persons ordered to self—isolate, are awaiting the COVID-19 test results, or are positive and medically stable.
2. Medically vulnerable street homeless persons.
3. Medically vulnerable person in emergency shelter or transitional housing.
4. Domestic Violence overflow rooms.

Reassessment will be conducted at least once every three months. Reassessment will include income eligibility, housing status and continuing need for service.

Domestic Violence (DV) programs administered by DV shelters will be exempt from participating in the coordinated entry system due to issues of confidentiality.

See page 26, Northeast Florida CoC Coordinated Entry System Policy and Procedure, for Domestic Violence Protocols.

Domestic Violence (DV) Shelters Protocol

Survivors of DV in current danger who are entering a DV shelter are screened using a tool specific to the single agency providing that service in Clay, Duval or Nassau counties. Shelter and outreach staff are familiar with their respective DV shelter's referral process; DV staff in turn provide safe access to their own intake process.

Non-Domestic Violence Provider Protocol
If a non-victim service provider becomes aware that a household being served is fleeing or attempting to flee violence, the provider should:
1. Offer the household a warm handoff/referral to a victim services provider; and
2. Check HMIS to see if there is an existing record. Follow safety protocols and client choice.

ESG-CV | COVID-19 NON-CONGREGATE SHELTER

Non-congregate shelter programs serve persons experiencing homelessness and have COVID-19 symptoms (as defined by CDC), MEDICALLY VULNERABLE, EXPOSED/TEST PENDING, INFECTED MEDICALLY STABLE, and is NOT in severe respiratory distress, which includes various sub-populations: households with children, individuals male or female, unaccompanied youth, and victims of domestic violence. The level of support services available to participants is on-site check-ins, food, and case management. The length of stay is generally expected to be less than 45 days.

Access to Non-congregate Shelter: Information on how to access Emergency Shelter is available 24 hours a day/7 days a week and can be accessed via the Changing Homelessness Website

Program Goals: Sub-grantee will implement services to meet the overall program goals pertaining to ESG-CV and Grantee's submission to DCF as listed below:

> **Non-Congregate Shelter Case Management**: Average length of stay in non-congregate shelter will be 45 days or less
>
> **Street Outreach:** Outreach expansion into Clay and Nassau Counties and support client in transition from street into hotel and/or permanent housing

For detailed contact information see page 2, COVID-19 Shelter Protocol.

Minimum standards

1. Minimum hours of operation 8 AM to 5 PM, with afterhours and weekend contacts (see COVID-19 Shelter Protocol.)
2. Staff supervision whether paid or volunteer must be provided during hours of operation of program
3. Provide a minimum of one meal per day
4. A minimal amount of personal information must be collected to establish a daily client roster to be kept in case of emergency and/or building needs to be evacuated
    a. At intake each participant shall be informed of evacuation procedures.
    b. Maps/diagrams of exits should be prominently placed throughout the facility
5. Follow HUD and CDC, Best Practice Approach with Private Individual Rooms as defined in Non-Congregate Approaches to Sheltering for COVID-19 Homeless Response

Discharge Plan
Individuals and households are expected to participate in case management services that allow for quick identification of housing, as well as a comprehensive needs assessment to ensure the households basic needs are being met. When household discharge becomes appropriate, either through placement in permanent housing, or due to rule or policy infractions, the following guidance should be followed:

Hotel Non-Renewal:
Should a partner hotel deny room renewal for a household due to rule violations, the Case Manager will work with other providers to secure alternative placement. If the behavior is egregious enough or endangers the safety of others, Case Management staff will contact agency management to discuss alternative placement options.

Hotel Rule Violations:
Should a household violate a hotel rule, Case Management staff will work with household to correct behavior. Case Management staff will alert the household that should situation continue that they could be faced with a non-renewal at the hotel.

Case Management Compliance:
All of our programs utilize a housing first framework with regards to service delivery. Should a household have difficulty completing case management goals and objectives, the case management team will utilize a progressive intervention framework in an attempt to move the household forward. Tools utilized in this framework include Motivational Interviewing, peer support services, and mutual goal setting. If issues are not resolved, case management staff will need to contact agency management to discuss alternative interventions.

Permanent Housing Exit:
When a household successfully exits into permanent housing, the non-congregate shelter case management staff will complete a warm-handoff with the RRH Case Management staff. Within 1-2 weeks of anticipated lease signing, the non-congregate shelter case management and RRH Case Management teams will meet with client together to ensure needs have been identified and that the household is prepared to transition.

Mainstream Services ESG-CV staff will participate in by-monthly case conferencing meeting and weekly By Name List meetings. Case Managers will connect clients to mainstream benefits as part of the housing stability plan.

ESG-CV | STREET OUTREACH

Per CDC Guidelines**:**

In the process of conducting outreach, staff should:

- Greet clients from a distance of 6 feet and explain that you are taking additional precautions to protect yourself and the client from COVID-19.
- If the client is not wearing a mask, provide them with one.
- Screen clients for symptoms by asking them if they feel as if they have a fever, cough, or other symptoms consistent with COVID-19.
- Children have similar symptoms to adults and generally have mild illness
    - Older adults and persons with medical comorbidities may have delayed presentation of fever and respiratory symptoms.
    - If medical attention is necessary, use standard outreach protocols to facilitate access to healthcare.
- Continue conversations and provision of information while maintaining 6 feet of distance.
- If at any point you do not feel that you are able to protect yourself or your client from the spread of COVID-19, discontinue the interaction and notify your supervisor. Examples include if the client declines to wear a mask or if you are unable to maintain a distance of 6 feet.

Minimum Standards

Support services provided focus on preventing, preparing for and responding to COVID-19:

1. Getting participants sheltered/housed
2. Linking participants to mainstream benefits and resources
3. Maintaining benefits which the participant is eligible for

Street Outreach Programs

1. Engagement (pro-active activities to find and engage persons experiencing homelessness)
2. Address/provide basic health/survival items (blankets, gloves, socks, personal care items, etc.)
3. Provide assistance with navigating system/link to services
4. Assist with obtaining housing
5. Minimum Safety Measures
    a. A minimum of two outreach workers must be available to go out
    b. Must always have charged cell phone and answer immediately if called
    c. Must sign in/out and include locations that will be visited with approximate times
    d. Try to be aware of possible gang activity for personal safety reasons and to alert homeless contacted (particularly homeless youth) to them

ESG-CV | HOMELESSNESS PREVENTION

Target: To prevent, prepare for, and respond to the coronavirus in context to prevention funding support for individuals and families impacted by COVID-19.

Program Goals. Sub-grantee will implement services to meet the overall program goals pertaining to ESG-CV and Grantee's submission to DCF as listed below.

Homelessness Prevention Case Management: The goal is exiting 85% of households to positive outcomes.

Prioritization: persons requesting assistance through Northeast Florida United Way 211 and the City of Jacksonville's help line 904.630.City

ESG-CV | RAPID RE-HOUSING (RRH)

In North Florida, Rapid Re-Housing is a critical strategy for ending homelessness for individual or families with children due to the extreme shortage of affordable housing. Rapid Re-housing programs in the North Florida continuum should provide housing relocation and stabilization services and short or medium term rental assistance as needed to help a homeless individual or family move as quickly as possible to permanent housing and achieve stability in that housing.

Target: To prevent, prepare for, and respond to coronavirus in context to rapidly rehousing individuals and families who have been impacted by COVID-19.

Program Goals. Sub-grantee will implement services to meet the overall program goals pertaining to ESG-CV and Grantee's submission to DCF as listed below:

> **Rapid Rehousing Case Management:** Households must be placed in permanent housing within 90 days of enrollment (30 days is our national goal) with an added goal of exiting 85% of households to positive outcomes.

Determining and prioritizing accepted clients vs. other forms of assistance

- Each adult referred will be assessed, using most recent version of SPDAT
- RRH providers will follow Housing First guidelines and screen people *in* rather than out. In doing so they commit to being good stewards of the funds, acting in the best interest of the client, and with transparency regarding the limits of the program.
- Families and individuals who cannot be assisted within regulatory guidelines will be routed to shelter and permanent supportive housing, or transitional housing

Determining what percentage or amount of rent and utilities costs each program participant must pay

Clients entering program could have zero income.

Household contribution to rental payments will be determined on a case-by-case basis. Clients will be encouraged to participate in progressive engagement. Those households with income below 30% AMI will not be encouraged to contribute financially toward rent payments. Clients who fall within 30%-50% of AMI will be encouraged to contribute while taking into consideration previous commitments to other lenders (medical bills, loan payments etc.). Clients will be recertified every 90 days while enrolled in the program. The amount contributed by the household toward rent will be re-evaluated at that time. When engaging in a housing-focused approach, progressive engagement is inherent in the concept of rapid rehousing. Progressive engagement strategies will be deployed when necessary a client is in need of more assistance.

Each RRH program should have a written standard on how they are going to determine how much rent a participant will be encouraged to pay. The standards should comply with the policy set forth by the funder or should be part of the policy and procedures of the program.

Length of time program participant will be provided with rental assistance

- Typical length of assistance: 12 months
- Each program provider should have a standard for when exit for when a participants can re-enroll or apply for the program once assistance have been given.

Whether and how the amount of assistance will be adjusted over time

- Income assessed quarterly and assistance adjusted up/down so participant pays a % of current household income per HUD guidelines or the program guidelines

Occupancy standards

All housing units, including scattered site programs owned and managed by private landlords, must meet applicable state or local government health and safety codes and have current certificate of occupancy for the current use and meet or exceed the following minimum standards:

1. Buildings must be structurally sound to protect from the elements and not pose any threat to health and safety of the residents
2. Must be accessible in accordance with Section 504 of the Rehabilitation Act, the Fair Housing Act and the Americans with Disabilities Act where applicable
3. Must provide an acceptable place to sleep and adequate space and security for themselves and their belongings
4. Each room must have a natural or mechanical means of ventilation
5. Must provide access to sanitary facilities that are in operating condition, private and clean
6. Water supply must be free of contamination
7. Heating/cooling equipment must be in working condition
8. Must have adequate natural or artificial illumination and adequate electrical resources to permit safe use of electrical appliances
9. Food preparation areas must have suitable space and equipment to store, prepare and serve food in safe and sanitary manner
10. Building must be maintained in a sanitary condition

11. Must be at least one smoke detector in each occupied unit of the program; and where possible near sleeping areas. The fire alarm system must be designed for hearing-impaired participants. There must be a second means of exiting the building in case of fire or other emergency.

Limits on the homelessness prevention or rapid re-housing assistance

- Maximum amount of assistance
    - Determined if the property meets both Rent Reasonableness and Fair Market Rent of appropriate-sized unit for Household
    - Fair Market Rent x 12 months
- Maximum number of months the program participant receives assistance
    - Assistance approved in 3-month increments, with reassessment every 90 days.
    - Average rental assistance will be based on progressive engagement.
- Maximum number of times the program participant may receive assistance
    - The requirement at 24 CFR 576.105(c) limiting the total period of time for which any program participant may receive the services under paragraph (b) to 24 months during any 3-year period is waived solely for those program participants who reach their 24-month maximum assistance during the period beginning on the presumed start of this crisis, January 21, 2020

Appendix 3: Key Terms

Acuity: When utilizing the VI-SPDAT Prescreens (triage tool), acuity speaks to the presence of a presenting issue based on the prescreen score. In the context of the Full SPDAT assessments, acuity refers to the severity of the presenting issues. In the case of an evidence- informed common assessment tool like the VI-SPDAT (Single), Family VI-SPDAT, Full SPDAT, acuity is expressed as a number with a higher number representing more complex, co-occurring issues that are likely to impact overall housing stability.

Access Points: For the purpose of this document, Access Points are designated areas located within our continuum where individuals or families can go to for intake and assessment of homeless prevention and housing services for which they may qualify.

Common Assessment Tool: A comprehensive and standardized assessment tool used for the purposes of housing prioritization and placement within a CoC Coordinated Entry System. The Northeast Florida Continuum of Care (Fl-510) has adopted the VI-SPDAT (Vulnerability Index Service Prioritization Decision Assistance Tool) as the Common Assessment Tool in April 2014 when we initially launched our Coordinated Entry System.

Chronic Homelessness (Final Definition 24 CFR 578.3, effective January 15, 2016):

(1) A "homeless individual with a disability," who: (i) lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and (ii) 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 12 months or on at least 4 separate occasions in the last 3 years where the combined occasions must total at least 12 months

>Occasions separated by a break of at least 7 nights

>Stays in an institution of fewer than 90 days do not constitute a break

(2) An individual who has been residing in an institutional care 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 paragraphs (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Disability is described as: 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 USC 15002)), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability 24 CFR 578.3.

Coordinated Entry: "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 Entry Committee: Entity responsible for implementation and upper-level management of Coordinated Intake System. Members of the Board are representatives from community providers within the service area.

Coordinated Systems: Within our community, coordinated systems is defined as interconnected network of systems that services homeless and at-risk households, and consists of coordinated intake and assessment, diversion, prevention, rapid re-housing, transitional housing, permanent supportive housing and other tailored programs and services, and linkages to mainstream resources.

Cultural and Linguistic Competency: All persons administering assessments shall us culturally and linguistically competent practices. Assessment shall include trauma-informed culturally and linguistically competent questions for first generation-subpopulations; youth; persons fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking; and LGBTQIA+ persons.

Disabling Condition: (1) a condition that: (i) is expected to be long-continuing or of indefinite duration; (ii) substantially impedes the individual's ability to live independently; (iii) could be improved by the provision of more suitable housing conditions; and (iv) is a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury; or (2) a development disability, as defined above; or (3) the disease of Acquired Immunodeficiency Syndrome (AIDS) or any conditions arising from the etiologic agent for Acquired Immunodeficiency Syndrome, including infection with the Human Immunodeficiency Virus (HIV). 24 CFR 583.5.

Diversion: Diversion is 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. Diversion programs can reduce the number of families becoming homeless, the demand for shelter beds, and the size of program prioritization lists. The main difference between diversion and other permanent housing-focused interventions centers on the point at which intervention occurs. Prevention targets people at imminent risk of homelessness, diversion targets people as they are applying for entry into shelter, and rapid re-housing/permanent supportive housing targets people who are already homeless.

Fair and Equal Access: All people in the CoC's geographic area shall have fair and equal access to the Coordinated Entry process, regardless of where or how they present for services. Fair and equal access means that people can easily access the Coordinated Entry process in person at the Urban Rest Stop, by phone, or some other method, and that the process for accessing help is well known.

Family: includes, but is not limited to the following, regardless of actual or perceived sexual orientation, gender identity, or marital status: (1) A single person, who may be an elderly person, displaced person, disabled person, near-elderly person, or any other single person; or (2) A group of persons residing together, and such group includes, but is not limited to: (i) A family with or without children (a child who is temporarily away from the home because of placement in foster

care is considered a member of the family); (ii) An elderly family; (iii) A near- elderly family; (iv) A disabled family; (v) A displaced family; and (vi) The remaining member of a tenant family. 24 CFR 5.403.

Fiscal Agent: For the purpose of this document, the entity that coordinates funding and provides oversight to the coordinated intake and assessment system. The fiscal agent for this community will be Changing Homelessness, Inc. This agent is also known as the "Lead Agency"

Emergency Transfer Plan: Provides for emergency transfers for DV survivors receiving rental assistance or residing in units subsidized under a covered housing program (including CoC and Emergency Solutions Grant (ESG) funded programs).

a. **External Emergency Transfer –** An emergency relocation of a tenant to another unit where the tenant would be categorized as a new applicant (i.e., tenant must undergo an application process to reside in the new unit.)
b. **Internal Emergency Transfer –** An emergency relocation of a tenant to another unit where the tenant would not be categorized as a new applicant. (i.e., tenant may reside in new unit without having to undergo an application process.)

HEARTH: The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) act of 2009 that includes Emergency Solutions Grant (ESG) and Continuum of Care (CoC) grants.

HMIS: Homeless Management Information System; a centralized data base designated to create an unduplicated accounting of homelessness that includes housing and services. ClientTrack is the HMIS system for this CoC.

Homeless – definition by category:

Category 1: Literally Homeless- An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:

> (i) 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, or camping ground;

> (ii) 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 programs for low- income individuals);

> or (iii) 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;

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

> The primary nighttime residence will be lost within 14 days of the date of application for homeless assistance;

> (ii) No subsequent residence has been identified; And

> (iii) The individual or family lacks the resources or support networks, e.g., family, friends, faith-based or other social networks, needed to obtain other permanent housing;

Category 3: Homeless Under Other Statues- Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who:

> (i) Are defined as homeless under section 387 of the Runaway and Homeless Youth Act (42 U.S.C. 5732a), section 637 of the Head Start Act (42 U.S.C. 832), section 41403 of the Violence Against Women Act of 1994 (42 U.S.C. 14043e 2), section 330(h) of the Public Health Service Act (42 U.S.C. 254b(h)), section 3 of the Food and Nutrition Act of 2008 (7 U.S.C. 2012), section 17(b) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)), or section 725 of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a);

> (ii) Have not had a lease, ownership interest, or occupancy agreement in permanent housing at any time during the 60 days immediately preceding the date of application for homeless assistance;

> (iii) Have experienced persistent instability as measured by two moves or more during the 60-day period immediately preceding the date of applying for homeless assistance; and

> (iv) Can be expected to continue in such status for an extended period of time because of chronic disabilities; chronic physical health or mental health conditions; substance addiction; histories of domestic violence or childhood abuse (including neglect); the presence of a child or youth with a disability; or two or more barriers to employment, which include the lack of a high school degree or General Education Development (GED), illiteracy, low English proficiency, a history of incarceration or detention for criminal activity, and a history of unstable employment; or

Category 4: Fleeing or Attempting to Flee Domestic Violence- Any individual or family who:

> Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence;

> (ii) Has no other residence; and

> (iii) Lacks the resources or support networks, e.g., family, friends, and faith-based or other social networks, to obtain other permanent housing.

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.

HUD: The Department of Housing and Urban Development; the United States federal department that administers federal program dealing with homelessness. HUD oversees HEARTH and CoC funded programs.

Lead Agency: The agency identified as the primary administrator of coordinated intake and assessment. For the purpose of this document that agency is the Changing Homelessness, Inc. or its sub-grantee who has been contracted to provide the Coordinated Intake and Assessment Services.

Linkage or Access to Mainstream Resources: An approach to help people stabilize their housing for the long term by linking them to resources for which they are eligible within their community.
Navigator: A certified intake worker whose responsibility is to provide coordinated intake and assessment for individuals or families seeking homeless prevention or housing services.

Permanent Supportive Housing (PSH): means community-based housing without a designated length of stay and includes both permanent supportive housing. Permanent supportive housing means long term permanent housing in which supportive services are provided to assist homeless persons with a disability to live independently. 24 CFR 578.3. The definition of rapid re-housing appears below.

Prioritization List: The prioritization List is thought of as a universal registry within the CoC for purposes of prioritization and housing placement. CoC and ESG funded agencies must make and take referrals off of this list for their programs.

Rapid Re-Housing (RRH): An intervention designed to help individuals and families exit homelessness as quickly as possible, return to permanent housing, and achieve stability in that housing. Rapid re-housing assistance, operating in a Continuum of Care and/or Housing First model, 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 housing identification and relocation, short-and/or medium-term rental assistance and move-in (financial) assistance, and case management and housing stabilization services. This assistance is subject to the definitions and requirements set forth in 24CFR§576.2 "Homeless" paragraph (1) and paragraph (4) who are residing in a place set forth in (1), 24CFR§576.105, 24CFR§576.106 and 24CFR§576.400. (24CFR§576.104 & Core Components of Rapid Re-Housing, National Alliance to End Homelessness).

SPDAT - (Service Prioritization Decision Assistance Tool): the evidence-based assessment utilized by all trained CoC providers in either enacting more detailed determinations of acuity for housing placement and/or ongoing use in case management to ensure housing stabilization. This is an ongoing case management tool suggested for your use. The SPDAT (or "Full SPDAT") has an individual and family tool. Staff must be trained by OrgCode Consulting prior to administering the tool. The SPDAT can be completed on paper or in HMIS and attached to a client record.

Severity of Service Needs: (a) For the purposes of Notice (CPD-16-11), this means an individual for whom at least one of the following is true:

i. History of high utilization of crisis services, which include but are not limited to, emergency rooms, jails, and psychiatric facilities; and/or

ii. Significant health or behavioral health challenges, substance use disorders, or functional impairments which require a significant level of support to maintain permanent housing.

iii. For youth and survivors of domestic violence, high risk of continued trauma or high risk of harm or exposure to very dangerous living situations.

iv. When applicable CoCs and recipients of CoC Program-funded PSH may use an alternate criterion used by Medicaid departments to identify high-need, high-cost beneficiaries.

(b) Severe service needs as defined in paragraphs i.-iv. above should be identified and verified through data-driven methods such as an administrative data match or through the use of a standardized assessment tool and process and should be documented in a program participant's case file. The determination must not be based on a specific diagnosis or disability type, but only on the severity of needs of the individual. The determination cannot be made based on any factors that would result in a violation of any nondiscrimination and equal opportunity requirements, see 24 C.F.R. § 5.105(a)

Transitional Housing (TH): housing to facilitate the movement of individuals and families experiencing homelessness into permanent housing within 24 months. 24 CFR 578.3.

VI-SPDAT - (Vulnerability Index-Service Prioritization Decision Assistance Tool): the evidence- based Common Assessment or Prescreen Triage Tool utilized by all projects in the Northeast Florida Continuum of Care to determine initial acuity (the presence of an issue) and utilized for housing triage, prioritization and housing placement. Note there are two versions of VI-SPDAT, the Individual and Family, both of which are available in HMIS. There is a Youth VI-SPDAT that was recently released for use specifically with youth and is available on the OrgCode website, with anticipation of HMIS release in the near future.

> PLEASE NOTE the VI-SPDAT is a different tool than the Full SPDAT; do not use these terms interchangeably as they are different

> The VI-SPDAT is the Common Assessment Tool, or Prescreen Triage Tool

> The Full SPDAT can be used as an ongoing case management tool

Appendix 4: HUD Guidance and Regulations

Continuum of Care Program Interim Rule
Coordinated Entry Core Elements
Coordinated Entry Landing Page – HUD Exchange
Coordinated Entry Policy Brief
Notice CPD-17-01: Notice Establishing Additional Requirements for a Continuum of Care Centralized or Coordinated Assessment System

Appendix 5: Acronym List

Continuum of Care Acronym List	
AES	Adaptive Enterprise Solutions (Adsystech)
AH	Affordable Housing
AHAR	Annual Homeless Assessment Report
AIRS	Alliance of Information and Referral Systems
AMI	Area (Annual) Median Income
APR	Annual Performance Report
ARD	Annual Renewal Demand (formerly called HHN)
CAHP	Coordinated Assessment and Housing Placement
CDBG	Community Development Block Grant
CE	Coordinated Entry
CH	Chronic Homeless
CHAP	Community Homeless Assistance Providers
CHO	Contributing HMIS Homeless Organization
CIS	Community Information Systems
CMS	Client Management System (our local HMIS)
CoC	Continuum of Care
CSBG	Community Services Block Grant
CSV	Comma Separated Values (csv exports used for HUD/Federal funding reporting)
DV	Domestic Violence
EHIC	Electronic Housing Inventory Chart
ES	Emergency Shelter
ESG	Emergency Solutions Grants
esnaps	Electronic data system for SNAP (see SNAP)
FAQ's	Frequently Asked Questions
FIPS	Federal Information Processing Standards Codes for States, counties, and named populated places.
FMR	Fair Market Rent
FPL	Federal Poverty Level
HEARTH	Homeless Emergency and Rapid Transition to Housing
HHN	Hold Harmless Need Amount (now called ARD)
HIC	Housing Inventory Chart
HIPPA	Health Insurance Portability and Accountability Act of 1996
HMIS	Homeless Management Information Systems
HP	Homeless Prevention
HUD	(U.S. Dept. of) Housing and Urban Development
I & R	Information and Referral
NOFA	Notice of Funding Availability
PATH	Projects for Assistance in Transition from Homelessness
PIT	Point In Time
PKI	Public Key Infrastructure
PPI	Personal Protected Information
PRN	Pro Rata Need Amount
PSH	Permanent Supportive Housing
QPR	Quarterly Performance Report
RFP	Request for Proposal
RHY	Runaway & Homeless Youth

RHYMIS	Runaway and Homeless Youth Management Information System
ROMA	Results-Oriented Management and Accountability
RRH	Rapid ReHousing
S+C	Shelter Plus Care (former PSH program for chronic homeless)
SA	Substance Abuse
SH	Safe Haven
SHP	Supportive Housing Program (includes TH, S+C, SPC and SRO)
SNAP	Special Needs Assistance Programs
SNAP	Supplemental Nutrition Assistance Program (food stamps)
SOAR	SSI/SSDI Outreach, Access, and Recovery Program
SRO	Single Room Occupancy
SSDI	Social Security Disability Income

Appendix 6: Agency Leads

Appendix 7: Sample Forms

HMIS

PRIVACY NOTICE & CLIENT CONSENT FORM

This agency participates in the Homeless Management Information System (HMIS) for Northeast FL Continuum of Care, the local community of homelessness services agencies.

What is the Northeast FL HMIS?

The Homeless Management Information System (HMIS) is a computerized data collection system designed to collect client information about the characteristics and service needs of individuals and households experiencing homelessness. Changing Homelessness is the HMIS Lead Agency as defined by HUD. ClientTrack is the HMIS application used by the Northeast FL Continuum of Care (CoC).

What is the benefit for clients who participate in HMIS?

Clients are encouraged, but not required, to participate in HMIS to help:

- Provide quality services to you
- Increase access to housing
- Improve access to services
- Decrease need to share personal information when accessing multiple services within the system
- Contribute to aggregate data used to improve the homeless service system

Types of identifying data collected, if you are willing to give it, could include name, address, zip code, phone number, date of birth, social security number, your family status, the nature of your situation and the types of services you receive from an agency, project entry and/or exit date, and unique personal identification number (HMIS Unique Identifier).

Reasons data is collected, used and/or disclosed by the agency and/or CoC:

- To provide services to you
- For functions related to funding for services
- For administrative purposes, planning and personnel decisions
- To research and better understand homelessness in the community
- To provide a government required count(s) of people receiving services by HMIS participating agencies
- Meet requirements of funders such as the U.S. Department of Housing and Urban Development (HUD)
- Develop and improve programs to work towards ending homelessness in our community

How is the information used?

- All information entered into the HMIS is protected and secured to protect your privacy.
- Only agency staff members, database administrators, or auditors who have signed a confidentiality agreement will be allowed to see, enter, or use the information entered into the HMIS.
- Based on your needs, your HMIS information may be shared to coordinate referrals for housing and services or to coordinate services such as food, utility assistance, counseling, etc.
- Information that does not identify you may be used for research in order to increase housing options and improve services.

Your rights:

- You have the right to refuse to participate in HMIS.
- You have the right to see your information in the HMIS, ask for changes, or ask for a printed copy upon request.
- Identifying Information stored in the HMIS will not be given to anyone outside the system without written consent, except as required by law through a court order or in the event of a public health emergency.
- Only information deemed necessary/appropriate to meet goals above will be collected.

By signing this form, you authorize Changing Homelessness and the Northeast FL CoC to share basic data about yourself and your household (if applicable). You understand that if you refuse to sign this consent you will not lose or be denied any benefits or services. This consent will expire in 7 years.

You can revoke this consent at any time by returning a completed Revocation of Consent form, available online at the Changing Homelessness website. Once complete, please email it to HMIS@changinghomelessness.org. If you have any questions or you feel your information has been misused in any way, please contact HMIS@changinghomelessness.org.

Client Signature Date

Printed Name

Agency Witness Date

HMIS Client Revocation of Consent Form

By signing this form, you revoke your authorization for this Changing Homelessness (as HMIS Lead Agency) and Northeast FL CoC to share basic data about yourself and your household (if applicable). You understand that by revoking your consent to share information you will not lose or be denied any benefits or services.

If you have any questions or you feel your information has been misused in any way you can contact the Northeast FL HMIS Administration at HMIS@changinghomelessness.org.

Client Signature Date

Printed Name

Agency Witness Date