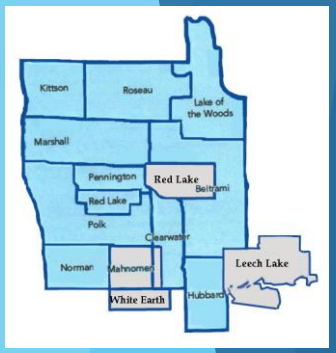


NWCoC Coordinated Entry Training

NWCoC System Overview and the "How To" of the NWCoC Homeless Response System

October 14th, 2021

Via Zoom Webinar

Presented By:

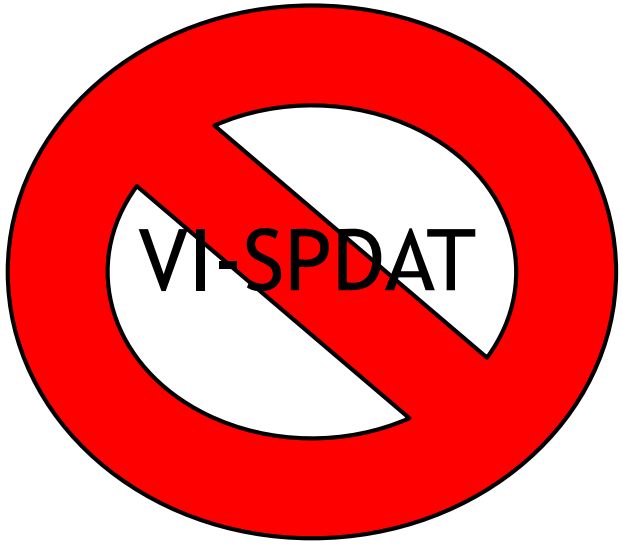
Cory Boushee, NWCoC Coordinator

Lori Anderson, NWCoC Priority List Manager

Scott McGillicuddy, ICA Coordinated Entry Specialist

Press Record!

A Fresh Start!!!! Turning over a new leaf the NWCoC with a new Assessment Process.



What's New?

- A process designed by peers of the NWCoC for the NWCoC. With engagement from the Youth Action Board.
- Meeting HUD requirements, while prioritizing NWCoC needs.
- A focus on Strength-Based and Client Choice process!

NEW ASSESSMENT LAUNCHES OCTOBER 25th, 2021

How did we get to this new assessment and where are we going?

- Multiple years of statewide planning created a statewide system to use the VI-SPDAT. In recent years CoC's have been moving away from the VI-SPDAT as being a mainstay in their homeless response assessments. This was due to feeling the scores did not accurately reflect the client's level of vulnerability or need to refer clients, and was furthering inequities in the system.
- After beginning this work in February/March 2021 the NWCoC Board of Directors approved a timeline to discontinue the VI-SPDAT and replace it before October 1st of 2021.
- Over a five month period a subcommittee of the NWCoC Membership met to design the new assessment and to make system improvements in response to the changing assessment. This process was presented to the NWCoC Board of Directors and Coordinated Entry Committee and approved to move forward as a six month pilot upon its start. The start is planned for October 25th, 2021.
- During this time our NWCoC Coordinated Entry Training planning consultant MESH did interviews with the subcommittees and attended case conferencing meetings to learn more about the existing system.
- During this six-month pilot period we will host monthly user group meetings to learn where we need to improve. This is the focus of Dynamic Planning.

Training Plan and Options for Engaging

Two trainings today:

Overview of the NWCoC Homeless Response System

The "How To" of the NWCoC Homeless Response System

- Q and A in the webinar if you have a question. If it seems we need to stop to answer a question we will do so.
- We have a live Q and A at the end and will plan to answer as many questions as we can. If we run out of time we can create a document to send out.
- Chat feature if you need assistance.
- Planned engagement points and Quizzes ☺ - Everyone will be required to complete a short quiz with an expected deadline at the end of October.
- You may hear the terms Coordinated Entry System and Homeless Response System today. These are meant to be used interchangeably.

Quick Overview of Forms

These are the main forms used in the Coordinated Entry System. These forms will be presented in greater detail during the “How To” section.

- Step 1: Active Listening Guide
- Step 2: Triage Questionnaire
- Step 3a: Minnesota Homeless Prevention Assessment Tool
- Step 3b: NWCoC Coordinated Entry Assessment
- NWCoC Coordinated Entry Receipt and ROI

Step 1: Active Listening Guide

NWCOC Proposed Triage Questionnaire

Step 1 Active Listening Guide

My name is _____, how can I help you today? Could you start by telling me where you are located?

Fill in Location_____.

Please tell me your name and what kind of resources do you feel would be most beneficial to help resolve your situation?
Active Listening: Let people tell you the story of their housing crisis. *Check the boxes as you listen.*

Resources Checklist (Check boxes based on client's story) *Not intended to ask about every option*		
Resource	***Checkbox***	***Referral Information (Agency Specific)***
Transportation		
Income and Employment		
Food		
Child Care		
Life Skills Classes		
Emergency Shelter		***Refer to DV Shelter or ES***
Fleeing Violence of Abuse		***Refer to DV Shelter or ES***
Security Deposits		
Utility Payments		
First Month's Rent		
Short Term Rent		
Housing Voucher (No Services)		
Supportive Housing w/ Case Management		
Housing Navigation Assistance		
Landlord Payment Plan		
Health Insurance		
Mental/Behavioral Health		
Substance use/chemical health		
Education / (School Homeless Liaison)		
Energy Assistance		
County Assistance		
Contacting a support network for help.		***assist client in making connections.***
Other		
BOLD = Likely Candidate for Assessment for Coordinated Entry		*Italic = Likely Candidate for Prevention*

If client indicates a need for any category that is BOLD or Italic continue on with assessment collect contact information and move onto Step 2. If not, make referral to appropriate mainstream resource available in your community based on clients housing story. (Assessor Judgement)

Client Name:	***Phone Number:***	***Other:***
E-mail:	***Facebook:***	
Contact information is optional to collect during Step 1.		

Assessor Notes:

Step 2: Triage Questionnaire Paper Version

NWCOC Step 2: Triage Questionnaire

Assessor's Name	*Assessment Location*	*Assessor's Organization*	*Assessment Date*

I appreciate you telling me about your situation and how we could best be of service to you. Would you mind if I ask you a few more questions to help me provide the best possible service today? ***(Pause for Response)*** *I cannot guarantee that we will be able to provide you with services today, but I will do my best to offer you what services are available and that you are eligible for. I will be entering your information into our data system, but will ask your consent prior to sharing or referring you to another agency. Could you start by telling me your name?*

First Name	*MI*	*Last Name*	*Date of Birth*	*Gender*
HoH:				☐ Male ☐ Female ☐ Other
2nd Adult:				☐ Male ☐ Female ☐ Other
Child 1:				☐ Male ☐ Female ☐ Other
Child 2:				☐ Male ☐ Female ☐ Other
Child 3:				☐ Male ☐ Female ☐ Other
Are any household members currently pregnant? ☐ Yes ☐ No			If yes, what is the projected due date?	
Are you an enrolled member of a Native American tribe? ☐ Yes ☐ No			If yes, of which tribe are you a member?	
Are you a veteran of the United State Military? ☐ Yes ☐ No				

What is your current housing situation? (Check the box for the most accurate selection)			
☐ Unhoused	☐ Staying in unsafe housing	☐ Staying with family or friends (Doubled-up)	☐ Staying in your own housing
Refer to CES assessment. If needed, refer to emergency shelter or domestic violence resources as well.			***Refer to either mainstream resources or prevention services, depending on the answer to the next question.***

Are you seeking housing due to concern for your safety or fear of violence or abuse from another person staying with you?	☐ Yes ☐ No	***Refer to DV ES and the Complete Step 3 CES Assessment***

How long are you able to stay in your current housing situation? (Check the box for the most accurate selection)		
☐ Client has an Eviction Notice	☐ Less than 14 days	☐ More than 14 days
Refer to prevention services, unless assessor determines client will become homeless. In that case, refer to Housing Access for Coordinated Entry assessment. If the client cannot stay in their current housing situation for another night, refer to emergency shelter.		***Refer to mainstream resources or prevention services.***
If you stay where you are, could your friends or family be evicted?		☐ Yes ☐ No ***If yes, refer to Step 3 CES Assessment***

Do you have any income? Do you have health Insurance?			
Employment (Earned) ☐	*Other Income Benefits* ☐		*Health Insurance*
Amount: $_____	*Source(s):*		☐*Yes* ☐*No*
	Amount:		*If yes, Source:*
Per: Week ☐*Month* ☐	*Per: Week* ☐*Month* ☐		
If no, Refer to Education and Employment Services	***If no, Refer to Income Benefits***		***If no, Refer to Medical Assistance***

Use the next set of questions as a resource to identify how much assistance a household will need to successfully resolve their current housing crisis. These notes will assist in the process of identifying the best solution. These questions will also assist the assessor in completing the Housing Stabilization Services Assessment. If the client is placed on the priority list include any relevant information in your Assessor Notes.

As we refer you to resources are you able to make it to these appointments in person? I may not have the ability to assist you with this, but it is helpful information to best assist you. (Ex. Will you need transportation, a virtual appointment or child care?)	*Assessor Notes:*
Do you feel that you could make appointments with the resources I referred you to today on your own? Would you like assistance in making appointments?	*Assessor Notes:*
Do you have any barriers that may impact your ability to get housing? (Ex. Criminal History, Evictions. Credit History)	*Assessor Notes:*
Do you have your vital documents today? (Ex. Birth Certificate/ Driver's License/ID/ SSN)	*Assessor Notes:* ***If no, refer to agency for assistance with obtaining documents.***
Have you applied for assistance in the past? If yes, what was the outcome? If the outcome was negative, ask client "What would have created a more positive outcome for your?"	*Assessor Notes:*

Step 2: Triage Questionnaire Paper Version

Housing Stabilization Assessment (To be completed by assessor)

Is the client at least 18 years old?	☐ Yes ☐ No
Is the person receiving the Medical Assistance Benefit?	☐ Yes ☐ No

If yes to both questions, continue with assessment for potential Housing Stabilization Services eligibility. Otherwise, if the client does not have health insurance, refer them to the county to inquire about Medical Assistance benefits.

Based on your experience with the client, review the following 5 questions and use your professional judgement when selecting your responses. You should not ask these questions of the person, instead they should be based on observations you have had during the assessment. A response option is available if an assessor is unable to answer the question. If yes to the question regarding housing instability, and yes to any of the remaining questions, the individual meets the assessed Need and Housing Instability requirements for Housing Stabilization Services.

Housing Stabilization Assessment Questions		
Is the person experiencing housing instability?	☐ Yes ☐ No ☐ Unable to Answer	*Yes indicates person has reported their current housing situation as one of the following:* • *Homeless (the person lacks a fixed, adequate nighttime residence)* • *At risk of homelessness (the person is faced with a situation that may cause them to become homeless)* • *Transitioning or recently transitioned from an institution, licensed, or registered setting*
Does this person need support communicating their needs to help with housing?	☐ Yes ☐ No ☐ Unable to Answer	*Examples of Yes responses may include:* • *Person is difficult for most listeners to understand* • *Person uses non-speech method (e.g., sign language, symbols, gestures) to communicate*
Does this person need support getting around to help with housing?	☐ Yes ☐ No ☐ Unable to Answer	*Examples of Yes response may include:* • *Person needs assistance or supervision to use transportation* • *Person walks with physical assistance from another person* • *Person does not typically walk* • *Person requires assistance from another person to complete tasks requiring fine motor skills such as reading, writing, or maintaining personal care* • *Person cannot walk for long periods without taking breaks*
Does this person need support in decision making related to their housing?	☐ Yes ☐ No ☐ Unable to Answer	*Examples of Yes response may include:* • *Person has reported significant short-term memory issues or confusion retaining or recalling recent events, experiences, skills, or information.* • *Person shows confusion or disorientation when asked about themselves* • *Person cannot weighs positives and negatives of issue in order to make appropriate decision.* • *Person is easily coerced into decisions that may not benefit them.*
Does this person need support managing challenging behaviors to help with housing?	☐ Yes ☐ No ☐ Unable to Answer	*Examples of Yes response may include:* • *Person exhibits behaviors that may require supports to prevent/mitigate breaking the law* • *Person would have difficulty to identify and problem-solve to take appropriate action without assistance in a potentially harmful situation* • *Person requires the availability of an identified/dedicated person to safely direct own activities and manage personal responsibilities*

Assessor Determination	
☐ Client is homeless or will become homeless without housing, including supportive services.	***Refer to Housing Access for Coordinated Entry assessment. Refer to emergency shelter if needed.***
☐ Client is a doubled-up youth. (16-24 years old)	
☐ Client could stay in housing with prevention services.	***Refer client to prevention services. (Typically CAP agencies have FHPAP funds.)***
☐ Client has safe housing, cannot receive prevention services, and does not want supportive housing.	***Refer to mainstream resources identified in Step 1. If looking for new housing, refer to PHA for Housing Choice Voucher.***
Please Note: Referral to Housing Access assessment is the least desirable outcome for agencies and the client as very few people are able to be housed from Coordinated Entry. (This may differ by location across NW CoC.)	

Contact Information

Could you provide me with your best available contact information and let me know how you would like to be contacted?

Phone Number	
E-mail Address	
Social Media (e.g. Facebook)	
What is the best way to maintain contact with client?	☐ Phone ☐ E-mail ☐ Social Media
Has the client completed the HMIS Release of Information?	☐ Yes ☐ No
Has the client completed the Case Conferencing Release of Information?	☐ Yes ☐ No

Step 3b: NWCoC Coordinated Entry Assessment Paper Version

Step 3b Coordinated Entry Assessment

I would like to ask you a few more questions that will help assist you in resolving your housing situation. Once we complete this assessment, if it seems like support-ive housing will be the best solution, I will add you to the NWCOC Priority List. It is not a guarantee that a housing program will have an opening. In the meantime, we should continue to work towards other options for resolving your situation. After this assessment we can chat through other options.

Client Choice and Strength-Based Questions

Assist client in understanding the different types of housing.

Please note if you have a need or a preference for each of the following:	***Need***	***Preference***	***Notes***
Cultural or population specific housing (tribal, HIV/AIDS, LBGT)	☐	☐	
Fixed Site	☐	☐	
Housing Support (GRH)	☐	☐	
Have a Front Desk	☐	☐	
Mobility/Access	☐	☐	
Access to public transportation	☐	☐	
Safety	☐	☐	
Scattered Site	☐	☐	
Stay enrolled in same school district	☐	☐	
Sober Housing/Treatment based	☐	☐	
Are you willing to live anywhere in the state?	☐ Yes ☐ No		

Client Preference County 1-3	1. 2. 3.
What city do you currently live in?	
What county do you currently live in?	
If you are not currently living in the city/county you want to live in, do you have any connections to the area?	☐ Yes – Employment ☐ Yes – Family ☐ No ☐ Other
Please explain any connections:	

Have you experienced discrimination in your community based on (medical diagnosis, disability, race, religion, or gender, sexual orientation)? Has that impacted your ability to find housing?	☐ Yes ☐ No	
Has your interaction institutional settings created barriers for you?	☐ Yes ☐ No	
Are your current (within last two weeks) health and emotional needs being met?	☐ Yes ☐ No	
Do you have children currently in school? What school are they attending? Have you worked with the school McKinney-Vento liaison?	☐ Yes ☐ No	
Assessor Notes: What else did you hear that may help this person with housing or a housing program case manager should be aware of?		

Client and Household Information

What gender do you identify with?	☐ Female ☐ Male ☐ Trans Female (MTF or Male to Female) ☐ Trans Male (FTM or Female to Male)	☐ Gender Non-Conforming (i.e. not exclusively male or female) ☐ Client doesn't know ☐ Client refused

Step 3b: NWCoC Coordinated Entry Assessment Paper Version

	☐ Data not collected			
Race (Select all that apply)	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Client doesn't know ☐ Client refused ☐ Data not collected			
Ethnicity	☐ Non-Hispanic/Non-Latino ☐ Hispanic/Latino ☐ Client doesn't know ☐ Client refused ☐ Data not collected			
Household Type	☐ Family ☐ Single ☐ Youth – Family ☐ Youth – Single	Household Size	Total # of Persons	
			Total # of Adults (18+)	
			Total # of Children (17 and under)	

Eligibility Information

Please record a current living situation together with the client.	
Please complete a housing summary together with the client.	
Extent of Homelessness by Minnesota's Definition	☐ Not currently homeless ☐ 1st time homeless and less than 1 year without home ☐ Multiple times homeless, but NOT meeting LTH definition ☐ Long term: At least 1 year OR at least 4 times in past 3 years.
Approximate Date of Most Recent Episode of Homelessness (MN)	*Day/Month/Year*

Total number of months homeless on the street, in ES, in SH, or doubled up/couch hopping in the past three years. Note, please do not factor months in staying somewhere that is considered a neutral event (e.g. TH).		
Did the client leave any of the places listed in the last 3 months before project start date?	☐ Adoptive home (from foster care) ☐ Foster Home ☐ Juvenile Detention Center ☐ County Jail ☐ State or Federal Prison ☐ Mental Health Treatment ☐ Drug or Alcohol Treatment	☐ Combined MI/CD treatment ☐ Group Home ☐ Halfway House ☐ Residence for people with physical disabilities ☐ Client doesn't know ☐ Client refused
Prior Living Situation	☐ Place not meant for habitation ☐ Emergency shelter, including hotel/motel paid w/ voucher ☐ Safe Haven ☐ Interim Housing/Bridge Housing ☐ Foster care home or foster care group home ☐ Hospital or other residential non-psychiatric medial facility ☐ Jail, prison or juvenile detention facility ☐ Long-term care facility or nursing home ☐ Psychiatric hospital or other psychiatric facility ☐ Substance abuse treatment facility or detox center ☐ Hotel/motel paid for w/out emergency shelter voucher ☐ Owned by client, no ongoing housing subsidy ☐ Owned by client, w/ ongoing housing subsidy ☐ Permanent housing for formerly homeless ☐ Rental by client, no ongoing housing subsidy ☐ Rental by client, with VASH subsidy ☐ Rental by client, with GPD TIP subsidy ☐ Rental by client, with other ongoing housing subsidy ☐ Residential project or halfway house with no homeless criteria ☐ Staying or living in a family member's room, apartment or house ☐ Staying or living in a friend's room, apartment or house ☐ Transitional housing for homeless persons (including homeless youth) ☐ Don't know	
Length of Stay in Previous Place	☐ One night or less ☐ Two to six nights	☐ 1 month to 90 days ☐ 90 days to one year ☐ Don't know ☐ Refused

Step 3b: NWCoC Coordinated Entry Assessment Paper Version

	☐ Over 1 week to under a month	☐ One year or longer	
Regardless of where they stayed last night - Number of times the client has been on the streets, in ES, or SH in the past three years including today	☐ Once ☐ Twice	☐ 3 times ☐ 4 or more	☐ Don't Know ☐ Refused
Total number of months homeless on the street, in ES or SH in the past three years	☐ 1 month (this episode w/in 1st month) ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9	☐ 10 ☐ 11 ☐ 12 ☐ More than 12 months ☐ Client doesn't know ☐ Client refused ☐ Data not collected	
Is the client Chronically Homeless?	☐ Yes ☐ No		

Did you serve on Active Duty, or in the National Guard or Reserves?	☐ No ☐ Yes, Active Duty (regardless of Guard/Reserve answer) ☐ Yes, National Guard	☐ Yes, Reserves ☐ Guard & Reserves ☐ Don't know ☐ Refused
Have you been referred to the Homeless Veteran Registry?	☐ Yes ☐ No	
If the client has not been referred to the Homeless Veteran Registry, take a moment and offer to complete the release of information/application form with them. More information can be found at https://mn.gov/mdva/ or by calling 1-888-LinkVet (546-5838).		
Do you have any disabilities?	☐ Mental Health Problem ☐ Physical ☐ Developmental ☐ Chronic Health Condition	☐ Alcohol Abuse ☐ Drug Abuse ☐ HIV/AIDS ☐ Other
Do you have a disability of long duration?	☐ Yes ☐ No ☐ Client doesn't know	☐ Client refused ☐ Data not collected

Have you been told by a medical professional that you have a severe mental illness (SMI)?	☐ Yes ☐ No	☐ Client doesn't know ☐ Client refused
Is the SMI disability documented?	☐ Yes ☐ No	
What accommodations do you require for housing due to health/disability?		
Are you seeking housing due to concern for your safety or fear of violence or abuse from another person staying with you?	☐ Yes ☐ No	
How many times have you moved in the past year?		
Please record any current case manager information.		

I appreciate you taking the time to go through this assessment. Based on our conversation from today, could we come up with three actions that you could take in order to help resolve your situation?

1.
2.
3.

End of document

NWCoC Coordinated Entry Receipt and ROI - DRAFT

NW MN COC COORDINATED ENTRY SYSTEM (CES) PARTICIPANT NOTICE AND CONSENT FOR RELEASE OF INFORMATION

NAME: _____

I understand that:

- My household will be placed on a housing list for ALL homeless programs in the Northwest MN region.
- The list is a priority list, not a wait list. This means persons are selected for open units based on need and eligibility, not first-come, first-serve criteria.
- I understand that partner agencies from the NW CoC will be attempting to contact me, and I have an obligation to respond to attempted communications. It is important and to my benefit to let the assessor know of any changes in my household or homeless status (i.e. I am no longer homeless, I have been evicted from housing, ect.) as soon as it happens.
- It is my responsibility to inform my case manager or agency contact person listed below of any changes in my contact information. If I cannot be reached using the contact information I have provided, my name may be removed from the Priority List. If my name is removed from the list, I will have the option to re-apply for homeless services.
- If my household is selected for a housing program, I may need to verify eligibility for the program. If my household is selected for a fixed-site housing unit, the property managers will still do a background check, however they will have less strict requirements. The Housing Agency will try to contact me using the information I have provided. There is a short response time to accept or decline an offer. If I cannot be contacted, another household will be selected.
- I have the right to turn down an offer of housing. If I turn down an offer of housing, my name will return to the Priority List. Valid reasons to turn down housing are: location, type of housing wanting fixed vs. scattered site) or conflict with the agency.
- If I am not satisfied with a CES decision for any reason, I have the right to make an appeal to the Housing Agency that issued the denial. If I have reason to fear contacting this person for any reason, I can contact the Priority List Manager, Lori Anderson, at 218-773-3521 or delores@tvoc.org.

AGENCY CONTACT: _____ PHONE: _____
AGENCY CONTACT E-MAIL: _____

The NW MN Coordinated Entry System (CES) is a partnership of agencies (full list attached) sharing information to provide a more coordinated homeless response system. The information from the CES screening and assessments is shared for the purpose of:

- Assessing my household's program eligibility
- Prioritizing my household's need for services
- Linking my household to the most appropriate services
- Evaluating the CES program and system performance
- Evaluating the homeless response system for gaps, needs, and duplication.

This form authorizes the following identifying information to be shared through Case Conferencing:

- Family/household information
- Income and benefits information
- Education and Employment history
- Housing history and barriers
- Homeless status and history
- Veteran and discharge status
- Program and service involvement and contracts
- General health information, including physical health and behavioral health (not including case records)

This authorization is voluntary and strictly for sharing information needed for entering and moving through the Coordinated Entry System and may NOT be used for any other purpose. The information collected, maintained and stored by the NW MN CoC and shared with service providers may include records relating to your behavioral and/or mental health, alcohol and drug abuse treatment, HIV/AIDS, and genetics.

This information is necessary for determining your eligibility for housing and services. You will not be denied help if you do not want to sign this form or if you do not want to allow CES to share your personal information. You have the right to review the information that is shared. You have the right to revoke this authorization at any time by giving verbal or written notice of revocation to this Agency or the NW MN CoC. Revoking this authorization will not affect any action taken or information shared prior to notice of revocation. You can cancel this consent at any time by calling the Agency contact listed. You will be given a copy of this authorization.

☐ I agree to have my information shared for the purpose of Case Conferencing as explained above.

☐ Do not share my information in Case Conferencing. I understand that I will not be denied services if I do not share, but the ability to quickly and appropriately identify services for me may be affected by my decision not to share my information.

By signing this form, I acknowledge that I completely understand what has been presented to me and I agree to allow my information to be shared through Case Conferencing in the Northwest CoC. This authorization takes effect the day that I sign it and expires upon my request.

PARTICIPANT NAME	SIGNATURE	DATE

☐ **The Coordinated Entry assessment was conducted via phone and the Participant(s) gave verbal permission to this assessor for their signatures. A copy of this Notice and Consent for Release of Information will be provided to the participant either electronically or by mail.**

ASSESSOR NAME	SIGNATURE	DATE

Training Agenda
NWCoC System Overview NWCoC Homeless Response System

- On October 12th, 2021 a training was offered on Dynamic Planning and the "Why" of the Homeless Response System
- Today's training will start with an overview of the Northwest Continuum of Care Homeless Response System. For the sake of HUD, everyone will be more familiar with calling it Coordinated Entry.
- During this training we will have a couple of planned stopping points for questions.
- After the training is completed everyone in attendance will be sent a google quiz to test your comprehension. This quiz will require a score of 90% and you may take it as many times as needed, and receive one on one assistance from the CoC Coordinator or Priority List Manager. Pay attention - we will be going through all the quiz questions today☺

Todays Agenda will Include:

- Values of the Homeless Response System
- Overview of the Homeless Response System
- Overview of the Roles of the System
- Stage of Access and Assessment
- Guiding Values of Prioritization
- Overview of the Referral Process
- Recap of the System

Values of the Homeless Response System

Utilizing progressive engagement, is **an approach to helping households end their homelessness as rapidly as possible**, despite barriers, with minimal financial and support resources. More supports are offered to those households who struggle to stabilize and cannot maintain their housing without assistance.

What other items can you think of that you feel are values or should be values of the NWCoC Homeless Response System?

Please add them to the chat!

Quiz Question 1

- What best describes CES?
  - A waiting list for housing resources across northwest Minnesota.
  - A homeless response system that diverts people from needing housing resources with mainstream and prevention resources whenever possible and prioritizes limited supportive housing resources for the most vulnerable.
  - A process some bureaucrat dreamed up that were forced to follow.
  - The VI-SPDAT assessment.

Overview of the Homeless Response System (Coordinated Entry)

Coordinated Entry Stage	Goal of the Stage	When to Complete	Responsible Staff
Access	Access is the first point of contact for a client experiencing a housing crisis. Access sites can provide direction to emergency services addressing the most immediate needs before moving onto the assessment phase.	Immediately	COC Designated Access Points Assessors and the entire COC Community to ensure people are referred to these access sites.
Assessment	The assessment stage gathers information from the client to understand the housing crisis, identify services the client could be eligible for, and determine the level of intervention needed , despite barriers, with minimal financial and support resources. More supports are offered to those households who struggle to stabilize and cannot maintain their housing without assistance. This is a progressive engagement approach.	As soon as possible once a housing crisis is identified by a access site.	COC Designated Access Points Assessors
Prioritization	The prioritization process uses the information gathered from the assessment stage to analyze a person's level of vulnerability or need. The persons priority is set based on the NWCoC prioritization guiding values and eligibility through discussions at case conferencing meetings. This process values client choice and a strength based client-centric approach.	This will happen at case conferencing meetings using the NWCoC Priority List.	Staff from housing and supportive services agencies. Priority List Manager
Placement (Referral)	Placement, or better known as referral is the process of actually making a referral to a housing program opening. Referrals are determined by the prioritization process. Housing case mangers and service providers will meet at case conferencing and determine which clients will be referred form the list to available openings. The list is not a wait list, it is a priority list and people are served based on vulnerability and need not time on the list. The system cannot be used to screen people out based on perceived barriers, but should assist in addressing barriers to stably house the client.	This will happen at case conferencing meetings.	Staff from housing and supportive services agencies. Housing Case Manager Priority List Manager

Quiz Question 2

What best describes the flow of the Coordinated Entry System?

1. Prioritization, Access, Assessment, Placement
2. Access, Assessment, Prioritization, Placement
3. Placement, Assessment, Prioritization, Access
4. Assessment, Prioritization, Placement, Access

Roles of the System

Assessor

- Determines level of resources needed through triage
- Places client on coordinated entry Priority list
- Maintains contact with client and updates CES entry as needed

Priority List Manager

- Manages the priority list
- Refers clients on priority list to agencies with openings
- Provides training and technical assistance to NW CoC agencies regarding CES/HMIS
- Coordinates Case Conferencing

It is the goal of the CoC to hire more Housing Navigators, but each agency must take on aspects of housing navigation to ensure clients are equitably housed. This falls to assessors and housing case managers now.

Housing Navigation

- Supports client in obtaining necessary eligibility documentation, including vital documents
- Link households to community resources
- Use motivational interviewing, client-centered and harm reduction practices to help clients reach desired goals
- Support housing search through search assistance, applications help, advocacy with landlords or property managers, and education on tenants rights and responsibilities.

Housing Provider / Case Manager

- Lets Priority List Manager know of openings
- Receives client referrals from Priority List Manager
- Works to house clients in program
- Updates HMIS with outcome of client referral (i.e., successful or unsuccessful program enrollment)
- Continues to support clients in maintaining housing for duration of enrollment in program

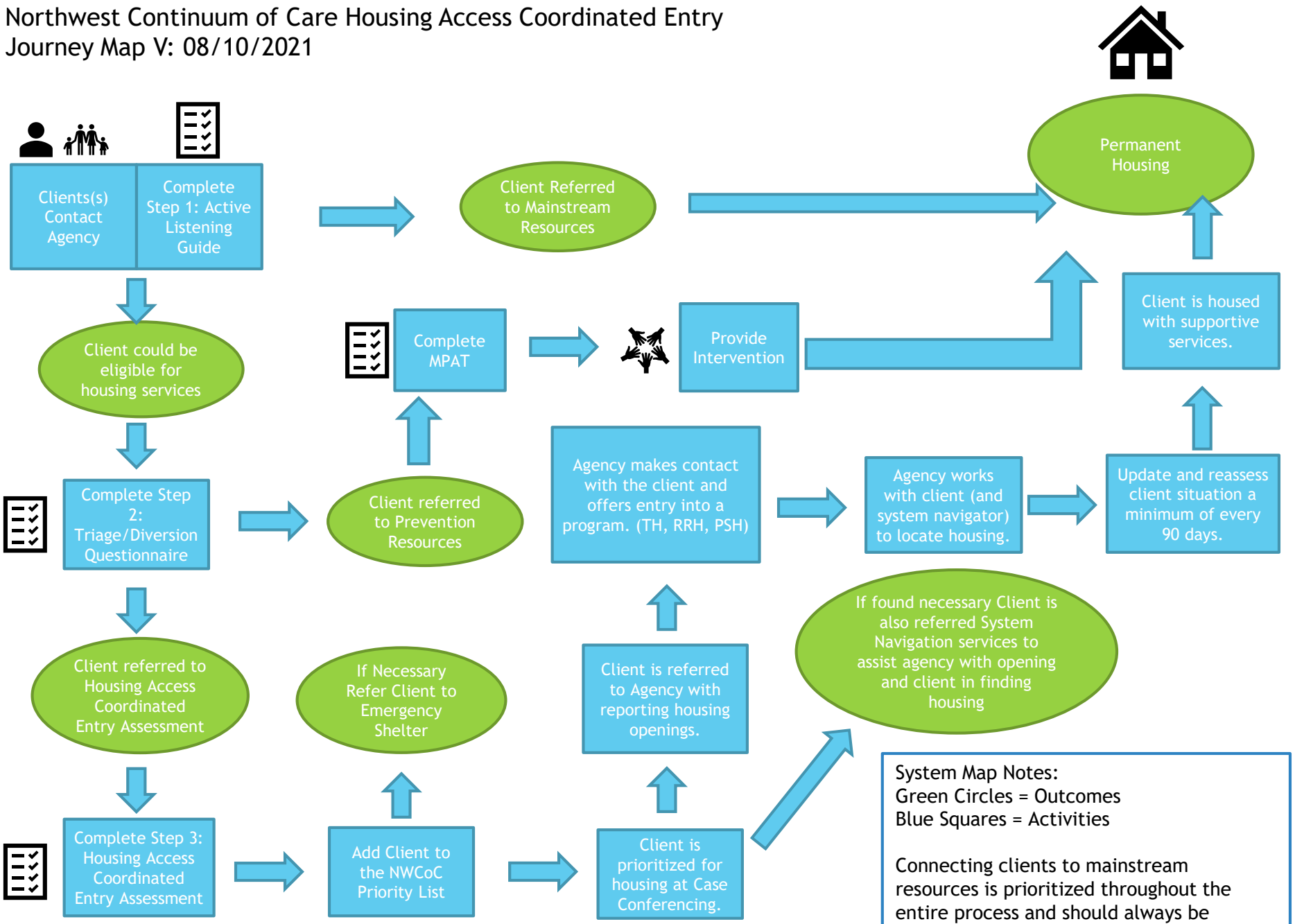
Quiz Questions 3

- This persons role is to meet with a client to help them determine the best intervention to solve the housing crisis, and maintain contact with the client until the crisis is resolved.

    1. Priority List Manager
    2. Case Manager
    3. Housing Navigator
    4. Assessor

- What is considered a referral to a mainstream resource or another program in the NWCoC Homeless Response System?
    1. Giving someone a brochure.
    2. Giving someone a phone number.
    3. Calling an agency or service provider and assisting the client access that resource.
    4. Giving someone a website link

Northwest Continuum of Care Housing Access Coordinated Entry Journey Map V: 08/10/2021



System Map Notes:
Green Circles = Outcomes
Blue Squares = Activities

Connecting clients to mainstream resources is prioritized throughout the entire process and should always be happening.

Assessment Workflow

Client makes contact with access site to speak with assessor. Or, Client is referred from Community Partner. Step 1 Active Listening Guide

Assessor determines no need for prevention or supportive housing, client referred to mainstream resources.

Assessor determines the client is in need of prevention or supportive housing services and performs Step 2 Triage Questionnaire

Step 2 determined that Prevention services are most appropriate step for clients eligibility.

In Step 3a the Assessor performs the MPAT or refers to agency with FHPAP or other Prevention services.

Refer client to Emergency Shelter if necessary.

OR

Step 2 determined that the client is in need of supportive housing services.

Complete Step 3b Coordinated Entry Assessment and place the client on the NWCoC Priority List

Maintain contact with the client while client is on list. Complete Interim Assessment at a minimum every 90 days.

Stages of ACCESS and ASSESSMENT

ASSSESSMENT STAGES	GOAL	WHEN TO COMPLETE	RESOURCE	RESPONSIBLE STAFF
1.Active Listening Guide	Designed to assist assessors in understanding what services the client may be looking for and what kind of referrals can be made to mainstream resources. If the client is likely in need of prevention or supportive housing the assessor will move on to Step 2 Triage/Diversion. Guide will either direct households to: • Mainstream services • Step 2: Triage/Diversion	First point of contact - after person has identified housing crisis or requested homeless services. Can be completed over the phone or in-person. Agency tailors form to match resource available in community.	NWCOC Access Points Step 1 Active Listening Guide	Assessor
Step 2: Triage/Diversion Questionnaire.	Designed to reduce the number of persons entering the homeless response by diverting to mainstream resources or prevention services. This questionnaire will determine if the person should be referred to: • Mainstream Resources • Prevention Services • Coordinated Entry Assessment • Housing Stabilization Services	Performed once the assessor determines the client is a likely candidate for prevention or supportive housing resources. Can be completed over the phone or in-person.	Step 2: Triage Questionnaire (HMIS)	Assessor

Stages of ACCESS and ASSESSMENT

ASSSESSMENT STAGES	GOAL	WHEN TO COMPLETE	RESOURCE	RESPONSIBLE STAFF
Step 3a. Prevention	The goal of prevention resources is to: • Reduce the number of people who become homeless for the first time (Prevent) • Reduce the number of people who experience homelessness (Rare) • Reduce the length of time people experience homelessness (Brief) • Reduce the number of people who return to homelessness (One-time)	ONLY after Triage/Diversion questionnaire has determined Prevention Services would be appropriate. If you complete Step 3a it is likely you are completed with the assessment and will not complete Step 3b. Can be completed over the phone or in-person.	MPAT (Paper Version)	Assessor
Step 3b. Assessment	Assessment for linkage to supportive housing (Transitional Housing (TH), Rapid-Rehousing (RRH), Housing Support, Permanent Supportive Housing (PSH) and Long-term Homeless (LTH) Vouchers). Linkage to resources is based on NWCoC prioritization criteria, client-choice, and peer to peer discussion through case conferencing meetings. NOTE: Being placed on the housing priority list does not guarantee a housing placement. Agencies should do everything possible to resolve the housing crisis without needing supportive housing services (housing with case management).	Only after Triage/Diversion questionnaire has determined supportive housing resources will be necessary. All clients who complete Step 3b are anticipated to be added to the NWCoC Prioritization list. Can be completed over the phone or in-person.	Step 3b Coordinated Entry Assessment (HMIS) NWCoC Prioritization List (HMIS) NW COC Receipt and CC ROI	Assessor Once a client is placed on the list it is the assessor's job to maintain contact with that client.
Step 4 Interim Assessment	The goal of the interim assessment is to ensure a client's situation is kept up to date until the client is housed. If the client has self-resolved, the client should be removed from the NWCoC Priority List to avoid unsuccessful referrals. If you are unable to maintain contact with the client you will remove them from being active on the NWCoC priority list and add them again once if you regain contact.	Must be completed a minimum of every 90 days to ensure client information is up to date. If client has been on the list for more than 90 days and you are unable to contact, consider removing from list.	Coordinated Entry Assessment (HMIS) NWCoC Prioritization List (HMIS)	Assessor, Housing Navigator or Housing Provider

Quiz Questions 4

- What best describes the Step 1: Active Listening Guide?
  1. A chance to listen and learn about a housing crisis, brainstorm solutions, and determine if the person may need prevention or supportive housing to resolve the crisis.
  2. Another form I have to fill out.
  3. The form to determine if someone should be on the Priority List.
- What is the purpose of Step 2: Triage/Diversion Questionnaire.
  1. Learn about demographic information.
  2. Collect information about the clients situation to pair with the most appropriate resources and divert clients from entering the homeless response system (coordinated entry system).
  3. Send clients to other locations for help.
- When would I complete Step 3b Coordinated Entry Assessment?
  1. First thing when I am contacted by a person seeking services.
  2. Once Step 2 Triage/Diversion Questionnaire has determined the person is homeless and will become homeless without supportive housing services. (housing with case management)
  3. After the person has been housed.
- How often do I need to update a clients information once they are placed on the Priority List?
  1. Whenever someone's information changes, or at a minimum every 90 days.
  2. Whenever the client comes back to the office for services.
  3. Once a year.

My Client is on this list - now what?
How are households prioritized?

- The NWCOC CES **Priority List** is not the **Waiting List**
  - A real-time up to date list of persons in NEED of supportive housing resources.
  - Persons on the list have generally tried all other forms of help, like utility assistance or one-time rent payments. Or it has been determined that without housing services and case management they will be homeless.
  - Prioritizes the most vulnerable and people with the highest needs.

- The Alternative Priority List.
  - DV Agencies and clients who refuse to sign the HMIS Release of Information.
  - The rest of the process is the same. Instead of using HMIS to interact with the priority list, you use the Alternative Priority List.
  - For access to the google doc e-mail Lori Anderson, Priority List Manager at delores@tvoc.org

The length of time someone has been homeless is an indicator of vulnerability and a factor in being prioritized for services.

The length of time a person has been on the priority list is not.

How are households prioritized?

The criteria is meant to inform the case conferencing process and assist in prioritization of individuals. Clients who meet these criteria will be determined to be the most vulnerable and prioritized based on the guiding values for prioritization.

Eligibility

- Current Living Situation (Where they are today and is updated as that changes)
- Previous (Prior) living situation (Where they are the night before the assessment)
- Length of Time Homeless
- Disability Information
- Household size (Total):
- Household Type
- Veteran Status

Barriers and Client Choice

- Client reports being Impacted by Societal Issues and Discrimination, creating additional barriers for the client to find housing.
- Interaction with the institutional systems.
- Where does client want to live? (Geography)
- What type of program/housing the client wants to be in?
- School Stability
- Client Reported Barriers / Needs
- Family Reconnection

Guiding Values of Prioritization

1. Serve the most vulnerable clients who without supportive services, case management and/or ongoing rental assistance will remain homeless or become homeless.

2. Addressing disparities in the homeless response system and who is being served by programs.

3. Clients are referred through a case consultation process to the best available resource.

4. Clients who are not referred to supportive services are offered help problem solving to end their housing crisis.

5. Prioritization is client-centric and strength focused. Clients are referred to services they identified are appropriate to end their housing crisis.

6. Through prioritization clients will be referred to programs they are in fact eligible to receive support from.

Quiz Questions 5

- What factor does not inform the prioritization of a client?
  1. Length of time homeless
  2. Disability status
  3. Geography where client wants to live
  4. Length of time on priority list

- Who should use / be on the Alternative priority list.
  1. Clients entering from DV Providers, and people who refused entry into HMIS.
  2. Everyone
  3. People who are on the main list but did not get housed.

- Which of the following is NOT a guiding value for prioritization?
  1. Addressing disparities in the homeless response system and who is being served by programs.
  2. Clients are referred through a case consultation process to the best available resource.
  3. A first come, first served approach to utilizing the limited supportive housing services.
  4. Serve the most vulnerable clients who without supportive services, case management and/or ongoing rental assistance will remain homeless or become homeless.

The Placement (Referral) Workflow

Step1: Housing Provider Completes Referral Request Form

Step 2: Case Conferencing Identifies Client(s)

Step 3: Priority List Manager Refers Client(s) to your Program in HMIS or from Alternative List.

Step 4a: Housing Provider Acknowledges Referral in HMIS and makes contact with the client to offer entry into program.

OR

Step 4b: Housing Provider makes 3 attempts in 5 days to contact and is unsuccessful in making contact. Or the client did not accept entry into the program. Or the housing provider finds the client is ineligible.

Mark the referral as unsuccessful in HMIS with the appropriate data. Or if using the Alternative list contact the PLM.

If the housing provider feels this client should no longer be on the Priority List please notify the original assessor and determine if client should remain on the Priority List.

Step 5: Client Accepts Referral into the program. Housing Provider Assists Client in finding housing.

Step 6: Client finds housing! Update HMIS with a housing move in date.

OR

Step 6b: Client is unable to find housing with help from the housing provider and exits the housing program. Conduct an Interim Assessment entry and put back on Priority List or Alternative list if still in need of supportive housing.

Note: This is a system illustration. A deeper dive into the step by step process is provided by ICA HMIS Training. If you are using the Alternative List you will need to communicate with the PLM throughout the process.

Placement (Referral) Stages

REFERRAL WORKFLOW STAGES	GOAL/ACTIVITY	WHEN TO COMPLETE	RESOURCE	RESPONSIBLE STAFF
Step 1: Report the Opening	The housing provider informs the Priority List Manager of a program opening. This is done through a google form. E-mail the Priority List Manager for the form. All programs required to fill slots through coordinated entry will need this form.	As soon as you have a program opening that needs to be filled through coordinated entry.	Housing Opening Referral Form	Housing Provider
Step 2: Case Conferencing	Referrals of housing programs will be filled through Case Conferencing meetings. Section XX provides more detail on the process of Case Conferencing. These peer to peer meetings will take in account program eligibility and the Guiding Criteria set for prioritization.	Case Conferencing is bi-weekly for YHDP. It is 2x a month for East & West.	Case Conferencing Meetings	All staff of the NWCoC and Service Providers
Step 3: Referral to the program.	The Priority List Manager will create a referral event in HMIS for the provider with the client that was identified to be referred to the program, or will send the information via e-mail if using the Google Doc list.	Once a client has been identified through Case Conferencing to be referred.	HMIS	Priority List Manager
Step 4a: Accept the Referral and contact the client.	The Housing Case Manager or Housing Navigator will Acknowledge the referral in HMIS to begin the process of working with the client. If you are using the Alternative List you will need to communicate with the PLM.	Review and accept the referral as soon as possible and contact the client. Staff will make a minimum of 3 attempts over 5 days to contact the client. Contact the original assessor for assistance.	HMIS Social Media Communication	Housing Program Staff Assessor

Placement (Referral) Stages

REFERRAL WORKFLOW STAGES	GOAL/ACTIVITY	WHEN TO COMPLETE	RESOURCE	RESPONSIBLE STAFF
Step 4b: Unable to Contact the Client	After exhausting all resources to contact the client the housing staff will need to mark the referral as unsuccessful in HMIS. If you feel the client should be removed from Coordinated Entry, work with the assessor to make that determination.	After making a minimum of 3 attempts over 5 days using all communication methods possible.	HMIS	Housing Program Staff
Step 5: Locate Housing for the Client	Housing providers will assist the client in locating suitable housing to get into the program, assisting them with working with the landlord. This is the responsibility of the housing provider or Housing Navigator if one is available.	As soon as you enter the client into the program.		Housing Program Staff
Step 6: Complete the Referral in HMIS	This client has found housing. The housing provider will update HMIS as instructed in the HMIS Data Entry Instructions for Housing Providers. If using the Alternative List you will work with the PLM.	As soon as the client has a housing move-in date.	HMIS	Housing Program Staff
Step 6b: Client unable to find housing	Housing providers must give a minimum of 10 days for a client to locate housing with your assistance. This timeline should be expanded if the client is actively working with you. Clients with barriers such as facing discrimination will need additional time and support to locate and find willing landlords. It is the housing providers' role to create successful outcomes for the client. If the client does not find housing, you will exit them from your housing program and return them to the Priority List following the HMIS Data Entry Instructions for Housing Providers.	A minimum of 10 days is a guideline. It will most likely always take longer. This guideline starts once the client accepts the referral into the program.	HMIS	Housing Program Staff

Quiz Questions 6

- What is the primary path for getting referral for your program opening from the coordinated entry list?
  - Calling the Priority List Manager
  - Calling 211
  - Completing a housing referral form and attending case conferencing
  - Asking the next person to walk in the office

- Why do we have a referral process in the homeless response system?
  - Because the COC Coordinator thinks they know to much
  - To ensure accountability to the guiding values of client prioritization
  - To share contact information

The Step by Step – In the Simplest Form

1. Assessor at Agency starts with the active listening tool and determines the following:
    1. Refer to Mainstream Resources (Internal and External) (Client likely does not qualify for housing or prevention)
    2. Refer to Step 2 Triage/Diversion Questionnaire (Client would likely qualify for housing or prevention)

2. Complete the Step 2 Triage Questionnaire on paper or in HMIS and determine the following:
    1. Refer to Mainstream Resources (All clients will be given resources to access mainstream resources)
    2. Refer to Prevention Resources (MPAT) (Client can remain in safe housing with prevention resources)
    3. Refer to Coordinated Entry Assessment (Client will is homeless or will be homeless without supportive housing resources)

3. Complete Step 3 Coordinated Entry Assessment
    1. Add client to the NWCoC Priority List
    2. Provide a client copy NWCoC CES Receipt – *Improved Language that Assessor will be trying to stay in touch with you.*

4. Agencies let the Priority List Manager know when you have a housing opening.

5. Agencies Attend Case Conferencing to assist with identifying clients for referral to program your programs, and your clients to other programs.

6. Accept referrals to your program and assist them in finding housing.

System Overview Q and A (approx. 15 minutes)

At this time we will focus on questions that are in regard to the system. The next part of our training will focus on the “How To” of the HMIS system.

BREAK 15 Minutes

Lets transfer to the “How To” of the training!
The How-To of the Northwest CoC CES

Agenda:

- Training Overview
- Agency Access Requirements
- Current Access Sites
- Overview of Forms and Process
- Overview of Case Conferencing
- -Short Break
- Overview of the Referral System
- System Resources
- FAQ’s
- Live Q and A

Where do I access the policy and procedures for the Homeless Response System and Coordinated Entry?

The NWCoC Website is always the most up to date resource.
https://www.nwmf.org/resources/strategic-partnerships/nwcoc/housing-access-coordinated-entry/

In order to pilot this assessment procedure we have not spent the time investment on updating the existing policy and prioritization policy manuals.

This training and the NWCoC CES Manual will serve as the guiding documents until a new policy and prioritization policy can be developed and approved by the board.

Upon launch of the new assessment tool on October 25th please use this training as your guide to the NWCoC Homeless Response System and Coordinated Entry. A user guide is being developed to accompany this training.

Please discard and disregard the currently approved:

- CES Policy Manual Approved October 2020
- Northwest Prioritization Policy

What's required of my agency to participate in CES

- Your first step to getting started is contacting the NWCoC Priority List Manager.
- In order for you or your staff to access the NWCOC CES the following needs to be completed.
  - Training.
  - CES Inter-Agency Data Sharing Agreement
  - Coordinated Entry Participation Agreement
- Once all of these items are completed the NWCOC Priority List Manager will notify you that your access has been approved.
- Access grants the following.
  - View/Edit Clients in HMIS that are in CES
  - View the NWCOC Priority List in HMIS and the Alternative List for DV providers and clients who refused to sign the HMIS Release of Information.
  - Request referrals to your program.

Quiz Questions 7

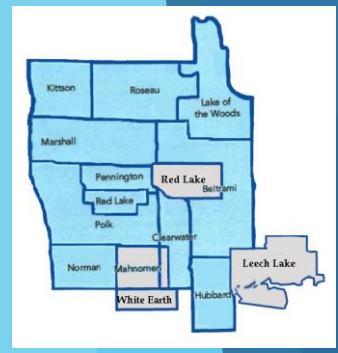
- Who do I e-mail to complete NWCOC trainings?
  - My Supervisor
  - Marcia Fudge
  - The NWCOC Priority List Manager
  - The NWCOC Coordinator

NWCoC Access Points

An access point is an existing agency or point-of-contact where households facing a housing crisis can go or call to be screened for entry to or diversion from the regional homeless response system.

NWCOC Access Sites

Northwest Minnesota Continuum of Care (NWCOC)



Coordinated Entry Access Sites for Homeless Assistance

BI-CAP (Bemidji)	(218) 751-4631 1(800) 332-7161	Beltrami County
Care and Share (Crookston)	218-281-2644	Polk County and Surrounding Area
Evergreen Youth & Family Services (Bemidji)	(218) 751-8223	**YOUTH/YOUNG ADULTS ONLY**
Housing Matters (Bemidji)	612-834-1470	Beltrami
MAHUBE-OTWA (Park Rapids & Mahnomen)	(218) 935-5022	Hubbard and MahnomenCounties & **YOUTH/ YOUNG ADULTS**
Inter-County Community Council (Oklee)	(888) 778-4008, Ext. 6	Red Lake, Pennington, East Polk, and ClearwaterCounties & **YOUTH/ YOUNG ADULTS**
Northwest Community Action (Badger)	218-528-3258 1-800-568-5329	Kittson, Lake of theWoods, Roseau & Marshall Counties **YOUTH/YOUNG ADULTS**
Northwest Indian Community Development Center (Bemidji)	218.759.2022	***Beltrami County YOUTH and YOUNG ADULTS**
ALUMA	**218-281-3940**	Kittson, Mahnomen, Marshall, Norman, Polk, or Red Lake County
Red Lake Homeless Shelter (on the Red Lake Reservation)	(218) 679-3171 (218) 679-3228	Note: Red Lake Tribal members ONLY **& YOUTH and YOUNG ADULTS**
Tri-Valley Opportunity Council (Crookston)	1-800-201-3475	Norman, West Polk, and West Marshall Counties & **YOUTH/YOUNG ADULTS**
Village of Hope (Bemidji)	(218) 751-0722	Note: Shelter residents ONLY
Violence Intervention Project (Thief River Falls)	(218) 681-5557 (800) 660-6667	Note: Domestic Violence ONLY
White Earth DHS/ Housing Program (White Earth Reservation)	(218) 935-5554	Limited to White EarthReservation

Indicates Youth Homelessness Demonstration Project Grantees

Step 1: Active Listening Tool Overview

Designed to assist assessors in understanding what services the client may be looking for and what kind of referrals can be made to mainstream resources. If the client is likely in need of prevention or supportive housing the assessor will move on to Step 2 Triage/Diversion. Guide will either direct households to:

- Mainstream services
- Step_2: Triage/Diversion

When does this step happen?

At intake, or over the phone, whenever you first meet the client.

NWCOC Proposed Triage Questionnaire

Step 1 Active Listening Tool

My name is _____, how can I help you today? Could you start by telling me where you are located?

Fill in Location_____.

Please tell me your name and what kind of resources do you feel would be most beneficial to help resolve your situation?
Active Listening: Let people tell you the story of their housing crisis. *Check the boxes as you listen.*

Resources Checklist (Check boxes based on client's story) *N… intended to ask about every option		
Resource	***Checkbox***	***Referral Information (Agency Specific)***
Transportation		
Income and Employment		
Food		
Child Care		
Life Skills Classes		
Emergency Shelter		***Refer to DV Shelter or ES***
Fleeing Violence of Abuse		***Refer to DV Shelter or ES***
Security Deposits		
Utility Payments		
First Month's Rent		
Short Term Rent		
Housing Voucher (No Services)		
Supportive Housing w/ Case Management		
Housing Navigation Assistance		
Landlord Payment Plan		
Health Insurance		
Mental/Behavioral Health		
Substance use/chemical health		
Education / (School Homeless Liaison)		
Energy Assistance		
County Assistance		
Contacting a support network for help.		***assist client in making connections.***
Other		
BOLD = Likely Candidate for Assessment for Coordinated Entry		*Italic = Likely Candidate for Prevention*

If client indicates a need for any category that is BOLD or Italic continue on with assessment collect contact information and move onto Step 2. If not, make referral to appropriate mainstream resource available in your community based on clients housing story. (Assessor Judgement)

Client Name:	***Phone Number:***	***Other:***
E-mail:	***Facebook:***	
Contact information is optional to collect during Step 1.		

Assessor Notes:

Step 2: Triage Questionnaire Overview

Designed to reduce the number of persons entering the homeless response by diverting to mainstream resources or prevention services. This questionnaire will determine if the person should be referred to:

- Mainstream Resources
- Prevention Services
- Coordinated Entry Assessment
- Housing Stabilization Services

In 2020 only 25% of people referred to the coordinated entry priority list received housing. Putting people on a list that is unlikely to match them with resources does not do them or the housing provider any good.

It is important to use this process to attempt a lighter touch approach before resorting to intensive interventions.

When does this step happen? Once you have determined that the client is likely in need of prevention or supportive housing services.

This step will be completed in the HMIS system.

For DV providers, or people who refused to sign the HMIS ROI this step can be completed in an alternative database.

Step 2: Triage Questionnaire Overview

- Walk through the Step 2: Triage Questionnaire in HMIS with Scott McGillicuddy of ICA
- Walk through Alternative Step 2 Form in JOTFORM with Cory Boushee, COC Coordinator
  - For access to the Alternative form e-mail priority list manager. https://form.jotform.com/212724406233043

Step 3a: Minnesota Prevention and Assessment Tool (MPAT)

- This training will not dive into the MPAT.
- Due to nearly all prevention resources in the NWCoC being offered through the Family Homelessness and Prevention Program which requires use of the MPAT a separate prevention tool has not been created at this time.
  - The following agencies can be contacted to assist someone with Prevention resource and complete an MPAT.
    - Bi-CAP
    - Northwest Indian Community Development Center
    - Evergreen Youth and Family Services (Youth Specific)
    - Mahube-Otwa
    - Red Lake Homeless Shelter
    - White Earth Homeless Program
    - Leech Lake Homeless Program
    - Tri-Valley Opportunity Council
    - Inter-County Community Council
    - Northwest Community Action
  - If your agency is not required to use this tool at this time you will not be required to use it.

The goal of prevention resources is to:

- Reduce the number of people who become homeless for the first time (Prevent)
- Reduce the number of people who experience homelessness (Rare)
- Reduce the length of time people experience homelessness (Brief)
- Reduce the number of people who return to homelessness (One-time)

When does this step happen? Once you have completed Step 2: Triage Questionnaire and have determined that Prevention resources are best. If you were to determine that more intensive Supportive Housing resources are needed you would skip this step and move onto Step 3b.

Step 3b: Coordinated Entry Assessment Overview

Assessment for linkage to supportive housing (Transitional Housing (TH), Rapid-Rehousing (RRH), Housing Support, Permanent Supportive Housing (PSH) and Long-term Homeless (LTH) Vouchers). Linkage to resources is based on NWCoC prioritization criteria, client-choice, and peer to peer discussion through case conferencing meetings.

NOTE: Being placed on the housing priority list does not guarantee a housing placement. Agencies should do everything possible to resolve the housing crisis without needing supportive housing services (housing with case management).

When tracking successful referrals from 4/1/2020 – 4/1/2021 data would tell us that Native Americans have a referral success rate of 21% while populations identifying as another race have success rates from 30-50%. During this time 206 referrals were declined or canceled, 47% (98 People) were due to the client disappearing or unable to contact. Of that 47% (98 people) unable to be contacted 78% were Native American (76 People) – The new guiding values for prioritization are designed to reduce this disparity.

When does this step happen? Only after Triage/Diversion questionnaire has determined supportive housing resources will be necessary. All clients who complete Step 3b are anticipated to be added to the NWCoC Prioritization list. Can be completed over the phone or in-person.

This step will be completed in the HMIS system.
For DV providers, or people who refused to sign the HMIS ROI this step can be completed in an alternative database.

Step 3b: Coordinated Entry Assessment Overview

- Walk through the Step 3b: Triage Questionnaire in HMIS with Scott McGillicuddy of ICA
- Walk through the Alternative Step 3b form with Cory Boushee, COC Coordinator
  - For access to the Alternative form e-mail priority list manager. https://form.jotform.com/212724406233043

HMIS Data Entry Instructions for Problem Solving/Diversion/Rapid Resolution Providers.

- Walk through the HMIS Data Entry Instructions for Problem-Solving/Diversion/Rapid Resolution Providers. with Scott McGillicuddy of ICA

Note: This walk through is not a substitute for watching the CES trainings on the MN HMIS website for those entering clients in CES in HMIS.

https://www.hmismn.org/coordinated-entry

NWCoC CES Receipt and Case Conferencing ROI

- The reason for the receipt and CES Consent for Release of Information is for both client and agency. The Notice & Consent for ROI should be given to the client after intake is complete and the client is going to be entered into Coordinated Entry. If the client is not completing intake in person, it can be sent electronically. Clients could also be encouraged to take a picture of it with their cell phone in case it gets lost. It can also be scanned and uploaded to HMIS.

- The Receipt should:
  - outline the responsibilities of the assessing agency and the client
  - let the client know their options (accept or refuse a referral),
  - Encourage the client to keep updated contact information and communicate changes in housing status.

Walk Through the NWCoC CES Receipt and Case Conferencing ROI with Priority List Manager, Lori Anderson.

NWCoC Coordinated Entry Receipt and ROI

When does this step happen? The Reciept and Case Conferencing ROI should be completed by agency and client that complete Step 3b: Coordinated Entry Assessment

Interim Assessment

- At a minimum of 90 days an Interim Assessment needs to be completed for anyone on the Priority List. This can be completed by the Assessor, a Housing Navigator, or Agency who has accepted a referral.

- An Interim Assessment ensures the clients entry into CES has the most up to date housing status and contact information for the household. Even if nothing changes for the client, the system needs to know that the client is still homeless and in need of supportive housing resources.

- If you are completing an Interim Assessment in HMIS follow the instructions provided by ICA in the. HMIS Data Entry Instructions for Housing Providers

Quiz Questions 8

- When do I complete the Step 2: Triage Questionnaire?
  - After I offer housing services to the client.
  - Once I have determined that the client is likely in need of prevention or supportive housing services.
  - When the client has housing, but asked for help with transportation and medical insurance.

- How often do I need to complete an Interim Assessment?
  - Every 6 months.
  - Whenever I have time to work it in to my schedule.
  - At a minimum every 90 days, and every time I have contact with the client.

Short Stretch Break

How do I get a referral to my program opening? Google Form

- The process starts with the google referral request form to notify the Priority List Manager that you have an opening.
- Walk Through Google referral form with Lori Anderson, Priority List Manager https://forms.gle/D13AdZaKtqb3Q3oq9
- Whether or not you are using HMIS or the Alternative Priority List forms you will use this referral form to request referrals.
- The typical next step is going to be case conferencing. If you have an urgent need for a referral for a client contact the Priority List Manager.
  - Remember Case Conferencing meetings are two weeks a part. It is the housing provider responsibility to be thinking ahead when you may have a program opening to get referrals in advance.

How do I get a referral to my program opening?
Overview of Case Conferencing

- **What are Case Conferencing meetings?**
  - Case Conferencing meetings are routine meetings designed to manage the Coordinated Entry Priority List. The Priority List Manager will facilitate these meetings.
  - Before each Case Conferencing meeting, the Priority List Manager will pull the current Priority List. Currently, the list is organized by Housing Category and the Priorities previously established by the NW CoC.
  - Meetings are held either twice a month or bi-weekly. There are three Case Conferencing groups meeting as follows:
    - YHDP – Every other Tuesday
    - East Area – 2nd and 4th Wed. of each month 9:30 – 10:30
    - West Area – 1st and 3rd Mondays from 10 – 12
  - In the event of an urgent, time-sensitive situation, a case conference meeting may be scheduled by contacting the Priority List Manager.

- **Who should attend Case Conferencing meetings?**
  - Housing Provider Representatives/Case Managers
  - Street Outreach staff
  - Advocates for Participants
  - Any direct service providers that can assist with case conferencing participants. Group members will adhere to privacy policies.

- **What is discussed at Case Conferencing?**
  - Current location of client (camping, shelter, doubled up, etc.)
  - Barriers (review and problem solve)
  - Safety issues
  - Households on the list for more than 90 days with no updated documentation.
  - Households currently in a Transitional or Rapid Rehousing program but the Case Manager has determined they are in need of a Permanent Supportive Housing program.
  - Next steps: Possible referrals, documentation that needs to be updated, agency roles

How do I get a referral to my program opening?
Guiding Values of Prioritization

1. Serve the most vulnerable clients who without supportive services, case management and/or ongoing rental assistance will remain homeless or become homeless.

2. Addressing disparities in the homeless response system and who is being served by programs.

3. Clients are referred through a case consultation process to the best available resource.

4. Clients who are not referred to supportive services are offered help problem solving to end their housing crisis.

5. Prioritization is client-centric and strength focused. Clients are referred to services they identified are appropriate to end their housing crisis.

6. Through prioritization clients will be referred to programs they are in fact eligible to receive support from.

How do I get a referral to my program opening?
Acknowledge a Referral – Accept of Deny

Now that you have made the PLM aware of your opening, and received a referral from the HMIS system you will need to acknowledge acceptance of the referral.

At this point there are few reasons to deny a referral. One example could be knowledge that the client is ineligible for the program.

If you need assistance throughout the referral process:

The MN HMIS website has detailed videos on accepting referrals, and the next steps HMIS Coordinating Instructions. https://www.hmismn.org/coordinated-entry

If you need assistance going through these instructions please contact Priority List Manger or the HMIS Helpdesk.

If your agency uses the Alternative Priority list contact the Priority List Manager for assistance.

How do I get a referral to my program opening? Mark a referral Successful or Unsuccessful.

- Now that you have Acknowledged and Accepted a referral you will work to contact that client and offer entry into your housing program.

- Contacting clients can be challenging. The general rule is to use all means of communication provided 3 times over a 5 day period. If you are unable to communicate complete the steps to mark the referral as unsuccessful. (Note: Our data is evident Native American populations may need additional time for communication, and we will need to work harder to maintain contact.)

- Once you have made contact and determined the client is in fact eligible for your program. Give the client time to accept the referral. This can be up to a week.

- Once the client has accepted the referral work with the client to find housing. This is generally a minimum of 10 days. Now, it would be pretty rare for anyone to find housing that soon in the northwest Region. That guideline is in place for instances where you are unable to maintain adequate contact, or the client is not actively working on finding housing with you.

How do I get a referral to my program opening? Client is Housed!!! ☺

At this point the client hopefully has found housing.

Close the CES entry – Be sure to add the housing move-in date!!

Provide case management to maintain housing stability.

If the client is unable to find housing.

Return the household to the Priority List using the detailed instructions in the HMIS Data Entry Instructions for Assessors. Or if using the Alternative list contact the PLM.

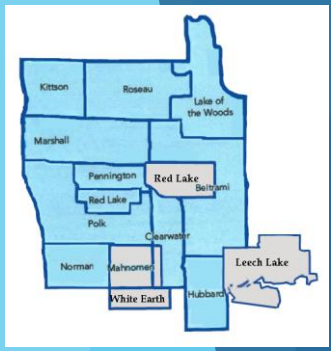
If the housing provider feels this client should no longer be on the Priority List please notify the original assessor and determine if client should remain on the Priority List.

Quiz Questions 9

- What is the first step I should take when I am sent a referral from the NWCoC Priority List?
  - Check for eligibility and Acknowledge the referral in HMIS or responding to PLM if using the Alternative List.
  - Find an apartment.
  - See if I have a program opening.

- What best describes Case Conferencing?
  - The Coordinated Entry Committee.
  - Case Conferencing meetings are routine meetings designed to manage the Coordinated Entry Priority List. The Priority List Manager will facilitate these meetings.
  - The COC CES user groups.
  - Where I send my clients.

System Overview –
Where are all the system resources to refer to?



- The NWCOC Housing Resource Guide can assist in finding resources available during each stage of the system. Link to Housing Resource Guide

Housing Resource Guide for Northwest Minnesota Housing Case Workers

Agency	Program	Coordinated Entry Triage/ Assess	Project Type	Intake Process	Service Area	Eligibility Notes
Bi-County CAP	Energey Assistance	Yes	Prevention/Diversion	Assessor Referral	Beltrami County/Cass County	Income limitations:
Bemidji HRA	Section 8 Vouchers		Mainstream Resource	Assessor Referral / Application Process	Clearwater, Hubbard, Mahnomen, Beltrami	Income limitations:
Bemidji HRA	Foster Youth Tenant Protection Vouchers	Yes	Rapid Re-Housing	Evergreen/County Referral	Beltrami County	Must have been in Foster Care.....
Care and Share	Emergency Shelter	Yes	Emergency Shelter	Assessor Referral/Call/Drop-In	Crookston Area	Care and Share is a homeless shelter that serves men, women, and families. We have 4 dorms rooms, up to three women's spaces, and up to 4 family spaces

The NWCOC System does not consider a phone number or brochure a referral. A referral means calling on behalf of the client to get information and setup an appointment.

Where do I go when I want to make change?

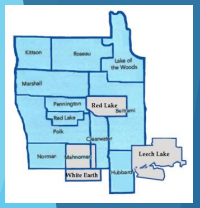
- The NWCoC has scheduled Coordinated Entry User Groups on
  - Thursday October 28th 1:00 – 2:30 first NWCOC – CES User Group Session
  - Next one is November 4th from 1:00 – 2:30. Following that, sessions will be first Thursday of every month.

These session are meant to be a place to come together and ask questions and go through scenarios where it seems the system is failing.

Other venues will be case conferencing, coordinated entry committee, CoC Membership.

You can always talk to the CoC Coordinator or Priority List Manager regarding the what is not working for you and your team.

Where do I go if I have questions



- **NWCOC coordinator**
  - For questions regarding the homeless response system and the Coordinated Entry System in Northwest Minnesota the COC Coordinator can be of help. You can contact Cory Boushee at coryb@nwmf.org.
- **Priority List Manager**
  - For questions regarding the priority list or client referral process in Northwest Minnesota, the Priority List Manager can be the best resources. You can contact Lori Anderson at delores@tvoc.org. Lori can also advise on HMIS system processes. If you have questions regarding the Alternative Priority List , Lori is also the best resource for that.
- **MNHMIS Website / Helpdesk**
  - The Institute of Community Alliances who serves as the lead agency for HMIS can answer any questions regarding the role of HMIS in coordinated entry and how to use HMIS. https://www.hmismn.org/coordinated-entry You can also e-mail the Help Desk at MNHMIS@icalliances.org and someone will quickly response to help.
- **NWCOC Website**
  - The NWCOC has a page dedicated the Housing Access Coordinated Entry System that has training resources, policies, and forms related for agencies. https://www.nwmf.org/resources/strategic-partnerships/nwcoc/housing-access-coordinated-entry/.
- **Grant Managers**
  - The program you are operating has a grant manager that can assist you with questions. Work with your supervisor if you need to ask a question of your grant manager. An important note is grant managers are not able to grant any variance to the policy and procedures of the NWCOC CES. Any variance to policy needs to be granted by the NWCOC board or a policy change needs to be implemented.

Frequently Asked Questions

- Do I need to use CES?
  - If your agency is providing supportive services it is likely your program requires the use of the Coordinated Entry System. All federally funded projects by the Continuum of Care program of Emergency Solutions Grant (ESG) program require the use of CES. This includes all homeless designated beds or vouchers must utilize the CES prioritization list to fill ALL open beds/units/vouchers. This includes: Transitional Housing, Rapid Re-housing, Permanent Supportive Housing, Emergency Solutions Grant THP, Community Living Solutions (formerly GRH), Long-term Homeless and Chronic Homeless voucher or site-based beds. Bridges, VASH, SSVF, and YHDP.

- I am already working with a client in a different program (i.e. County Social Services) and they need housing assistance, can I house them without using coordinated entry?
  - The simplest answer is no. You may end up still working with this client. But, they should work through the stages of assessment as everyone else.

- My grant says I need to use coordinated entry, but my funder says I only have to use certain parts.
  - It is important to remember there is only one CE system in NWCOC, meaning your grant funder cannot approve a change to how your program interacts with the CES system. **The NWCOC has authority over the CE system.** If you have questions regarding whether or not your program slots need to be filled with the CE system, please reach out the NWCOC Coordinator.

Frequently Asked Questions

Q. Who receives an assessment?

Households who are homeless or doubled up.

Exceptions:

If a client applies for housing/homeless assistance and already has a landlord who will rent to them, they would not have to be entered into CES IF you are assisting with a one-time assistance from a program such as FHPAP that does not have a requirement to pull from the priority list. If the client has a need for on-going rental assistance and you will be assistance with a program such as PSH, Rapid Rehousing, THP, or other programs that have CE as a requirement, you would do an assessment.

If a client has been "doubled up" with the same household for a year or more, they are not considered to homeless. They may be "at risk" due to a variety of circumstances. Assessor expertise will determine if a client in this situation is entered into CES. Be sure to enter detailed Assessor Notes in this case.

Q. When do you enter a client into CES:

You can complete the Assessment either directly in HMIS/ServicePoint or do a paper copy and enter later. Enter their information as soon as possible after completing an application.

AVOID DUPLICATE ENTRIES. Before you enter a household into CES, check their HMIS record to make sure they have not been entered into CES by another agency in our CoC. This is one reason it is important to enter clients within a day or two of intake. If a household already has an open CES entry for NW CoC, you can update the HMIS record by adding an interim update (see below).

Frequently Asked Questions

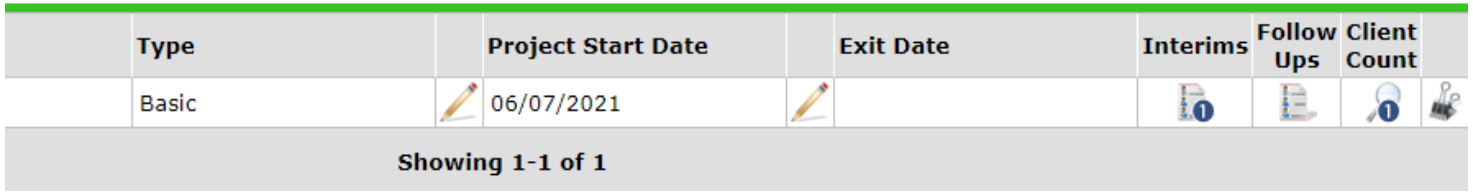
Q. How Often do we update a client's CES entry? What is this process?

The agency that does the intake and assessment has the responsibility to keep in contact with the household and update the CES record accordingly. Update notes should be recorded in the Assessor Notes in the CES record. Be sure to have good contact information. **DO NOT UPDATE A RECORD IN THE ASSESSMENT TAB.**

When a client has been referred to an agency, that agency will also update the assessor notes as to their attempts to contact (# of times, method, date) and results of the contact.

Client CES entries should be updated by adding an **Interim Review** to the clients CE at least once every 90 days.

1. Go to the client's record in HMIS, (be sure to EDA to CES).
2. Choose Interim in the NW CoC CES project.
3. Add Interim Review,
4. Review type is Update.



	Type		Project Start Date		Exit Date	Interims	Follow Ups	Client Count	
	Basic		06/07/2021						
Showing 1-1 of 1									

Whenever you update, be sure to add a note to the Assessor Notes toward the bottom of the assessment. Do not do the updates through the Assessment tab – always use the Interim function. Updates can be made by the assessing agency, referral agency, or PLM.

Frequently Asked Questions

Q. When do we remove (EXIT) a client from CES? Which agency should remove the client.

An assessor, housing provider, or the Priority List Manager can remove a HH from CE if they have information showing that the HH has left the area, is not responsive to attempts to contact, or self-resolves. If there is any question on if a HH should be removed, you can contact the Priority List Manager.

- Client is no longer in contact with assessing agency (assessor)
  - Assessing agency will issue a CES receipt that instructs the client to maintain contact with the agency and update their information. The assessing agency will update the client HMIS record at least every 90 days from date of entry.
  - There should be 3 attempts in a 2 week period to contact the client using the various contact information provided by the client. Record the dates, times, methods and result of each attempt as an update in the client's CES record in HMIS.

- Client rejects several referrals.
  - PLM will contact the client to see if there is another course of action that we should consider or if client should be removed from the list.

- Agency who received referral cannot contact client after several attempts.

  There should be 3 attempts in a 2 week period to contact the client using the various contact information provided by the client. Record the dates, times, methods and result of each attempt as an update in the client's CES record in HMIS. In all instances, give the client a dead-line in which to contact you. If you do not hear back from the client, contact the assessing agency to see if the client is active with their agency. If not, close the CES record.

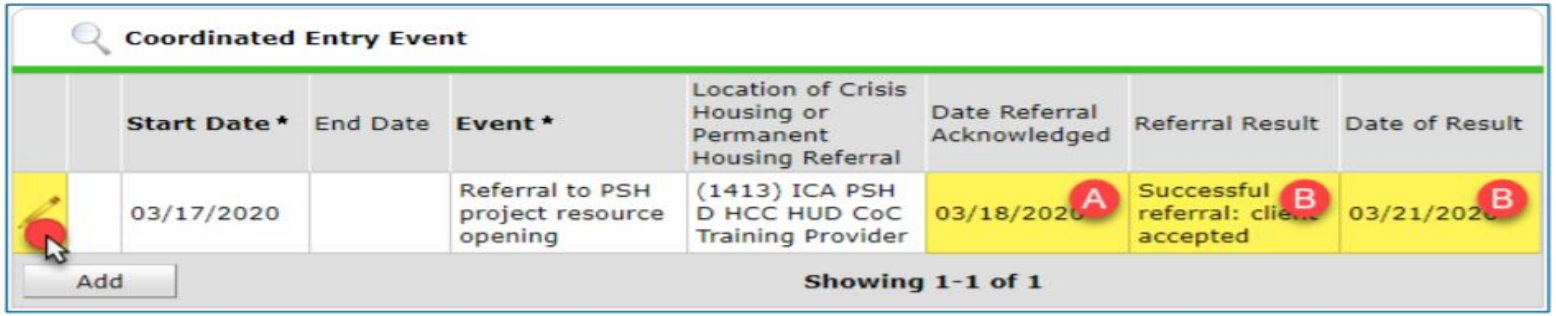
- When they are housed via Coordinated Entry (agency who received the referral and houses the client removes)

- When they are housed outside of Coordinated Entry, the exit will be made by the agency who obtained the housing information. Try to get the date housed and record that in the CES exit from HMIS.

Frequently Asked Questions

Q. I am an assessor – how do I check to see if my client has an active referral to a Housing Program?

- EDA to CES. Using the Assessment tab, find the Coordinated Entry Event sub-assessment. **Remember: Do Not Enter Data Into the Assessments tab.**
- If the Priority List Manager has made a referral to a housing program, you will see this in the Coordinated Event. It will show when the referral was made, who the referral was sent to, when the referral was acknowledged, and the result of the referral.



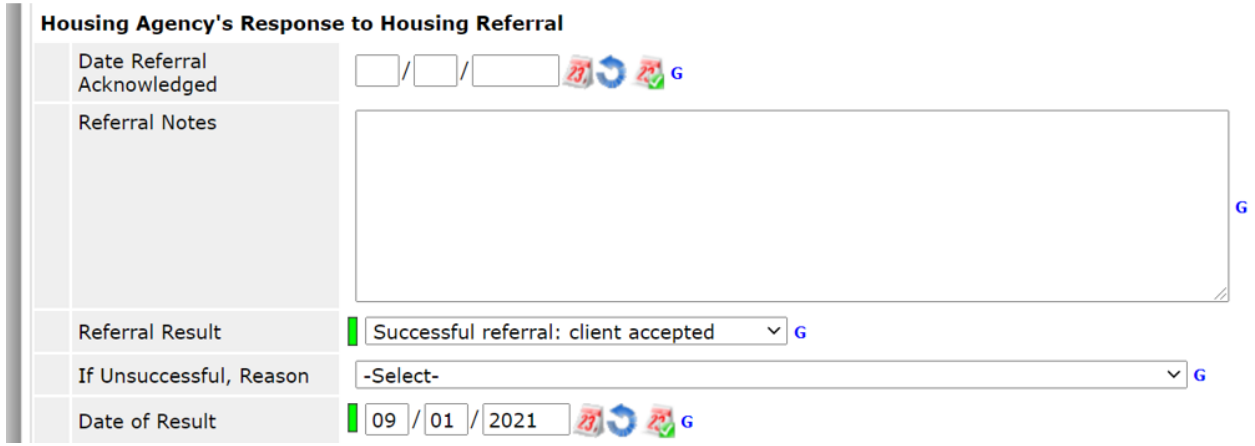
Q. I am a housing provider and unsure of the steps in the Referral Process.

Using Transitional Housing as an example:

1. Your THP program has an opening. The THP Program requests a referral from the Priority List.
2. PL Manager puts the referral in Coordinated Entry Event.
3. PL Manager e-mails you that the referral has been made.
4. Your Housing Program (THP) acknowledges the referral, puts the result in when it is complete.
5. If you cannot get in touch with the client after several attempts, you can decline the referral.
6. You enter the client into your housing program.
7. If it is a successful referral and the household is housed, you will EDA to your Coordinated Entry Provider and close the Coordinated Entry. Don't forget to add the Date Housed.
8. If they don't find housing or leave the area, you would then close them out of your housing program and go back into the referral (EDA to housing provider). You would then fill out the "Client Exited Program without Housing" portion of the CE Event. This will return them to the Priority List. If you know that they should not be on the Priority List because they found other housing (Section 8, other subsidized housing) or they have left the CoC, you should exit them from CES so their name does not come up on the PL.

Frequently Asked Questions

- **Q. A referral I accepted is still showing up on the Pending Referral tab.**
  - This is usually due to missing dates. Be sure to enter the date Acknowledged. Remember to EDA to the Housing
  - Program that is accepting the referral when you are entering data here.

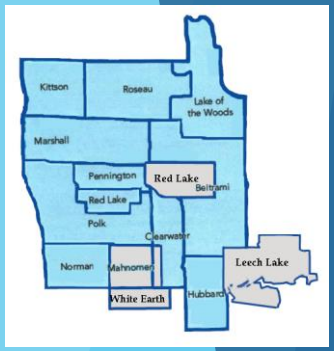


CES TIP

When you are assessing a household, make sure to ask all questions and enter them into HMIS. Missing data may affect when and if a person gets housing.

Bookmark this: https://www.hmismn.org/coordinated-entry. It is your HMIS resource for CES training, reviewing, and reporting. You will find the instructions for CES Assessors and Housing Providers. There are Data Entry Videos that are short and easy to understand. There is also a FAQ section for CES questions.

Live Q and A



- Use the Q and A box below or unmute.

What's next for training?

- Working with MESH to develop a COC Homeless Response System training plan that includes Coordinated Entry.
- We will get this training up on the website.
- October 28th 1:00 – 2:30 first NWCOC – CES User Group Session – Another detailed walk through.
  - Next one is November 4th from 1:00 – 2:30. Following that, sessions will be first Thursday of every month.
- Attend the HMIS User Groups sessions with ICA! They can help!
- As always please reach out to Cory, COC Coordinator or Lori, Priority List Manager if you have any questions.
- Do not stay stuck! We can provide help or locate the right person to help you if we know.

- **EVALUATION** https://form.jotform.com/212835256845159