MARYLAND
BALANCE OF STATE
CONTINUUM OF CARE

Coordinated Entry System Policies and Procedures

Updated: September 2020

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The CoC's CES Committee shall be responsible for the revision, review and approval of the CES Policies & Procedures. The revision process will be completed at least once annually. The most recent version serves as the prevailing document.

Document Version	Release Date	Key Changes
1.0	September 17, 2020	Board Approved

Section I: Coordinated Entry Overview

In accordance with 24 CFR 578.7(a)(8) and CPD-17-01, the Maryland Balance of State Continuum of Care (CoC), MD-514, has established and operates a Coordinated Entry System (CES) that:

- Connects people to appropriate services as quickly and effectively as possible
- Establishes a uniform and standard assessment and referral process to be used for all those seeking housing assistance
- Prioritizes referrals based on need and vulnerability
- Offers a system-centric, transparent and consumer-driven process
- Utilizes data for decisions, planning, resource allocation and performance evaluation
- Ensures the CoC knows all people experiencing homelessness by name
- Supports a Housing First approach
- Complies with HUD, VA and ESG policy and funding priorities

The Maryland Balance of State Continuum of Care Coordinated Entry Policies and Procedures outline the framework for the Coordinated Entry System (CES). The Maryland Balance of State Continuum of Care (MD BoS CoC) is composed of multiple counties, known as Local Homeless Coalitions (LHC) and the CES is a hybrid approach of local, regional and CoC-wide operations. In order for a local coordinated entry process to be recognized by the MD BoS CoC, communities must implement coordinated entry according to these standards.

The policies and procedures laid out within this document apply to the entire geography of MD-514 BoS CoC. This document is intended to ensure that the MD-514 CES is easily accessible for those seeking services, is well advertised, employs a comprehensive and standardized assessment tool and all households will receive a comprehensive assessment upon entry. Additionally, MD-514 will assure that client safety is at the forefront of the CES through specific protocol designed for those fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking; regardless if they choose victim or non-victim serving projects.

The MD-514 CoC will verify that all CES protocols are consistent with any written standards created by ESG recipients; and in consultation with ESG recipients, will use the policies herein to determine eligibility and prioritization requirements for all participating homeless services projects. A copy of the CoC's Written Standards can be found by clicking here.

MD-514 Coordinated Entry Guiding Principles

The BoS CoC has established the following guiding principles for the Coordinated Entry System. The CES will:

1. Operate with a person-centered approach and with person-centered outcomes.
2. Ensure that participants quickly receive access to the most appropriate services and housing resources available.
3. Reduce the stress of the experience of being homeless and limit assessments and interviews to only the most pertinent information necessary to resolve the participant's immediate housing crisis.
4. Incorporate cultural and linguistic competencies in all engagement, assessment, and referral coordination activities.
5. 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 them.

6. Integrate mainstream service providers into the system, including local Public Housing Authorities and VA medical centers.
7. Utilize HMIS for the purposes of managing participant information and facilitating quick access to available CoC resources.
8. Ensure that participants do not wait on the prioritization waiting list for periods in excess of 90 days.

Racial equity statement

Operating the Coordinated Entry and addressing homelessness through a lens of racial equity is a priority for the Balance of State Continuum of Care. Black, Indigenous and People of Color experience disproportionate impacts of homelessness across the nation and and People of Color experience disproportionate impacts of homelessness across the nation and the BoS CES assessment and prioritization processes should actively address these disparities. Without intentional intervention, inequitable outcomes linked to race will persist within the homelessness response system.

While addressing racial inequality within the BoS and within the effort to end homelessness is a significant and complex process; the CES is a major component of the CoC's plan to reduce homelessness and should be utilized as a device to measure and ensure equity in the day to day operations of the CoC. The CoC will review CE processes to understand the impact on people of different races and ethnicities, on an annual basis or as needed throughout the year. A diverse group of CES providers, current or former participants with lived experience, committees, CoC and HMIS Lead agencies will participate in the evaluation, update and change implementation to the CES.

Relationship between DHCD and Communities

The BoS Lead Agency, the State of Maryland Department of Housing and Community Development (DHCD), is responsible for ensuring that individuals in all participating communities have broad access to homeless services in coordination with regional and county leadership. DHCD supports this process by establishing policies and procedures, uniform tools, published written standards for homeless services and training designated providers. DCHD will set expectations that providers train staff regularly to ensure necessary skills and tools are available to complete the initial intake and assessment process. To support compliance, DHCD will provide oversight, monitoring, performance metrics and expectation, and plans for ongoing improvement. Each Local Homelessness Coalition (LHC) will operate with clearly defined roles and responsibilities while following the CoC-wide standardized Coordinated Entry System policy and procedure.

LHCs will facilitate day to day client assessment and prioritization on the BoS-wide By-Name-List (BNL). The BNL includes basic intake data and vulnerability scores, and is sortable by location, preferred placement locations and special population designation, e.g., veteran, families, youth or chronicity. Referrals to vacant beds/units will be made based on assessed priority needs and vulnerability of the households on the BNL, eligibility, and client location preference. Households must be on the BNL to be referred to appropriate housing options, including: Rapid Re-housing, Transitional Housing, Permanent Supportive Housing and other permanent housing.

Housing providers receiving funding from the CoC, state Homelessness Solutions Program (HSP), or Emergency Solutions Grant (ESG) funds are required to participate in Coordinated Entry and use the BoS BNL as the sole source of project referrals. The CoC strongly encourages all housing and service providers, regardless of funding source, to utilize the CES BNL to fill openings to maximize the efficient and effective use of all community resources to end homelessness.

Section II: Eligible Clients

The BoS Coordinated Entry System serves all individuals and families experiencing or facing literal

homelessness and households fleeing or attempting to flee domestic violence, categories 1 and 4 respectively of the HUD Homeless Definition; and ensures that all will have equal access to the system.[1] The process to serve those fleeing domestic violence will be described in Section IV: Coordinated Entry Workflow, Step I: Access and Connection to Coordinated Entry under the subtitle Safety Planning for Victims of Domestic Violence.

Coordinated Entry must be accessible to all households experiencing literal homelessness or fleeing or attempting to flee domestic violence, regardless of race, color, national origin, religion, sex, age, familial status, disability, actual or perceived sexual orientation, gender identity or marital status.

Diverting individuals from homelessness serves as a fundamental goal of the CES, and efforts will be made throughout CES participation to divert individuals and families, regardless of where they may be in the housing process. Additionally, households that are not literally homeless or are fleeing domestic violence will be engaged through problem-solving conversations, diversion planning and connections to other community and mainstream resources including: community action agencies, food access programs,childcare, and natural support networks such as family, friends or co-workers.

Verification of Homeless Status

The BoS CoC follows HUD's Order of Priority for verification of homeless status. All referrals are at a minimum self-certified and have additional verification of homeless status where possible.

Documentation priority/preference:

1. HMIS record
2. Third party verification
3. Self-certification

The following scenarios are recommendations for obtaining appropriate documentation, but may vary by region.

Emergency Shelter: Staff at emergency shelters are expected to assist residents in developing a housing plan, including third party verification of homeless status for the CoC's By Name List (BNL). Being on the BNL is the only way for homeless individuals to gain access to CoC and ESG funded projects.

Non-shelter settings: For households that do not enter Emergency Shelter, the BoS CES staff works with local providers, Street Outreach and each jurisdiction's case management workgroup to supplement information for those referrals with only a self-report of literal homeless status.

Individuals and families retain the right to decide what information they provide during the CES process. This includes victims of domestic violence and those fleeing or attempting to flee domestic violence, dating violence, sexual assault or stalking whose identifying information is not submitted into HMIS. The CoC will not deny assessment or services to a participant if they refuse to provide certain pieces of information.

Verification of Disability

Some housing types require additional eligibility elements prior to enrollment, primarily a disabling condition. Third Party Verification will be required to establish disability status for program eligibility. The specific format and process may look different from one region to another, however, an individual or

[1] Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH): Defining "Homeless" Final Rule/ https://goo.gl/HSRs2c.

head of household's qualifying disability must be documented by one of the following:

- Written verification of the disability from a professional licensed by the state to diagnose and treat the disability and his or her certification that the disability is expected to be long-continuing or of indefinite duration and substantially impedes the individual's ability to live independently
- Written verification from the Social Security Administration
- The receipt of a disability check (e.g., Social Security Disability Insurance check or Veteran Disability Compensation)
- Intake staff-recorded observation of disability that, no later than 45 days from the application for assistance, is confirmed and accompanied by evidence above
- Acceptable evidence of a disability for an individual with HIV/AIDS would include written verification from a professional licensed by the state to diagnose and treat HIV/AIDS. There would not be an expectation that the licensed professional would also certify that the condition is expected to be of long-continuing or indefinite duration and substantially impede the individual's ability to live independently.

Privacy Protections & Participant Autonomy

The Homeless Management Information System (HMIS) Privacy Notice describes the privacy policy of the HMIS and the agencies participating in HMIS. The notice outlines the purpose and use of collected personal information. The notice ensures that collected information may only be disclosed to comply with legal and other obligations. The Client Informed Consent and HMIS Release of Information Authorization forms must be signed at the time of CES assessment.

All clients have a right to refuse to participate in HMIS and the CoC will not deny services to any participant based on the refusal to allow personal information to be shared unless Federal statute requires collection and reporting of personally identifiable information as a condition of program eligibility and participation. Where appropriate, non-personally-identifiable, information about participants who refuse consent should be logged into an electronic case file that uses pseudonyms necessary to preserve as much non-personally-identifiable information as possible for statistical purposes.

The CES assessment process does not require disclosure of specific disabilities or diagnosis. However, specific diagnosis or disability information may be required for purposes of determining program eligibility. Only those meeting the HUD definition of Chronically Homeless will be considered for PSH program enrollment.

All data entered into or accessed or retrieved from the HMIS must be protected and kept private in accordance with the HMIS Data and Technical Standards as announced by the CoC Interim Rule at 24 CFR 578.7 (a) (8).

Section III: CES Roles and Responsibilities

1. ***Balance of State, CoC Board of Directors: Coordinated Entry System Committee***

The Maryland BoS CoC is responsible for the development, implementation, planning and oversight of the Coordinated Entry System. These responsibilities are assigned to the Coordinated Entry System Committee. DHCD and HMIS staff will carry out these activities with oversight and collaboration from the Committee.

Responsibilities include, but are not limited to:

- Develop, update and distribute CES related policies and procedures
- Create, maintain and oversee the CES By Name List and Housing Resource List
- Coordinate implementation planning and training efforts with Local Homeless Coalitions, develop

training content and annual schedule, maintain list of trained CE assessors
- Prepare agency and system performance reports for Coordinated Entry
- Monitor agency compliance, facilitate client appeal process, and take corrective action with noncompliant or poor-performing agencies
- Coordinate system-wide review and annual evaluation in coordination with the CoC board, CES workgroup and LHCs to ensure continuous improvement in meeting established CoC goals

2. ***Local Homeless Coalition CES Designated Access Agencies***

Homeless Services Agencies may be selected to serve as Coordinated Entry Access Points and are responsible for ensuring that all households presenting as homeless have prompt and equal access to the system and receive a standardized intake and assessment.

Designated Access Agency Responsibilities:

- Ensure and document that staff are trained on CES procedures, intake and assessment tools
- Follow the CES HMIS Data Standards including using standardized intake and assessment tools
- Submit client and assessment data to the local CES Coordinator
- Honor CES hours of operation

3. ***Local Homeless Coalition CES Participating Providers***

Homeless Service Agencies within the MD BoS are encouraged to participate in the Coordinated Entry System. Agencies receiving HUD CoC, ESG, or State Administered HSP funds are required to participate in CES. Required agencies must adhere to the CoC established guideline that 100% of project enrollments come from CES.All agencies within the MD BoS serving households experiencing homelessness are encouraged to participate in the Coordinated Entry System.

Participating Providers Responsibilities:

- Ensure that all literally homeless clients are directed to an appropriate Designated Access Agency
- Enter all client data entered into HMIS and ensure all files are complete and accurate
- Regularly update the housing resource list to reflect any changes in client status and bed availability
- Participate in Coordinated Entry Planning Meetings and Case Conferencing

4. ***Local Homeless Coalition CES Roles***

The roles described below serve to describe the various functions typically needed to appropriately operate a Coordinated Entry System. At the Local Homeless Coalition level, the implementation of these roles, or tasks, is expected to look different, based on staffing levels and community needs.

a. **Local CES Coordinators (County or Regional)**:
The Local Homelessness Coalition Coordinator is responsible for ensuring that the CES process is compliant and is operating efficiently and effectively at the local level. The LHC Coordinator oversees assessors, housing & service referrals and the BNL; and is responsible for all CES related training and reporting to local staff. The LHC Coordinator consults with the BoS CES Coordinator on a routine basis.

LHC Coordinator Responsibilities:

- Responsible for ensuring that client data is updated and maintained in the HMIS Housing Priority List and on the local By-Name-List
- Facilitate monthly, at a minimum, case conference meetings among relevant local providers

- Support continuous improvement of the CoC CES
- Educate and train new local CES Assessors
- Provide regular updates to the BoC CES Coordinator for the CES manual and education materials
- Provide ongoing engagement with local housing providers to identify project openings
- Provide technical support to local CES Assessors
- Compile local CES data and statistics
- Attend all required trainings and staff meetings

b. Assessor

Assessors are responsible for initiating the Coordinated Entry process for those who meet the eligibility requirements and are seeking assistance in the housing crisis response system. Assessors are responsible for ensuring that all requests for assistance are treated equally and fairly, regardless of the individual circumstances of the household requesting assistance. They are responsible for being transparent about the housing crisis response system with participants.

Assessor Responsibilities:

- Conduct CES assessment, including the HUD Assessment, Self Sufficiency Matrix and other identified needed elements (diversion, etc)
- Assures the accuracy, completeness and confidentiality of records
- Maintain any records required for the completion of reports
- Complete any required reports within scheduled time period, as they are identified
- Make referrals to community agencies as appropriate
- Attend community meetings regarding case conferencing and other service issues
- Assess and monitor for risk, symptoms of trauma, and indications of abuse and neglect; use appropriate reporting mechanisms
- Provide crisis intervention as needed
- Assists in the training and development of new assessors
- Attend all required trainings and staff meetings

c. Navigator / Case Manager

The Navigator and/or Case Manager role serves as the main point of contact for targeted individuals once they are matched to eligible housing opportunities. This roll will help collect all critical documents needed for housing placement and may provide additional support necessary to finalize housing. The navigator / case manager may provide referrals, offer coordination, or provide in-person support to clients for their housing search, mental health, physical health, entitlement enrollment and other service needs. The level of support provided is based on a client's independence and an agency's capacity to provide supportive services. Additionally, this role is responsible for ensuring that referred client eligibility has been met and enrolling clients into appropriate HMIS programs.

Navigator / Case Manager Responsibilities:

- Assist with critical documentation required for housing eligibility
- Serve as primary point of contact for assigned clients
- Assist with housing search, as needed
- Assist with referrals and services, as needed
- Ensure warm handoff to housing case manager

d. Local Homeless Coalition Interagency Workgroups:

Responsible for participating in case conferencing sessions to facilitate placement and supportive services. Workgroups will include case management and program staff from participating agencies as well as key partners providing supportive services.

Workgroup Responsibilities:

- Participate in case conference sessions and facilitate service coordination, follow-up and referral review
- Review and oversee local enrollments on the BNL to verify prioritization, identify assessment gaps and review current tools and processes to ensure racial equitability
- Participate in annual BoS CES System review and evaluation activities

Training Overview

MD-514 is committed to ensuring that all staff who assist with CES operations receive sufficient training to implement the CE system in a manner consistent with the vision and framework of the CES, as well as in accordance with the policies and procedures of its CE system. Training will be offered at no cost to the agency or staff, and will be delivered by an experienced and professional trainer who is identified by the CoC through various media outlets.

Coordinated entry training will include, at a minimum, the following elements:

- Balance of State Coordinated Entry Policy and Procedure
- HMIS and Data Collection Requirements
- Safety Planning and Risk Assessment
- Service Delivery Best Practices

The general Coordinated Entry System training curriculum will be reviewed and updated by the BoS CES Committee, assessed in the annual CES evaluation and reviewed by the BoS CoC Board of Directors annually.

Section IV: Coordinated Entry System Workflow

Step 1: Access

The CoC adopts a “no wrong door” approach to CE, which ensures that no matter which homeless assistance provider a person goes to for assistance, he/she will have access to the same resources, referrals, and assessment and prioritization processes. Please see Appendix XX for a list and map of all access points.

The CoC’s entire geographic area is accessible to CE processes either through defined location-specific access points or through a 211 community information and referral hotline that is accessible throughout the CoC geography. The 211 hotline provides access to basic CES intake services 24 hours a day and can be contacted from any location within the CoC.

With support from the BoS, each LHC is responsible for regional outreach and marketing to ensure that the local community has awareness and equal access to the Coordinated Entry System. Outreach and

marketing efforts are ongoing and, at minimum, includes materials created for distribution during the Point in Time (PIT) count and by each jurisdiction's Community Homeless Resource Day.

At a minimum, outreach targets should include private and public agencies, veteran service agencies, social service agencies, schools, childcare centers, hospitals, detention centers and jails and local elected bodies. CES materials should also be distributed in areas known to be frequented by people experiencing housing instability and/or homelessness, including: 24-hour establishments, restaurants, food pantries, places of worship, grocery stores, check cashing locations and Wi-Fi accessible locations.

Street outreach staff and volunteers will receive ongoing training from the Balance of State Lead Agency staff on CES and BNL to ensure understanding of CES processes necessary to obtain housing. CES information will also be posted on the BoS CoC and provider websites and other relevant social media outlets.

All BoS providers receiving CoC, ESG or HSP funds are responsible for ensuring that any person experiencing a housing crisis has access to the Coordinated Entry System (CES). Every household seeking housing assistance is expected to receive a standardized intake, assessment and referral; the process of which is managed by designated providers with trained staff. If an individual or family is not physically able to access their designated local provider, alternative means will be arranged in person or through phone, text or web-based meetings. The CoC will ensure that CES services are physically accessible to persons with mobility barriers. All CES communications and documentation will be accessible to persons with limited ability to read and understand English.

Emergency shelter enrollment is operated locally and not a current referral of the BoS CES. When an individual presents in crisis, the first step is to connect them with shelter, as capacity allows, then connect to a designated CES access point as appropriate. Emergency shelter and service providers should operate with as few barriers to entry as possible. In the event prospective participants attempt to access designated access points during non-business hours, those persons will still be able to access emergency shelter without first receiving an assessment through coordinated entry. CES screening and assessment will be attempted on all ES participants within 3 days after entry to ES.

While not all providers in the homeless services system are responsible for the comprehensive intake and assessment, homeless services case management and outreach staff should be trained in conducting problem-solving conversations to identify options for diversion and homelessness prevention services along with directing clients to designated access points for CES assessment.

Street outreach teams will function as access points to the CES process, and will seek to engage persons who may be served through CES but who are not seeking assistance or are unable to seek assistance via projects that offer crisis housing or emergency shelter. Street outreach teams will be trained on CES and the assessment process, and will have the ability to offer CES access and assessment services to participants they contact through their street outreach efforts.

Safety Planning for Victims of Domestic Violence

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 CE geographic area.

The CoC provides safeguards for victims of domestic violence and those fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking who are accessing and utilizing the

coordinated entry system.

The CES will include a domestic violence hotline, 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 CES.

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.

Additional safe-guards include:

a. Locations of domestic violence shelters are secure and non-published
b. Survivors receive immediate referral to victim services
c. Whenever possible, participants can choose to be housed in any of the communities participating in the BoS
d. All personal identifying information is kept secure and confidential. HMIS record is ID number only
e. Providers adhere to CoC policy of non-discrimination for victims of domestic violence and those fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking
f. All CES staff and Non-victim service providers receive training in trauma-informed care, safety planning protocols, data protection and confidentiality and have clear guidance on how to manage housing referrals within the CES system

Victim service providers funded by CoC and ESG program funds are not required to use the CoC's coordinated entry process, but CoC- and ESG-funded victim service providers are allowed to do so. Or, victim service providers may use an alternative coordinated entry process for victims of domestic violence, dating violence, sexual assault, and stalking.

Step 2: Assessment

The Maryland Balance of State CoC has identified the Self Sufficiency Matrix (SSM) to serve as the CES assessment tool. The purpose of the assessment tool is to ensure that all individuals receive a uniform and consistent intake to best identify those with the highest vulnerabilities and prioritize accordingly. All persons served by CES will be assessed using the SSM. The SSM will be housed in the HMIS and should only need to be completed once at enrollment into CES. The goal being to limit the number of times a client must share personal details. All access points across the CoC must use this tool to ensure that all persons served are assessed in a consistent manner, using the same process.

The SSM assessment measures client status across 18 domains with a scoring scale of 1 to 5, 1 being the lowest level of progress and 5 being the highest. Therefore, the lower the client score on the SSM, the higher the level of vulnerability and need. The SSM will be utilized during the assessment phase for prioritization purposes, but should also be completed at least annually on clients enrolled in housing projects to: determine progress in the 8 areas of measurement, client engagement and to develop appropriate, personalized case plans. Ultimately, the SSM can be used as a measurement for client Move On plans.

The SSM documents a set of participant conditions, attributes, need level and vulnerability, allowing the CES process to identify the most appropriate level of service intervention. Please see Appendix XX for a

copy of the assessment tool.

The assessment phase will be used to identify: length of time homeless, level of vulnerability and a preliminary identification of chronic homelessness. If the assessment phase identifies a client as potentially chronically homeless, additional documentation will be required for certain program eligibility.

Households shall not be prevented from accessing the coordinated entry system due to barriers including, but not limited to, income, active or history of substance abuse, domestic violence history, lack of interest in services, disabling condition, evictions, poor credit, lease violations or criminal record.

It is crucial that persons served by the CoC's CES have the autonomy to identify whether they are uncomfortable or unable to answer any questions during the assessment process, or to refuse a referral that has been made to them. In both instances, the refusal of the participant to respond to assessment questions or to accept a referral shall not adversely affect his or her position on the CES prioritization list. Throughout the assessment process, participants must not be pressured or forced to provide CES staff with information that they do not wish to disclose, including specific disability or medical diagnosis information.

Note: some funders require collection and documentation of a participant's disability or other characteristics or attributes as a condition for determining eligibility. Participants who choose not to provide information in these instances could be limiting potential referral options.

Participant consent is required in order to collect and share information for the purposes of referring through the CES. Verbal or written consent is obtained through relevant HMIS forms. Without the client's consent, the BoS is not able to place participants on the BNL or refer them to the appropriate resources. Following assessment, information for all literally homeless individuals and individuals at imminent risk of homelessness is entered into HMIS, including the Release of Information.

Progressive Engagement
All projects participating in CES will follow the assessment and triage protocols of the CES system. The assessment process will progressively collect only enough participant information to prioritize and refer participants to available CoC housing and support services.

CoC employs a phased approach to assessment which segments the collection of participant information into the following stages:

•Initial Triage: resolving the immediate housing crisis; identification of the CoC crisis response system as the appropriate system to address the potential participant's immediate needs
•Diversion and/or Prevention Screening: examination of existing CoC and participant resources and options that could be used to avoid entering the homeless system of care
•Crisis Services Intake: information necessary to enroll the participant in a crisis response project such as emergency shelter or other homeless assistance projects
•Initial Assessment: information to identify a participant's housing and service needs with the intent to resolve participant's immediate housing crisis
•Comprehensive Assessment: information necessary to refine, clarify, and verify a participant's housing and homeless history, barriers, goals, and preferences; assessment information supports the evaluation of participant's vulnerability and prioritization for assistance

Participant assessment information should be updated at least once a year, if the participant is served by CES for more than 12 months. Additionally, staff may update participant records as new or updated information becomes known by staff.

The assessment shall not be modified in order to change the initial score in order to alter the referral option. Falsifying client information is considered fraud and must be reported.

Subpopulation Entry Points

- Adults without children: any access point
- Adults accompanied by children: any access point
- Unaccompanied youth: any access point for youth 18 – 24; youth age 17 and under are referred to minor serving agencies
- Households fleeing or attempting to flee domestic violence dating violence, sexual assault, stalking, or other dangerous or life threatening conditions (including human trafficking): any access point and domestic violence providers
- Persons at imminent risk of literal homelessness for purposes of administering homelessness prevention assistance: referred to agencies with prevention funds

Step 3: Prioritization

Prioritization refers to the process by which all persons in need of assistance who access the BoS CoC CES are ranked in order of priority. This process ensures that people with the most severe service needs and highest levels of vulnerability are prioritized for housing and homelessness assistance before those with less severe service needs and lower levels of vulnerability. All are prioritized, but higher priority are served 1st.

Prioritization refers to the process by which all persons in need of assistance who access the BoS CoC CES are ranked in order of priority. This process ensures that people with the most severe service needs and highest levels of vulnerability are given a higher priority for housing and homelessness assistance and are served before those with less severe service needs and lower levels of vulnerability.

While prioritization applies to all PSH, RRH and TH units, it does not include emergency services, such as: drop-in center programs, emergency shelters, domestic violence shelters and other short term crisis residential programs. These emergency services are a critical crisis response resource, and access to such services will not be prioritized, these programs should operate with as few barriers to entry as possible.

The MD BoS will use data collected through the CES process to prioritize homeless persons within the CoC's geography. Data gathered from the SSM and the HUD assessment will be used to determine: chronic homelessness, length of homelessness, disability, level of need and other factors pertinent to determining the most appropriate service intervention.

Eligible clients will be placed on the statewide By-Name-List (BNL) once the assessment phase is complete. The order of placement on the BNL will be based on the CoC prioritization standards below.

Specific scoring guidance here.

The Coordinated Entry System facilitates access to the most appropriate housing intervention for each participant's immediate and long-term housing needs. The following criteria are used to match participants to the most appropriate housing intervention:

HOUSING INTERVENTION	TARGET POPULATION	ELIGIBILITY CRITERIA
Permanent Supportive Housing	Chronically homeless households	● Chronically homeless ● Head of household with disabling condition ● Fleeing/attempting to flee domestic violence
Rapid Re-Housing	Not chronically homeless Less vulnerable Newly homeless Bridge housing when PSH not available	● Literally homeless ● Fleeing/attempting to flee domestic violence
Transitional Housing	Grant Per Diem (GPD): Veterans Addictions Domestic Violence Youth Aged 18-24	● Literally homeless ● Fleeing/attempting to flee domestic violence

Permanent Supportive Housing (PSH):

The prioritization for PSH is consistent with HUD's Prioritization/PSH Notice. Persons eligible for PSH will be prioritized for available units based on the following criteria (applying the definition of chronically homeless set by HUD in its December 2015 Final Rule):

1. Chronically homeless individuals and families with the longest history of homelessness and with the most severe service needs, as established in the SSM.
2. Chronically homeless individuals and families with the longest history of homelessness but without severe service needs.
3. Chronically homeless individuals and families with the most severe service needs.
4. All other chronically homeless individuals and families not already included in priorities 1 through 3.
5. Homeless individuals and families who are not chronically homeless but do have a disability and severe service needs.
6. Homeless individuals and families who are not chronically homeless but do have a disability and a long period of continuous or episodic homelessness.
7. Homeless individuals and families who are not chronically homeless but do have a disability and are coming from places not meant for human habitation, Safe Havens, or emergency shelters.
8. Homeless individuals and families who are not chronically homeless but have a disability and are coming from transitional housing.

- Tie Breaker—When two households in the same priority are scored equally on the Prioritized List, the following tiebreakers will be used in this order:
    - longest length of homelessness
    - higher level of vulnerability
    - date of assessment

Transitional Housing (TH):

The prioritization for persons who are determined to be eligible for TH will be consistent with the CoC's scoring range for need and vulnerability associated with TH projects. The CoC will prioritize the following

persons for TH, in no particular order, based on length of time homeless and vulnerability level.

1. Veteran households.
2. Households fleeing or experiencing domestic violence as the primary cause of their current housing crisis.
3. Households consisting of unaccompanied youth.
4. Participants seeking treatment services for behavioral health conditions such as mental illness and/or substance use disorders, when appropriate.

- Tie Breaker—When two households in the same priority are scored equally on the Prioritized List, the following tiebreakers will be used in this order:
    - longest length of homelessness
    - higher level of vulnerability
    - date of assessment

Rapid Re-Housing (RRH):
The prioritization for persons who are determined to be eligible for RRH will be consistent with the CoC's scoring range for need and vulnerability associated with RRH projects. Additionally, the CoC has opted to prioritize the following persons for RRH,in no particular order, based on length of time homeless and vulnerability level.

1. Veteran households.
2. Households experiencing domestic violence.
3. Households consisting of at least one adult and one child.
4. Households consisting of unaccompanied youth.
5. Households with a previous episode of homelessness within the most recent 12 months.

- Tie Breaker—When two households in the same priority are scored equally on the Prioritized List, the following tiebreakers will be used in this order:
    - longest length of homelessness
    - higher level of vulnerability
    - date of assessment

The HMIS system will automatically generate the BNL based on identified data points and sort clients into the identified order of priority. The prioritization list will be organized according to participant need, vulnerability and risk, and provide an effective way to manage an accountable and transparent prioritization process. The list will be sortable by jurisdiction, subpopulation and any other specific eligibility criteria needed to facilitate placement into available housing opportunities.

Each local CES Interagency Workgroup will have the ability to review specific clients during routine case conference meetings to determine if considerations need to be made on behalf of a given client. These considerations may move the client into a different position on the BNL.

Homeless Documentation and Record Keeping
Process pending.
https://files.hudexchange.info/resources/documents/HomelessDefinition_RecordkeepingRequirementsandCriteria.pdf

Step 4: Referrals
All CoC and ESG funded housing projects must accept referrals and enroll new participants exclusively

through the CoC's defined CES process. All other CoC projects and services voluntarily participating in CES should consider the CES process the sole source for referrals.

To facilitate prompt referrals and to reduce vacancy rates, participating providers must notify LHC CES Coordinator of any known and anticipated upcoming vacancies. The housing provider agency with a vacancy must alert the LHC CES Coordinator via email within 10 business days of the vacancy. The notification must include specific details of the vacancy, including the project name, unit size, location and any funder-defined eligibility requirements. The Coordinator will use this information to identify a prioritized household to assign to the vacancy.

Each LHC CES Coordinator will be responsible for managing referrals in their jurisdiction. To prioritize placements and identify appropriate housing matches, the local CES coordinator is responsible for regular review of both the by-name-list and an oversight of a comprehensive list of housing resources within their jurisdiction. While all providers of TH, RRH, PSH and other Permanent Housing opportunities are expected to update the list of housing resources when clients are enrolled and exiting their programs, the CES Coordinator is responsible for regular follow-up with providers and data quality reviews. The full list will be accessible to each LHC CES Coordinator, local CES work groups and providers.

Referrals are made on a rolling basis by the LHC CES Coordinator based on the established system-wide prioritization standards. Once an appropriate housing referral match is identified, an e-mail is sent to the housing provider receiving the referral, the assessor who completed the comprehensive assessment, and any case managers listed within HMIS. The referral includes the HMIS history of current and past programs in which the client participated, assuming the client has signed a release form allowing for sharing this information. Housing providers are asked to notify the LHC CES coordinator if they cannot locate the client after 10 business days and have followed all required contact protocol. A minimum of 5 unique attempts to contact the household should be made within the 10 day period. Requirements for efforts to contact households are spelled out in Section V: Referral Challenges: Declining a Match and Program Transfers.

Once a client has been notified of a pending match, they have up to 5 business days to decide whether they will accept the match. Once a client has accepted the placement, they are then enrolled in the program in HMIS. Clients are only matched to one program and unit at a time. Furthermore, a match is not a guarantee of housing, it simply means that a unit has been identified and is being held. Additional details on the housing search and inspection process are outlined in Section IV: Coordinated Entry System Workflow, Step 6 & 7: Provider Intake & Enrollment and Inspections. Details on client or project referral declines are outlined in Section V: Referral Challenges.

Case conferencing complex referrals

The majority of households will be placed into housing through direct referral from the CES Coordinator to a provider with an open and appropriate housing placement opportunity. However, finding appropriate placements and coordinating support needed for a successful placement may be more difficult for clients with higher challenges and barriers. To provide additional support, each LHC is expected to form a CES Interagency Workgroup to include case managers from housing providers as well as other community partners. The CES Workgroup is responsible for holding regular, ongoing case conference meetings to coordinate transition support or identify other potential referral options for clients with more complex needs and placement challenges.

Referrals between counties within the BoS

Where appropriate and reflective of client preference, local CES Coordinators may also make referrals to available housing resources in other counties located within the MD BoS. The referral will follow largely the same process, although there are several additional steps required to confirm the placement is

appropriate and to support the household's transition. First, the CES coordinator from the referring county is asked to organize a planning call with the CES Coordinator and provider in the receiving county, as well as with any case managers who are currently working with the client, to plan for case management transition, transportation and match confirmation. The referral details should be shared with the CES Interdisciplinary Workgroups in both locations.

Step 6: Provider Intake and Enrollment
Housing providers are responsible for follow up with clients matched through Coordinated Entry, and for initiating the household intake process in HMIS, upon match confirmation to an open unit. The specific intake process may vary from provider to provider, but should include the opportunity for clients to visit the facility for site-based programs as well as provide the client with an overview of the following: supportive services available, program rules, client/tenant responsibilities, rent/utility calculations, and program grievance and termination policies. After the intake appointment, the client may decide to decline placement in the housing program. If this happens, the client is placed back on the by-name list and shall maintain their place on the list; the housing program is given another name for an eligible and appropriate referral.

Step 7: Inspections (tenant-based units only)
Tenant-based programs will assist clients with finding a unit in the area and are responsible for initiating an inspection following federal and local requirements. Once the inspection is complete, the program will communicate inspection results to the client. If the unit is tenant-based, clients may have the option to choose from multiple units.

Every reasonable effort should be made to help the client find a unit that matches their preferences. Reasonable accommodations for clients with disabilities must be granted throughout this process, especially pertaining to requests for time extensions related to medical issues or hospitalizations.

Step 8: Move-In
Once the client has been approved by the program and has a unit that has passed inspection, the household is able to move into the unit. Housing programs should make every effort to help clients matched with housing to overcome potential barriers to a successful move. Examples include ensuring appliances are connected and working, utilities are connected and basic furnishings are in place.

Rental and Financial Assistance Determinations in Rapid Rehousing
The Balance of State CoC shall determine the percentage or amount of rent each program participant must pay while receiving rapid rehousing assistance as documented in the CoC Written Standards.

Standards for determining the share of rent and utilities costs that each program participant must pay, if any, will be based on the following guidelines:

a. The maximum amount of rent that a participant can pay is up to 100% of the rental amount.
b. Providers may provide up to 100% of the cost of rent in rental assistance to participants. However to maximize the number of households that can be served with rapid re-housing resources, it is expected that providers will provide the level of need based on the goal of providing only what is necessary for each household to be stably housed for the long term. Some programs may change the level of assistance over the duration of program participation.
c. Rental assistance cannot be provided for a unit unless the rent for that unit is at or below the Fair Market Rent limit, established by HUD. A complete listing of Fair Market Rents for Maryland

counties can be found at: counties can be found at: https://www.huduser.gov/portal/datasets/fmr/fmrs/FY2020_code/select_Geography.odn

d. The rent charged for a unit must be reasonable in relation to rents currently being charged for comparable units in the private unassisted market and must not be in excess of rents currently being charged by the owner for comparable unassisted units.
e. For more details see sections 578.37 and 578.51 of the HUD CoC rapid re-housing and rental assistance guidelines.

Standards for Duration of Assistance in Rapid Rehousing

The BoS CoC shall determine the duration of assistance as documented in the CoC Written Standards. Providers may provide a program participant with up to 24 months of rental assistance. Participants may be eligible for rapid re-housing assistance on multiple occasions, however, if a participant needs assistance more than once, the participant will be subject to a re- assessment process for a different level of service intervention. However, there is an expectation of progressive engagement to ensure that clients are advancing in service plans and working towards self-sufficiency,

There must be a lease between the landlord and the tenant, although the housing provider may also be party to the lease, and the leases must be for at least one-year, renewable for at least one year and terminable only for cause.

Section V: Referral Challenges: Declining a Match and Program Transfers

Declining a Match

There are five main reasons why a housing program may not be able to provide housing to a client that is matched through Coordinated Entry:

1. No actual vacancy is available: The CES Coordinator is responsible for regular communication with providers to ensure that the housing resource list is up-to-date. However, there may be situations where availability is not accurately captured.
2. Provider is unable to make contact with the household after five unique attempts within 10 business days.
3. Households present with more/fewer people than were referred and the receiving program's unit size is not a match for the increase/decrease in household size.
4. Client does not meet program requirements: The Coordinated Entry system attempts to ensure that all matched clients meet the requirements of the program to which they are matched. A client not meeting the program's requirements can occur for the following reasons:
    a. When a client completes intake at the housing program, the program may discover that information provided to Coordinated Entry during the intake or assessment phase is not accurate. This could be the result of an error on the part of the assessor to properly document eligibility. This inaccuracy may result in the services available through the project not being sufficient to address the intensity and scope of participant need.
    b. Coordinated Entry may not screen for specific factors that may be used to determine a client's eligibility for some programs. For example, some providers may be required to conduct a criminal background check for all residents. Coordinated Entry does not participate in these intake procedures, so a client who is matched through the system may be determined not to meet the specific program criteria.
5. Client refused placement: The client may decline the placement in the program for any reason, without repercussion. In this case, the client is placed back on the list and offered the next unit based on their prioritization score. Once a client refuses placement, the unit is offered to the next client on the list. Refusing a placement has no negative impact on a client, but clients are not

guaranteed the same level of priority previously established if a more vulnerable client enters the system.

An agency must communicate the referral decline to the CES Coordinator within 3 business days of the refusal. The agency must notify the CES Coordinator why the referral was rejected, how the referred participant was informed, what alternative resources were made available to the participant, and whether the project staff foresee additional, similar refusals occurring in the future.

All instances of a client declining a placement in a housing program will be flagged for review by the local CES Workgroup and the LHC Coordinator to ensure compliance with Housing First, Non-discrimination, Equal Opportunity and Coordinated Entry Protocols.

Participants who are not located and have not received any CoC services within the previous 90 days, as documented in HMIS will be moved from active to inactive status. Participants making contact with the system, once moved to the inactive list, will be immediately reinstated to active. Intake staff will complete an updated assessment.

Transfer Policy

This Transfer policy applies to the following types of transfers through the Coordinated Entry System.

- Rapid Rehousing to Rapid Rehousing
- Rapid Rehousing to Permanent Supportive Housing
- Permanent Supportive Housing to Permanent Supportive Housing
- Permanent Supportive Housing to Rapid Rehousing
- Permanent Supportive Housing to Other Permanent Housing

Under certain circumstances, a client may be better served by a transfer from one housing program to another. Transfers will be facilitated by the local CES Coordinator.

Transfers may be initiated by a housing provider that no longer has the ability to serve a client appropriately, or initiated directly by the client. Housing providers are required to contact the CES Coordinator to request transfer if a change in client's circumstance makes them ineligible for their specific service. Housing programs receiving transfers are required to accept these incoming clients through the Coordinated Entry system. Clients enrolling in a housing program through a transfer must meet the same standards and have the same rights as a client enrolling through the typical Coordinated Entry process.

Transfers may be requested for the following reasons:

1. The provider **and** client feel that another program is better suited to the client's individual needs.
2. The client feels that they are not getting the services they need, or are being treated unfairly by the current housing provider and all attempts to resolve the client's concern without a transfer have been unsuccessful.
3. The client has experienced a change in household composition that can't be accommodated by the current housing provider.
4. There is a significant risk of harm to the client in the current placement
5. The client needs a reasonable accommodation that the provider needs the assistance of a transfer in accommodating. All requests will be reviewed as part of the transfer request process.
6. Other issues affecting a current client's placement that will be reviewed on a case-by-case basis.

Unless the client transfer request is related to domestic violence and the safety of the household, the prioritization rank of the transfer will be considered on a case by case basis. The Local Homeless Coalition Interagency Workgroup should make such determinations in cheduled case conference meetings.

Client Initiated Transfers
Clients seeking a transfer should complete the Client Transfer Request Form. A client may request a transfer through their current housing provider or by contacting the CES Coordinator. Clients will only be considered for transfers to programs for which they meet the eligibility requirements.

Coordinated Entry matches clients to multiple types of housing programs funded by different federal, state and local grants operating under different eligibility requirements. As a result, eligibility and procedures for transfers may vary for clients living in different housing programs. Residents newly enrolling in these programs will be informed of any variations or limitations in transfer policy and will have the opportunity to decline the housing opportunity.

If a transfer request involves a client grievance, the local CES Coordinator and Bos Coordinator will investigate the grievance as part of the transfer review process. Requests will be considered on a case by case basis.

All transfers are based on current unit availability and prioritization methods.

Provider Initiated Transfers
Providers seeking to transfer a client must complete and submit a Provider Transfer Request Form to the CES Coordinator. Provider-initiated transfers can only occur in circumstances where the transfer is necessary to prevent a client's return to homelessness. This may occur when a client has a change in household composition that the program cannot accommodate or if the client is facing termination from a site-based program. Documentation of the reason(s) for the transfer request must be submitted with the transfer request form as well. All transfers are based on current unit availability and prioritization methods. Clients will only be considered for program transfers to programs for which they meet the eligibility requirements.

Transfer Request Processing
Once the Transfer Request form is submitted, the local CES Coordinator will acknowledge receipt in writing within ten business days. Final determination will be made within 15 business days. If the client needs emergency accommodations before the transfer review process can be completed, the CES Coordinator should be notified by phone as soon as possible. Providers do not need the CES Coordinator's approval before making emergency accommodations in the interest of a client's safety.

Terminations
Providers who are considering termination of a client must first review transferring the client to another program as an option to prevent the client's return to homelessness. Providers must continue to provide services until the transfer is made. or if the client declines a transfer. If the transfer is declined, the client may lose their housing through the termination and eviction process although the housing provider should work to prevent this outcome. Clients at risk of returning to homelessness should complete another vulnerability assessment; however, the length of time homeless will be newly calculated using the exit date from the previous housing program.

Special grant considerations for programs include:

- *CoC-Funded Tenant-Based Rental Assistance (TBRA) Programs*: Program may not terminate a household unless the household no longer meets HUD eligibility for housing or is not fulfilling HUD program requirements. If a client faces or experiences an eviction due to serious lease violations

or non-payment of rent to the landlord, the program must continue to work with the client and assist them in locating a new unit.

- *CoC-Funded Sponsor-Based Rental Assistance (SBRA) Programs*: Program may terminate a client if the landlord evicts the client from the unit due to serious lease violations, no longer meets HUD eligibility, or is not fulfilling HUD program requirements. However, this should occur only as a last resort and only if the program has exhausted all other reasonable, alternative options available. The program must consult directly with CES Coordinator if the cause for a transfer request is related to a pending termination from the program.
- *CoC-Funded Project-Based Programs*: Program may terminate a client from the program if the client commits serious lease violations, no longer meets HUD eligibility, or is not fulfilling HUD program requirements. However, this should occur only as a last resort and only if the program has exhausted all other reasonable, alternative options available. The program must consult directly with their local CES Coordinator if the cause for a transfer request is related to a pending termination from the program.

Section VI: Client Rights: Grievance & Appeals, Non-Discrimination & Equal Opportunity

Grievance and Appeals Process

An appeal is a request to reconsider a decision on eligibility. A grievance is an official complaint filed if a client is dissatisfied with the behavior or actions of a provider agency or the CES Coordinator.

Coordinated Entry partners must provide all individuals and families with a copy of the Coordinated Entry Appeals and Grievance Policies (see Appendix XX). Individuals and families must have the option to file their appeals or grievances orally or in writing. All appeals and grievances must be resolved promptly and fairly, in the most informed and appropriate manner.

Agency grievances are grievances that are related to the individual or family's experience with a CES Partner agency, including the agency providing the Assessment, Referral, and/or Housing Providers. These grievances should be redirected back to the agency to follow the agency's grievance policy and procedures.

Coordinated Entry Appeals are appeals related to the Coordinated Entry Policies and Procedures and/or related to CES decisions, including decisions made by the CES Coordinator or local interagency workgroup. These appeals shall be directed to:

Maryland Department of Housing and Community Development
c/o: Homeless Solutions Program
Division of Neighborhood Revitalization
7800 Harkins Rd
Lanham, Maryland 20706
coordinatedentry.dhcd@maryland.gov

Non-discrimination and Equal Opportunities

The CoC operates the coordinated entry system 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 CoC and HSP funded service providers must ensure equal access to the HUD-assisted program in accordance with all General HUD Program Requirements as specified in 24 CFR Part 5. An evaluation of agency specific policies is reviewed during the annual audit.

CoC requires service providers to practice a trauma-informed, person-centered model that incorporates

participant choice and inclusion of all homeless subpopulations, including homeless veterans, youth, and families with children, individual adults, seniors, victims of domestic violence, and Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, and Intersex (LGBTQI) individuals and families. All CoC and HSP funded service providers must ensure that all people have fair and equal access to the coordinated entry 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.

Policies and procedures for addressing complaints against either a funded agency or the CoC can be found in Appendix XX.

The CES participant information packet must include a form that details who the point of contact is for filing and addressing any nondiscrimination complaints, which can be filed by participants if they believe the nondiscrimination policy has been violated in their case during the CES process.

Additionally, this form will describe and provide contact information on how to access the appeal process if they are not satisfied with or have any questions regarding how their complaints are handled. This form must be reviewed at the access point by CES staff, and must be signed by each participant.

Reasonable Accommodations

The CoC ensures that persons with disabilities have equal access to the Coordinated Entry System through compliance with the requirements of Title II and Title III of the Americans with Disabilities Act and providers do not discriminate against individuals with disabilities in the CoC's services, programs or activities. The CoC's written standards require that all CoC and HSP service providers have written non-discrimination polices in place and these policies are reviewed during the annual audit.

All coordinated entry access points must be accessible for persons with disabilities, including those who use wheelchairs and those who are least likely to access homeless assistance. Upon request, all agencies must provide appropriate and reasonable accommodations for persons with disabilities and/or Limited English Proficiency (LEP) so they can participate equally in the Coordinated Entry process. This includes qualified language interpreters, and other ways of making information and communications accessible to people who have speech, hearing or vision impairments, disabilities, or those with LEP.

Section VII: Homelessness Prevention

CoC's written CE policies and procedures must document a process for persons seeking access to homelessness prevention services funded with ESG Program funds through the coordinated entry process

The Coordinated Entry system is designed to match clients with Permanent Supportive Housing, Rapid Re-Housing and Transitional Housing resources. These project types require that clients to either be literally homeless (as defined by HUD and described in Section II: Eligible Clients) or fleeing or attempting to flee domestic violence.

At this time, the Maryland BoS CES does not triage clients for Homeless Prevention services. Clients can access homeless prevention services directly from housing providers in each jurisdiction. All intake and assessment staff who encounter clients seeking homelessness prevention services should refer their clients directly to local providers offering these services, or reach out to their local CES Coordinator for more information on homelessness prevention services in their jurisdiction.

Section VIII: Diversion

Process pending.

Section IX: CES Review and Evaluation

The CoC will engage stakeholders from all participating BoS counties with regards to the implementation of the CES to assure the specific data we collect is resulting in services being made available to all homeless persons.

In addition to committee meetings, the CoC solicits feedback annually from funded agencies and households that participate in coordinated entry to gather data regarding the quality and effectiveness of the entire coordinated entry experience. Data is gathered through the following methods:

Client and Provider Surveys and Focus Groups

- Surveys are available on the BoS website and at local provider agencies to gather data from individuals who have participated in the coordinated entry system. Clients are notified by their caseworkers that the survey is available and feedback is appreciated. Paper surveys will be made available at all times.
- A survey to gather data from funded agencies is sent during the month of annually by the CoC. Agencies are notified via e-mail of the availability of the survey and reminded that participation in the annual survey is mandatory.
- An annual focus group session conducted with representatives from households served over the last year, provider agencies, DHCD and at least one member of each of the BNL local subcommittees.

System-level reviews

The BoS is expected to undertake a system-wide review of the CES system each year. This comprehensive review should include all client and provider input described above, as well as the following:

- Review of both county-level and BoS HMIS data looking at performance measures including: data quality, number of clients served by program type, median length of stay for stayers and leavers, and exits to permanent housing.
- Review of county and BoS housing resource availability by program type, data quality, and time between client placements.

Information gathered during the annual CES evaluation is afforded all necessary protections to ensure privacy of all participant information collected. The BoS CES workgroup, BoS Coordinator and BoS CoC Board evaluate the feedback received and make necessary updates to the coordinated entry process written policies and procedures, if necessary, to improve user experiences and system outcomes.

Ongoing CES Performance Review

The CES will be evaluated using HMIS data on, at a minimum, a quarterly basis. Dashboard results will be published on the CoC website and will be discussed as needed during case conference sessions.

Section X: Terms & Definitions

Access Points: Places, either virtual or physical, where a participant or household in need of assistance accesses the Coordinated Entry System. Examples include central locations which cover the entire CoC, 211 or Homeless Helpline, and any homeless service provider. All entry points utilize the same assessment process to connect a participant to coordinated entry.

Assessment: The tool used across a CoC to determine level of vulnerability in order to most appropriately prioritize clients in Coordinated Entry.

Balance of State: Jurisdictions in a state that are not covered by any other CoC, may include non-metropolitan areas and smaller cities.

Case Conferencing: Local process for CES staff to coordinate and discuss ongoing work with persons experiencing homelessness in the community, including the prioritization or active list. The goal of case conferencing is to provide holistic, coordinated and integrated services across providers, and to reduce duplication.

Chronically Homeless: A homeless individual with a disabling condition who lives either in a place not meant for human habitation, a safe haven, or in an emergency shelter, or in an institutional care facility (including a jail) if the individual has been living in the facility for fewer than 90 days and had been living in a place not meant for human habitation, a safe haven, or in an emergency shelter immediately before entering the institutional care facility.

In addition, the individual must meet one of the following criteria:

- Homeless continuously for at least 12 months **or**
- At least 4 separate occasions in the last 3 years where the **combined occasions must total at least 12 months**
- Each period separating the occasions must include at least 7 nights of living in a situation other than a place not meant for human habitation, in an emergency shelter, or in a safe haven.
- A "chronically homeless family" is defined to mean a family with an adult or minor head of household that meets the definition of a chronically homeless individual. A chronically homeless family includes those whose compositions have fluctuated while the head of household has been homeless.

Continuum of Care (CoC): Group responsible for the implementation of the requirements of HUD's CoC Program interim rule. The CoC is composed of representatives of organizations, including nonprofit homeless providers, victim service providers, faith-based organizations, governments, businesses, advocates, public housing agencies, school districts, social service providers, mental health agencies, hospitals, universities, affordable housing developers, law enforcement, organizations that serve homeless and formerly homeless veterans, and homeless and formerly homeless persons.

Continuum of Care (CoC) Program: HUD funding source to (1) promote community wide commitment to the goal of ending homelessness; (2) provide funding for efforts by nonprofit providers, and state and local governments to quickly rehouse homeless individuals and families while minimizing the trauma and dislocation caused to homeless individuals, families, and communities by homelessness; (3) promote access to and effect utilization of mainstream programs by homeless individuals and families; and (4) optimize self-sufficiency among individuals and families experiencing homelessness.

Coordinated Entry System (CES): An approach to the coordination and management of a crisis response

system's resources that allows users to make consistent decisions from available information to efficiently and effectively connect people to interventions that will rapidly end their homelessness.

Department of Housing and Community Development (DHCD): The designated lead agency for the MD:514 Balance of State Continuum of Care.

Disabling Condition: A physical, mental or emotional impairment, including impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury that is expected to be long-continuing or of indefinite duration, substantially impedes the individual's ability to live independently, and could be improved by the provision of more suitable housing conditions; includes:

- Developmental Disability is defined in §102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 USC 15002). This is defined as a severe, chronic disability that Is attributable to a mental or physical impairment or combination AND Is manifested before age 22 AND Is likely to continue indefinitely AND reflects need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. An individual may be considered to have a developmental disability without meeting three or more of the criteria listed previously, if the individual is 9 years old or younger AND has a substantial developmental delay or specific congenital or acquired condition AND without services and supports, has a high probability of meeting those criteria later in life.
- HIV/AIDS criteria includes 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).

Emergency Shelter (ES): Short-term emergency housing available to persons experiencing homelessness.

Emergency Solutions Grant (ESG) Program: HUD funding source to (1) engage homeless individuals and families living on the street; (2) improve the quantity and quality of emergency shelters for homeless individuals and families; (3) help operate these shelters; (4) provide essential services to shelter residents; (5) rapidly rehouse homeless individuals and families; and (6) prevent families and individuals from becoming homeless.

Diversion: Diversion facilitates a conversation about safe alternatives to shelter, outside the homeless system, and often includes facilitating connection between a person in crisis and their support system through mediation/conflict resolution. Diversion is an approach which focuses on a person's strengths and supports their process of identifying the resources available to them to help resolve their housing crisis.

Equity: Equity refers to proportional representation (by race, class, gender, etc.) of opportunities in housing, healthcare, employment, and all indicators of living a healthy life. When talking about equity, it is helpful to distinguish it from equality. Equality is typically defined as treating everyone the same and giving everyone access to the same opportunities. Equality is about sameness; it focuses on making sure everyone gets the same thing. Equity is about fairness; it ensures that each person gets what the person/population needs. To achieve equity, policies and procedures may result in an unequal distribution of resources, but will lead to equitable outcomes for everyone.

Homeless:

- **Literally Homeless (HUD Homeless Definition Category 1)**:
  (1) Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) Has a primary nighttime residence that is a public or private place not meant for human habitation;

(ii) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or (iii) Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

- **At imminent risk of homelessness (HUD Homeless Definition Category 2)**:
  Individual or family who will imminently lose their primary nighttime residence, provided that: (i) 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 needed to obtain other permanent housing.
- **Homeless under other Federal statutes (HUD Homeless Definition Category 3)**:
  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 the other listed federal statutes; (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 due to special needs or barriers.
- **Fleeing domestic abuse or violence (HUD Homeless Definition Category 4)**:
  Any individual or family who: (i) Is fleeing, or is attempting to flee, domestic violence; (ii) Has no other residence; and (iii) Lacks the resources or support networks to obtain other permanent housing.

Homeless Helpline: A phone number persons experiencing homelessness or are at-risk of homelessness can call to receive resources, explore options to keep from entering the homeless system, or to have an assessment completed.

Homeless Management Information System (HMIS): Local information technology system used by a CoC to collect participant-level data and data on the provision of housing and services to homeless individuals and families and to persons at risk of homelessness. Each CoC is responsible for selecting an HMIS software solution that complies with HUD's data collection, management, and reporting standards.

The U. S. Department of Housing and Urban Development (HUD) and other planners and policymakers at the federal, state, and local levels use aggregate HMIS data to obtain better information about the extent and nature of homelessness over time. Specifically, HMIS can be used to produce an unduplicated count of homeless persons, understand patterns of service use, and measure the effectiveness of homeless programs.

Housing First: An approach to quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry.

Local Homelessness Coalition (LHC): The former Continuums of Care who now comprise the Balance of State CoC.

Outreach Teams: Teams from various agencies who work with persons experiencing homelessness who are unsheltered. Services provided are based on the needs of the individual. Outreach teams may focus on specific populations (youth, mental health, physical health) or provide general services.

Participating Agencies: Homeless Service providers who wish to or are required to participate in the

Coordinated Entry System. Participating Agencies sign a Memorandum of Understanding to identify the roles and responsibilities as a partner.

Permanent Housing: Community based housing options that are long-term. This includes rapid re-housing, permanent supportive housing, market based interventions, shared housing, and housing without assistance.

Permanent Supportive Housing (PSH): An intervention designed to assist individuals and families who meet the chronically homeless definition and need long term housing assistance and support services to maintain housing stability.

Prevention: Programs or services designed to prevent homelessness for individuals or participants at risk of eviction or foreclosure by providing short-term assistance.

Projects for Assistance in Transition from Homelessness (PATH): Substance Abuse and Mental Health Services Administration (SAMHSA) funded program to provide outreach and services to people with serious mental illness (SMI) who are homeless, in shelter or on the street, or at imminent risk of homelessness.

Public Housing Authority (PHA): Local entity that administers public housing and Housing Choice Vouchers (HCV) (aka Section 8 vouchers).

Racial Equity: Racial equity is the condition that would be achieved if one's racial identity no longer predicted, in a statistical sense, one's housing, economic, and health outcomes. With racial equity, race would no longer be used to predict outcomes, and outcomes for all groups are improved. Racial equity includes addressing root causes of inequities, not just outcomes. This includes elimination of policies, practices, attitudes, and cultural messages that reinforce differential outcomes by race or otherwise fail to address them. Racial equity is a process. This means that Black people, Indigenous people, and people of color—those most impacted—are part of the decision-making about funding, policies and programs.

Rapid Re-Housing (RRH): An intervention designed to help individuals and families quickly exit homelessness and return to permanent housing. Rapid re-housing assistance is offered without preconditions and the resources and services provided are tailored to the unique needs of the participant.

Receiving Program: All participating Rapid Re-housing, Permanent Supportive Housing and Transitional Housing who receive a referral from the Coordinated Entry System and are responsible for responding to that referral and participating in case conferences, in compliance with the protocols described in this manual.

Release of Information (ROI): Written documentation signed by a participant to release personal information to authorized partners.

Transitional Housing (TH): Program providing homeless individuals and families with the interim stability and support to successfully move to and maintain permanent housing. Transitional housing funds may be used to cover the costs of up to 24 months of housing with accompanying supportive services. Program participants must have a lease (or sublease) or occupancy agreement in place when residing in transitional housing. In accordance with HUD recommendations, this intervention should be limited to youth, victims of domestic violence.

Section XI: Appendices

Forms In Progress