EATON COUNTY CONTINUUM OF CARE

COORDINATED ENTRY POLICIES AND PROCEDURES

ADOPTED ON JANUARY 8, 2018

Updated and approved by the Eaton County Continuum of Care May 13, 2019; May 11, 2020

This policy meets the requirements of 24 CFR 578.7 (a) (8).

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OVERVIEW

COORDINATED ENTRY

The U.S. Department of Housing and Urban Development (HUD) requires that Continuums of Care (CoC) establish and operate a coordinated entry (CE) process – and that recipients of CoC Program and Emergency Solutions Grants (ESG) program funding within the CoC's area must use that CE process.

Coordinated entry refers to the process used to assess and assist in meeting the housing needs of people at risk of homelessness and people experiencing homelessness. This process can be accessed by the following CE agencies (using a no wrong door approach):

- Housing Services Mid Michigan (HSMM)
    - Housing Assessment Resource Agency (HARA)
    - PATH Outreach Services
- SIREN Eaton Shelter
- Child & Family Charities-Gateway Youth Services
- Volunteers of America (VOA) Supportive Services for Veteran Families (SSVF)

Key elements of Eaton County's coordinated entry include:

- The use of standardized entry tools to assess client housing needs (VI SPDAT, VI-F SPDAT, TAY-for youth and Lethality Assessment for DV);
- Having a method for prioritizing clients with the most barriers to returning to housing;
- Making referrals, based on the results of the entry tool, to homelessness assistance programs and, when appropriate, other related programs;
- The use of a prioritization protocol;
- Capturing and managing data related to entries and referrals in a Homeless Management Information System (HMIS); and
- Having methods and procedures in place to evaluate the quality and effectiveness of the coordinated entry process.

The Eaton CoC believes that the coordinated entry process, when implemented effectively, benefits the CoC and its clients in many ways. The process is designed to:

- Reduce the amount of research and the number of phone calls people experiencing homelessness must make before finding crisis housing or services;
- Reduce new entries into homelessness through coordinated system wide diversion and prevention efforts;
- Prevent people experiencing homelessness from entering and exiting multiple programs before getting their needs met;
- Erase the need for individual provider wait lists for services; and
- Improve the CoC's ability to respond to community needs and to make progress on ending homelessness.

THIS DOCUMENT

These policies and procedures will govern the implementation, governance, and evaluation of the coordinated entry in Eaton County. These policies may only be changed by the approval of the Eaton County Continuum of Care (CoC).

BASIC DEFINITIONS

- **Access Points-**Designated areas located within the CoC where individuals or families can go to for intake and assessment for which they may qualify.
- **Acuity**- acuity refers to the severity of the presenting issues when utilizing the VI-SPDAT, VI-F SPDAT, or the TAY VI-SPDAT assessment tools.
- **Assessor**-The individuals who complete the common assessment tools (SPDATs) for housing triage and who prepares the information to be entered into HMIS. These individuals are located at all access points are trained to use these tools required by the Eaton County CoC.
- **Chronically Homeless**- An individual or family who: (i) resides in a place not meant for human habitation, a safe haven, or in an emergency shelter or institutional care facility (has been living in the institutional care facility fewer than 90 days and was living in a place not meant for human habitation, a safe haven, or in an emergency shelter immediately prior to entering the care facility) and has been homeless and residing is such a place for a least 12 months or on at least four separate occasions in the last three years where the combined occasions must total at least 12 months; and (ii) has a head of household with a diagnosable substance use disorder, serious mental illness, developmental disability (as defined in Section 102 of the Developmental disabilities Assistance and Bill of Rights Act of 200 (42 U.S.C. 15002)), post-traumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical illness or disability.
- **Client –** Person at risk of or experiencing homelessness or someone being served by the coordinated entry process.
- **Diversion**- A strategy that prevents homelessness for people seeking shelter, or other homeless assistance, by helping them identify immediate alternate housing arrangements and, if necessary, connecting them with services and financial assistance to help them return to permanent housing.
- **Family**-includes, but is not limited to the following, regardless of actual or perceived sexual orientation, gender identity, or marital status; (1) A single person; or (2) A group of persons residing together with or without children.
- **Housing Assessment and Resource Agency (HARA)**- The selected agency or group of collaborating agencies working together to provide housing assessment and referral for those experiencing homelessness or who are at-risk of becoming homeless.

- **HMIS**-Homeless Management Information System; the state wide information technology system used to collect client-level data on homeless and those at-risk of becoming homeless, complies the data used to track and provide services to individuals and aggregate into reports for review to improve delivery systems, to report to funding sources, and inform the general public.
- **Homeless**- (Category 1) an individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) an individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; (ii) an individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, State, or local government programs for low- income individuals); or (iii) An individual who is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution; (Category 2) An individual or family who will imminently lose their primary nighttime residence, provided that: (i) The primary nighttime residence will be lost within 14 days of the date of application for homeless assistance; (ii) No subsequent residence has been identified; and (iii) The individual or family lacks the resources or support networks, e.g., family, friends, faith-based or other social networks, needed to obtain other permanent housing; or (Category 3) Any individual or family who: (i) Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence; (ii) Has no other residence; and (iii) Lacks the resources or support networks, e.g., family, friends, and faith- based or other social networks, to obtain other permanent housing. 24 CFR 578.3.
- **Housing First**- An approach used to quickly and successfully connect those experiencing homelessness to permanent housing without preconditions or barriers to entry, such as sobriety, treatment, or services participation requirements. Supportive services are offered to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to permanent housing entry.
- **Housing Interventions –** Housing programs and subsidies; these include transitional housing, rapid re-housing, and permanent supportive housing programs, as well as permanent housing subsidy programs.
- **Rapid Re-Housing (RRH)** –An intervention designed to help individuals and families exit homelessness as quickly as possible, return to permanent housing, and achieve stability in that housing. Rapid re-housing assistance is offered without preconditions

(such as employment, income, absence of criminal record, or sobriety) and the resources and services provided are typically tailored to the unique needs of the household. The core components of a rapid rehousing program are housing identification and relocation, short-and/or medium term rental assistance, move-in (financial) assistance, case management, and housing stabilization services.

- **SPDAT (Service Prioritization Decision Assistance Tool)**—The evidence informed assessment tool utilized by all trained CoC providers in determining acuity for housing placement and/or ongoing use in case management to ensure housing stabilization. The SPDAT (or "Full SPDAT") has an individual and family tool. Staff must be trained by OrgCode Consulting or Balance of State CoC staff on the SPDAT. The SPDAT can be completed on paper or in HMIS and attached to a client record. Other forms of the VI SPDAT utilized throughout the CE include:

  VI-F SPDAT: Vulnerability Index for Families
  TAY-VI SPDAT: Vulnerability Index for Transitional Age Youth
- **Transitional Housing (TH)** – Housing, where all program participants have signed a lease or occupancy agreement, the purpose of which is to facilitate the movement of individuals and families experiencing homelessness into permanent housing within 24 months. 24 CFR 578.3.
- **Permanent Supportive Housing (PSH)**- Community-based housing without a designated length of stay including supportive services provided to ensure housing stability.
- **Program –** A specific set of services or a housing intervention offered by a provider.
- **Provider** – Organization that provides services or housing to people experiencing or at-risk of homelessness.
- **Prioritization List-** A list in Goggle docs that uses the SPDAT score and gathers information including, Chronically Homeless status, individual or family household type, disability, and length of time homeless to assist with the selection process for the various housing programs.
- **Violence Against Women Act (VAWA)-** piece of legislation that sought to improve criminal justice and community-based responses to domestic violence, dating violence, sexual assault and stalking in the United States.

TARGET POPULATION

The CE covers the entire geographic area claimed by the Eaton County CoC which includes all of Eaton County, Michigan and all of the municipalities therein. This process is intended to serve people experiencing homelessness, Category 1, and those who believe they are at imminent risk of homelessness. Homelessness will be defined in accordance with the official HUD definition of literal homelessness. People at imminent risk of homelessness are people who meet the HUD definition of homelessness Category 2 and those fleeing from domestic violence, Category 4.

GOALS AND GUIDING PRINCIPLES

The goal of the coordinated entry process is to provide each client with adequate services and supports to meet their housing needs with a focus on returning them to housing as quickly as possible. Below are the guiding principles that the Eaton CoC agencies will follow to meet these goals:

- **Client Choice –** Clients will be given information about the programs available and to which they are eligible for, and will participate in making their program choice. They will also be engaged as key and valued partners in the implementation and evaluation of coordinated entry through forums, surveys, and other methods designed to obtain their thoughts on the effectiveness of the coordinated entry process. If eligible for more than one program, the client will determine which program is utilized.

- **Collaboration –** Because coordinated entry is being implemented system wide, it requires a great deal of collaboration between the CoC providers, mainstream assistance agencies (e.g., Department of Health and Human Services, hospitals, jails, etc.), funders, and other key partners. This spirit of collaboration will be fostered through open communication, transparent work by the Strategies/Grants Committee which consistently schedules coordinated case manager's meetings (Interagency Case Review Team), and consistent reporting on the performance of the coordinated entry process to the CoC membership.

- **Accurate Data –** Data collection on people experiencing homelessness is a key component of the coordinated entry process. Data from the entry process that reveals what resources clients need the most will be used to assist with reallocation of funds and other funding decisions. To capture this data accurately, all entry staff and providers must ensure data entry into HMIS in a timely fashion. Client rights with regard to access to and release of privileged information will always be made explicit to clients during the intake process, with clients' signature a requirement, and no client will be denied services for refusing to share personal data.

- **Process Evaluation –** Decisions about and modifications to the coordinated entry process will be driven primarily by the need to improve the performance of the homelessness assistance system on key outcomes. These outcomes include reducing new incidences of homelessness, reducing lengths of episodes of homelessness, and reducing repeat occurrences of homelessness. Changes may also be driven by a desire to improve process-oriented outcomes, including reducing the amount of wait time for a program entry. All of these processes and outcomes will be under on-going review by the Strategies/Grants Committee which will conduct an annual review minimally.

- **Housing First –** Coordinated entry will support a housing first approach, and thus will work to connect households with the appropriate permanent housing opportunity, as well as any necessary supportive services, as quickly as possible. No one will be denied entry to housing based on prerequisites such as sobriety.

- **Prioritizing the Hardest to House –** Using the standardized tool (SPDATs), the coordinated entry will prioritize those households that appear to be the hardest to house or serve for available program beds and services.

- **Non-Discrimination Policy**

  The CoC has developed and operates a coordinated entry that requires recipients of Federal and State funds to comply with applicable civil rights and fair housing laws and requirements. Recipients and sub-recipients of the CoC Program and ESG Program-funded projects must comply with the nondiscrimination and equal opportunity provisions of Federal civil rights laws, including but not limited to the following:

  - The Fair Housing Act prohibits discriminatory housing practices based on race, color, religion, sex, national origin, disability, or familial status.
  - Section 504 of the Rehabilitation Act prohibits discrimination on the basis of disability under any program or activity receiving Federal financial assistance.
  - Title VI of the Civil Rights act prohibits discrimination on the basis of race, color, or national origin under any program or activity receiving Federal financial assistance.
  - Title II of the Americans with Disabilities Act prohibits public entities, which includes State and local governments, and special purpose districts, from discriminating against individuals with disabilities in all their services, programs, and activities, which include housing, and housing-related services such as housing search and referral assistance.
  - Title III of the Americans with Disabilities Act prohibits private entities that own, lease, and operate places of public accommodation, which include shelters, social service establishments, and other public accommodations providing housing, from discriminating on the basis of disability.

    SEE APENDIX A for the policy approved by the Eaton Continuum of Care and the form used by the client.

A. PLANNING

COMPLIANCE TIMELINE

The Eaton CoC first adopted this CE process on January 8, 2018 at a regular Continuum of Care meeting. Updating was completed on May 13, 2019. The next update was completed on May 11, 2020.

CORE REQUIREMENTS

The Eaton CoC's coordinated entry process meets the requirements listed below, as established by the CoC Program interim rule:

The CoC has a Coordinated Entry System (CES) that covers the entire geographic area claimed by the CoC: all of Eaton County, Michigan and all the municipalities therein. The HARA-Housing Services Mid Michigan, SIREN/Eaton Shelter, and Gateway Youth Services and VOA offers satellite services to serve Eaton County residents.

1. The CE is easily accessed by individuals and families seeking housing or services as all agencies in the Eaton CoC are assessable, on the public bus line, EATRAN, and use standardized hours of M-F, 8:30am to 5pm, with an after-hours 800 number hotline available for after-hours issues provided by SIREN/Eaton Shelter.

2. The Eaton CoC Providers ensure the methods of entry into the CE are visible and posted in areas frequently accessed by those experiencing homelessness by using the below bulleted, marketing strategies to ensure active marketing for the general population and all special populations:

    - Visibly posted in areas frequently accessed by those experiencing homelessness:
        - Eviction Court
        - Department of Health and Human Services
        - Local food banks
        - County Jail

    - Consistently messaging and promoting the intake hotline number on participating agency social media accounts and websites:
        - 211
        - Providers Facebook pages
        - Providers Websites
        - Providers promotional materials

    - Targeting non-housing provider groups who may come into frequent contact with those experiencing homelessness by providing education about the Coordinated Entry System as well as posting critical marketing information:
        - Hospitals/Health Clinics- Hayes Green Beach, Eaton Rapids Medical Center, Cherry Health, and Eaton Behavioral Health, Urgent Care facilities
        - Law Enforcement- local police departments and the Eaton County Sheriff
        - Faith Communities- all area churches
        - Mental Health Service Provider- Eaton County Counseling Center
        - Drop-In Centers – Charlotte Crosswalk, Eaton Rapids
        - Schools- McKinney-Vento CoC representative who distributes information on behalf of the CoC to all school liaisons
        - Local social service providers – see HSMM's Resource Directory

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

Further, population-specific projects (e.g. women only, tribal nation members only, chronically homeless etc.) are permitted to maintain eligibility restrictions as currently defined and will continue to operate and receive prioritized referrals.

Additionally:

- Provider websites will provide information about their services including all information about special populations and how to obtain those services
- The CE after-hours hotline phone number will be listed on the Eaton CoC website.
- Housing Services Mid Michigan Resource Directories are made available online with free paper copies available to all clients
- "No Place to Go" information sheet used by area churches, food banks, and partnering agencies to assist with directing walk-ins to the correct services (See Appendix B)
- Auto-referrals from DHHS
- Requires that the non-discrimination policy guides all advertising
- Special populations such as youth, CH, Veterans, families with children, LGBT, and survivors of DV are included in all marketing materials

3. The CE uses the Service Prioritization Decision Assessment Tools which are: VI SPDAT, VI F SPDAT, TAY SPDAT and Lethality Assessment for Domestic Violence. All HUD funded agency providers use the same Universal Data Elements (UDE) in HMIS. DV providers use a separate data base with its own VAWA requirements.

4. The CE provides an initial, comprehensive assessment of individuals and families for housing and service using the above stated tools. This housing assessment acts as a prioritization tool in order to ensure the most appropriate housing intervention is recommended to each household. It further gives priority to those experiencing the greatest need and is designed to assess vulnerability and life areas affected by homelessness in order to begin the prioritization process. Additionally, it provides a method to add these assessed households to the Prioritization List when appropriate. (See Appendix C)

5. It is the policy of the Eaton CoC that when an individual or family is fleeing, or attempting to flee domestic violence, dating violence, sexual assault, stalking, or human trafficking, but who are seeking shelter or services from non-victim specific providers, that they be promptly referred to SIREN/Eaton Shelter which then conducts its DV assessment.

6. The CoC, in consultation with recipients of Emergency Solutions Grants program funds within the geographic area, has established and consistently applies its standardized assessment tool to implement the written standards for providing Continuum of Care assistance which can guide the development of formalized policies and procedures for the coordinated entry process:

- Written standards provide guidance for evaluating individuals' and families' eligibility for assistance under 24 CFR Part 578.
- Written standards provide guidance for determining and prioritizing which eligible individuals and families will receive transitional housing assistance.
- Written standards provide guidance for determining and prioritizing which eligible individuals and families will receive rapid rehousing assistance.
- Written standards provide guidance for determining what percentage or amount of rent each program participant must pay while receiving rapid rehousing assistance. Under MSHDA ESG, the HARA is required to pay the gross rent to the landlord. However, effective October 1, 2018, **participants are required to pay 30% of gross monthly projected income toward their monthly rent directly to the landlord**. Households with zero income qualify and have zero rental contribution. Income must be re-verified after three months of rental assistance, i.e., prior to paying the fourth month's rent.

However, the HARA is **not required to cancel** ESG rapid re-housing participants that do not make their monthly payment to landlord, **but meeting monthly with all rapid re-housing participants is required.**

- Written standards provide guidance for determining and prioritizing which eligible individuals and families will receive permanent supportive housing assistance. (See Appendix C)

The CoC affirmatively markets housing and supportive services to eligible persons regardless of race, color, national origin, religion, sex, age, familial status, disability, or who are least likely to apply in the absence of special outreach. And, will do so by requiring all Providers to abide by its non-discrimination policy – see Guiding Principles.

Additionally, the CoC requires the following:

a. Agencies post all projects on their websites
b. Each funded agency be trained in fair housing laws
c. A fair housing log be maintained by the HARA to meet ESG rules
d. All housing agencies use the fair housing logo on all literature

To ensure client's rights, each CE Providing agency will provide every client a copy of the approved Non-discrimination Policy and its own Grievance Policy and will require each client to sign-off on the receipt of these policies. The original sign-off sheet will remain in the client's file as a permanent record. (See Appendix D)

B. ACCESS

The Eaton CoC offers the same assessment approach (the various SPDAT tools or the Lethality Assessment at SIREN/Eaton for Domestic Violence cases) at all access points. All access points

are usable by all people, including those in sub-populations, who may be experiencing homelessness or are at risk of homelessness.

The access points are:

- Housing Services Mid Michigan (HSMM)
  - Housing Assessment Resource Agency (HARA)
  - PATH Outreach Services
- SIREN/Eaton Shelter
- Child & Family Charities-Gateway Youth Services
- Volunteers of America (VOA) Supportive Services for Veteran Families (SSVF)

Gateway and SIREN/Eaton Shelter each have a 24 hour, 800 number hotline for use after-hours.

ACCESS MODELS

The following overview describes the path a household would follow from an initial request for housing services through housing placement. The overview also lists key roles and expectations of partner organizations who play a critical role in the Eaton County CE system.

- Step 1: Initial Request for Housing Services/Connection to the Coordinated Entry System

  Individuals may call the HARA for a screening, walk-in to any CE office (HSMM, SIREN, Gateway- Youth, or VOA-Veterans,) or receive initial services by a Street Outreach worker (PATH or Gateway).
  *If the individual or family is currently fleeing domestic violence, appropriate safety planning will be developed with the client and then a direct referral to SIREN/Eaton Shelter, the domestic violence provider is made.

- Step 2: Diversion

  At the time of the initial request for housing services, a strategic diversion attempt is made by the agency in order to assist the household in diverting them away from the homeless system; when applicable. Diversion attempts are conducted using an evidence informed nine step process that includes conflict resolution, mediation, in-depth problem solving as well as outreach and referral from assessment staff. Outreach and referrals to other partner agencies or friends/family are made by the housing agency in order to more effectively assist the household with the immediate housing crisis, rather than entering the homeless system. (See Appendix E)

- Step 3: Housing Assessment

  When diversion is unsuccessful or not appropriate, a housing assessment takes place in order to assess the current vulnerability and needs of the household seeking housing

assistance. The housing assessment will act as a prioritization tool in order to ensure the most appropriate housing intervention is recommended to each household as well as to give priority to those experiencing the greatest need. The common assessment tool(s) utilized throughout the Eaton CoC are designed to assess vulnerability and life areas affected by homelessness. Tools utilized include the VI SPDAT, VI-F SPDAT, and TAY-VI SPDAT and the Lethality Assessment for DV. The assessment results are entered into the Prioritization List. Each household must update its version of the SPDAT every six months to remain on the Prioritization List.

- Step 4: Housing Referral

Information gathered from the assessment is used to determine which housing intervention is most appropriate to end the household's homelessness (Rapid-Rehousing, TH, or Permanent Supportive Housing). Once the assessment is completed, a SPDAT score is generated and placement on the Eaton Prioritization List is done automatically which is visible to all access points through a sharing agreement. Sub-populations will receive additional referrals and consideration as necessary. Coordination between the sub-population servicing agency with the HARA is anticipated where appropriate.

- Once placed on the Prioritization List the Interagency Case Review Team which includes representation from the HARA as well as case managers of all specified housing programs to determine the appropriate/first available housing intervention meet to fill housing openings. (See Appendix C-Prioritization)

- Step 5: Housing Navigation and Placement:

Once appropriate housing program type is determined, the household is matched with the appropriate case manager related to that particular housing program. This case manager meets with the household to determine housing preference/choice and appropriate location/housing type that best meets the needs of the household. Once housing has been identified and the household is set to move in, the case manager provides follow up services as dictated by program requirements and guidelines.

- Step 6: Housing Supports

Case managers work with the household to support maintaining housing long-term. These supports are determined by each program's guidelines.

NONDISCRIMINATION

It is the policy of the CoC that all agencies participating in the coordinated entry process comply with the equal access and nondiscrimination provisions of Federal civil rights laws. Each client is given a copy of the nondiscrimination policy and the grievance process at the time of intake. For additional language regarding gender identity. (See Appendix A)

The Eaton County CoC's referral process is informed by Federal, State, and local Fair Housing laws and regulations and ensures participants are not steered toward any particular housing facility or neighborhood because of race, color, national origin, religion, sex, age, familial status, disability, actual or perceived sexual orientation, gender identity or marital status. (See Non-Discrimination Policy, Appendix D)

ACCESSIBILITY

Fair and Equal Access

Providers participating in the Eaton County Continuum of Care must ensure fair and equal access to its Coordinated Entry System programs and services for all clients regardless of actual or perceived race, color, religion, national origin, age, gender identity, pregnancy, citizenship, familial status, household composition, disability, Veteran status, or sexual orientation. (See Non-discrimination policy, Appendix A)

All of the CoC's access points are easily accessed by individuals and families seeking homeless or homelessness prevention services. The entire geographic region is served by EATRAN, which provides door-to-door public transportation, including those with mobility needs. All access points have accessible buildings and are located in proximity to public transportation and are also compliant with accessibility requirements for individuals with disabilities including individuals who use wheelchairs per ADA regulations.

This CoC serves all sub-populations at all of its access points. This approach is accomplished by using the standardized assessment tools (all of the SPDATs and the DV Lethality Assessment) to determine the appropriate measures taken with each situation.

These sub-populations include:

- Veterans
- Youth (18-24)
- Families with Children
- Disabled
- Domestic Violence

Further, it is the policy of the CoC that participants will not be denied access to the coordinated entry process on the basis that the participant is or has been a victim of domestic violence, dating violence, sexual assault, stalking, or human trafficking by using the same assessment approach at all access points.

If necessary, providers make referrals to other organizations to ensure that the household is best served.

Additionally, the provider agencies offer appropriate auxiliary aids and services necessary to ensure effective communication (e.g. Braille, audio, large type, assistive listening devices and sign language interpreters) at walk-in locations as well as through the call center. Additionally, access points offer Coordinated Entry process materials and participant instruction in multiple languages to meet the needs of minority, ethnic, and groups with Limited English proficiency.

1. The CoC's access points offer reasonable accommodation on a case-by-case basis, including: meeting the client where they are located, intake by phone or fax, intake materials in the form of Braille, audio, large type, assistive listening devices and sign language interpreters or language interpreters.

2. Providers automatically refer all clients for mainstream and community-based emergency assistance services. For example, access points use Resource Directories (see Appendix F), DHHS Navigators, and the 211 Resource line.

Emergency Services

The Eaton CoC's CE process requires emergency services and emergency shelter, including the region's 211 line, its domestic violence shelter, and other short-term residential programs, to operate with as few barriers to entry as possible. People are able to access emergency shelter, independent of the operating hours, by using SIREN/Eaton Shelter's and Gateway's 24-hour, 800 number hotline with automatic referral for appointments with the HARA within 48 hours. During this appointment the HARA completes the housing assessment and then makes appropriate referrals to housing programs based on need identified through client choice and the assessment process.

Prevention Services

It is the Eaton CoC policy that clients seeking prevention services are processed through Housing Services Mid Michigan (HARA), its prevention agency. If the HARA concludes there is an immediate housing need, households will proceed to a full housing assessment or be scheduled for a housing assessment within two business days. The CE Prevention Policy prioritizes those most in need by targeting those at immediate risk of homelessness (Category 2).

For those above 30% AMI, the HMIS Self-Sufficiency Matrix is used to determine need, and other funds, when available are used on a first come, first served basis. For this population, separate community raised funds will be used on a case by case basis.

Marketing Materials for Special Populations

It is the CoC's CE policy and procedure that each access point complies with local, state and federal laws related to accessibility. All Eaton CoC access points are accessible to individuals with disabilities, including those who use wheelchairs. Information about accessibility is listed on the Eaton CoC website and by calling 211.

The CoC's access points take reasonable steps to offer CE process materials and participant instruction in multiple languages to meet the needs of groups with Limited English Proficiency (LEP). Staff are also educated on the use of translation tools (e.g. google translate) to be able to translate documents into multiple languages

Additionally, the provider agencies are required to ensure effective communication when serving individuals with disabilities by providing appropriate auxiliary aids and services (e.g., Braille, audio, large type, assistive listening devices, and sign language interpreters) by arraigning the use of these aids on a case by case basis.

SAFETY PLANNING

The Eaton County Coordinated Entry System ensures participants may not be denied access to the coordinated entry process on the basis that the participant is or has been a victim of domestic violence, dating violence, sexual assault or stalking. All area agencies provide these households with a direct referral to appropriate agencies that serve the above sub-populations.

Trainings are offered on how to write a safety plan to all of the participating providers so each may provide the necessary safety and security protections for persons fleeing or attempting to flee family violence, stalking, dating violence, or other domestic violence situations. This annual training allows the CE agencies to also offer safety planning to assist clients who feel they are unable to leave their current living situation.

The safety plan includes minimally a baseline assessment of the participant's safety needs and referral to appropriate trauma-informed services if safety needs are identified. (See appendix G for a sample plan developed by the National Center on Domestic Violence and Sexual Assault)

Anyone fleeing or attempting to flee domestic violence and victims of trafficking entering the Eaton CoC CE process are ensured safe and confidential access to the coordinated entry process and victim services with immediate access to emergency services and shelter

Eaton CoC shelter providers can accommodate individuals whose self-identified gender or household composition creates challenging dynamics by offering that individual or household private accommodations to ensure safety.

STREET OUTREACH

Street outreach efforts for the Eaton CoC include PATH, Gateway, and Volunteers of America. These activities are linked to the Eaton CoC coordinated entry process in the following ways: All Street Outreach staff ensure that persons encountered on the street are offered the same standardized process as persons who access coordinated entry through access points by making

immediate referrals to both the HARA and appropriate shelter. SIREN/Eaton Shelter has an assigned liaison to the Outreach Team to ensure immediate sheltering if needed.

Bimonthly meetings with the Street Outreach Team are held to discuss access issues and delivery of best practices for clients to access the CE system.

C. ASSESSMENT

Assessment Process Overview

Housing assessment through the Eaton County CoC's Coordinated Entry System will be consistently applied at every access point. When shelter diversion is unsuccessful or not appropriate, a housing assessment takes place in order to assess the current vulnerability and needs of the household seeking housing assistance. The housing assessment acts as a part of prioritization process in order to ensure the most appropriate housing intervention is recommended to each household as well as to give priority to those experiencing the greatest need. The common assessment tool(s) utilized throughout the CoC are designed to assess vulnerability and life areas affected by homelessness. These tools include the VI SPDAT, VI-F SPDAT, TAY-VI SPDAT and the DV Lethality Assessment. Following completion of the assessment, it is entered into a password protected spread sheet for this purpose thus creating the by names list which also coordinates the Prioritization List thus creating the by names list that is used by the Interagency Case Review Team to suggest appropriate housing intervention.

All clients whether assessed by the VI-SPDAT or DV Lethality assessment, are assessed through the CE and Prioritization process. Those clients who fall into the HUD defined category- YOUTH- are served by Child and Family Gateway program. (See Appendix C)

Ensuring Low Barriers to Entry

The Eaton County Coordinated Entry System prohibits any providers from screening people out of the coordinated entry process due to perceived barriers to housing or service, including but not limited to, too little or no income, active or a history of substance abuse, domestic violence history, resistance to receiving services, the type or extent of a disability-related services or supports that are needed, history of evictions or poor credit, lease violations or history of not being a leaseholder, a criminal record or the refusal to answer assessment questions.

To ensure the above:

The CoC requires all participants be screened using one of the appropriate SPDAT or DV Lethality assessment tools before entering the household onto the Prioritization List. These tools standardize the assessment process and eliminates bias towards too little or no income, active or

a history of substance abuse, domestic violence history, resistance to receiving services, the type or extent of a disability-related services or supports that are needed, history of evictions or poor credit, lease violations or history of not being a leaseholder, or a criminal record. Refusal to answer these questions does not exclude the household from services.

ASSESSOR TRAINING

The Eaton County CoC uses the Michigan Coalition Against Homelessness (MCAH) and DHHS among other evidenced-based providers to provide training opportunities for the all CoC organizations The purpose of the training is to provide all staff administering these assessments with access to materials that clearly describe the methods by which assessments are to be conducted with fidelity to the CoC's coordinated entry written policies and procedures

The Eaton CoC also uses OrgCode podcasts and training materials as a methodology to update and distribute training protocols at least annually to those agencies conducting SPDAT assessments. The purpose of this training is to provide access to materials that clearly describe the methods by which the SPDAT assessments are to be conducted with fidelity for the Eaton County CoC's Coordinated Entry System.

Annually all HMIS users are required to obtain a privacy and confidentiality certification. These trainings are on MCAH's website. Also specialized trainings for the appropriate use of HMIS are required and are conducted on a case-by-case basis at the monthly user meetings held by MCAH on the Go to Meeting platform.

All assessment staff are also trained on how to conduct a trauma-informed assessment of participants. Special considerations and application of trauma-informed assessment techniques are afforded to victims of domestic violence or sexual assault to help reduce the chance of re-traumatization. Assessors receive additional training focused around culturally and linguistically competent practices and assessments. These trainings are ongoing and are provided through various methods such as webinars and face to face.

To ensure fidelity of the CoC's processes, its trainings will be hosted at Peckham, Inc and will include: An annual review of the CoC's written CE policies and procedures, including any adopted variations for specific subpopulations and updates; prioritization protocols; criteria for uniform decision-making and referrals; self-sufficiency; domestic violence safely planning and any other trainings the Eaton CoC determines necessary to maintain its Coordinated Entry process. Documentation of trainings are held in the Training Library at Peckham, Inc and will be available for organizations to access at any time.

Continuous Quality Improvement (CQI)

To ensure data collection and its management Peckham, Inc provides the leadership for the on-going Continuous Quality Improvement (CQI) Committee meetings that are held monthly to address any on-going training issues and needs amongst providers and assessors. A staff member from each of the HMIS entering agencies must be assigned to this CQI Committee where data is used to determine quality improvement topics. CoC performance measures will be reviewed by the CQI Committee quarterly. Improvements areas will be discussed and methods to improve will be implemented as a CQI process.

Client Centered

The Eaton CoC requires that all physical assessment areas are safe and confidential to allow for individuals to identify sensitive information or safety issues in a private and secure setting. This requirement is met by the agency meeting households either in their building where individual offices are located or by making arrangements with other partners to use that partner's secured private office areas for intake and assessments with discreet exits available (e.g.: SIREN/Eaton Shelter has as a number of private offices in the rear of the building with a separate entry to ensure privacy.

Participant Autonomy, Privacy and Protections

Participants of the Eaton County CoC's Coordinated Entry System are freely allowed to decide what information they provide during the assessment process, to refuse to answer assessment questions, and to refuse housing and service options without retribution or limiting their access to other forms of assistance.

At time of referral, clients are informed of their right to request a "lesser" program and that they have the choice and the right to refuse the program. A household can choose not to accept a referral when it is made from the Priority List or from the program once the intake is complete, they will be placed back on the Priority List in the same position as they had been prior to referral. If a client is referred to a program, is accepted to that program, but then cannot find a housing unit within the appropriate time frame allowed by the program's requirements, they will remain on the priority list in the same position as they had been prior to referral.

All data collected through the Coordinated Entry process is collected in HMIS which is provided through the Michigan Coalition Against Homelessness (MCAH. A standardized Release of Information process utilized by all providers to input data into HMIS is used by all providers. This ROI is based on a Michigan statewide adopted, HIPPA compliant release. Participants of the Coordinated Entry System are informed that the assessment process cannot require disclosure of specific disability or diagnosis. Specific diagnosis or disability information may only be obtained for purposes of determining program eligibility to make appropriate referrals.

It is the policy of the CoC that all Providers have a grievance policy that allows a participant to file a non-discrimination complaint. Participants must be informed of the ability to file a nondiscrimination complaint by each CE access agency. Should there be dissatisfaction with the results from the agency's decision/grievance, participants may file a complaint through the original funding source (e.g.: HUD, MSHDA, Emergency Food and Shelter Program).

ASSESSMENT PROCESS

SCREENING PROCEDURES

When emergency shelter is sought, Case Managers will attempt to arrange and conduct a screening interview using the following questions or concerns:

- Shelter diversion options
- Review with potential clients any safety issues/concerns. If needed, referral to domestic violence services is made.
- If appropriate, provide information and referral of available services
- Advise the potential client on the time frame for acceptance/and eligibility determination
- Answer any other questions the potential client might have

Since the Eaton CoC employs the Housing First oriented assessment process, following shelter diversion, the focus is on rapidly housing participants without preconditions. To gather the information needed for sheltering or housing search assistance the following steps are conducted:

- If homeless services are sought, prepare VI-SPDAT documentation
- Review with potential clients the scope of the program including; length of stay, shelter availability, rules and guidelines, and services available.
- Place on the Prioritization list, as appropriate
- Assess type of shelter to be offered (e.g.: homeless scattered site, or motel)
- Assist with accessing shelter elsewhere if SIREN cannot accommodate.

(See Prioritization Policy Appendix C)

CLIENT-CENTERED

1. Using the VI-SPDAT, assessment questions are adjusted according to specific subpopulations (i.e., Youth, Individuals, Families, and Chronically Homeless). For example, if a participant is under the age of 18 questions related to Veteran status and experience with the armed services can be skipped.

2. All providers will explain the VI-SPDAT to reflect the developmental capacity of participants being assessed by clarifying questions as they arise or as the providers deems necessary by using the introductory script and the uniform clarification guidance. (See Appendix J).

3. The intake incorporates a person-centered approach, including questions which address the following:
    - Assessments are based in part on the participant's strengths, goals, risks, and protective factors.
    - Tools and assessment processes are easily understood by the participants.
    - Assessments are sensitive to the participant's life experiences.
    - Participants are offered choice in decisions about location and type of housing. Each participant is given the Eaton County Apartment Guide and the weekly local housing listing to assist them in their housing search.
    - Each participant who qualifies for a specific program is offered an overview of that program and is given an opportunity to ask questions and make informed decisions.

ENSURING HOMELESS CHILDREN ARE CONNECTED TO MCKINNEY-VENTO LIAISONS

The policy and procedures adopted to inform individuals and families who become homeless about education services include the following:

- On-boarding of new CE employees specific training about the McKinney-Vento and the processes used internally to make referrals

- The McKinney-Vento Regional Grant Coordinator will provide the CoC with a list of all Local Education Agency contacts in the fall of each year once new Liaisons have been appointed in each district.

- All homeless families presenting at any CoC agency will be informed of their educational rights at intake regardless of where they present and are given instructions on how to enroll their youth. Educational rights for eligible children and youth through McKinney-Vento homeless grant include the following:
    - Receive a free, appropriate public education.
    - Enroll in school immediately, even if lacking documents normally required for enrollment.
    - Enroll in school and attend classes while the school gathers needed documents.
    - Enroll in the local school (School of residence); or continue attending the last school attended, while permanently housed, or the school in which they were last enrolled (school of origin), based on the preference of the parent, guardian, or unaccompanied homeless youth.
        - If the school district believes that the school selected is not in the best interest of the child, then the district must provide a written explanation of

the school's position and give the parent or guardian the option to appeal the decision.

- Receive transportation to and from the school of origin, if needed.
- Receive educational services comparable to those provided to other students, according to the needs of each child.

- Case management will assist older adolescents to explore higher education options.

In addition, there is a formal, documented referral process between the Coordinated Entry staff, McKinney-Vento Regional Grant Coordinator, and Local Education Agency Homeless Liaisons for McKinney-Vento. When a homeless family with school age children present themselves at a Coordinated Entry agency, they are informed of their educational rights. Intake paperwork includes enrollment questions and the housing plan includes instructions on how to enroll their children. Once a determination has been made as to where the children will be attending school, a referral is completed by CE staff and sent directly to the local McKinney-Vento Liaison and the Grant Coordinator. The CE staff and M-V team will pool resources and work closely together to provide any needed services for each family.

Incorporating Mainstream Services

The CoC includes many mainstream services. Examples of these services include: DHHS, Community Mental Health, the Health Department, the Battle Creek VA medical center and VOA-SSVF program, along with a list of others. (See Appendix F for the resource directories)

Additionally, the CoC holds monthly meetings in which mainstream service providers give presentations and overviews on referrals, services, and activities to assist the CoC with:

- Identifying people at risk of homelessness;
- Facilitating referrals to and from the coordinated entry process;
- Aligning prioritization criteria where applicable;
- Coordinating services and assistance; and
- Conducting activities related to continual process improvement.

The approved CoC policy to make referrals is to use the HARA referral form. The form can be faxed or emailed directly to the HARA. This referral form is available on the HARA's website. (See Appendix J for referral form)

Street Outreach

Street outreach activities use the same standardized assessment process for all populations. Providers conduct assessments using the VI-SPDAT on the spot during street outreach which utilizes the same criteria as all of the CE access points.

The Tri-County Outreach Team covers the Eaton County CoC area. It conducts both planned outreach activities and spontaneous activities based on leads or other information. The Team

uses the VI SPDAT for assessment and makes referrals to the CE for additional assistance (motels) or assists the clients with locating immediate shelter at local shelter system locations.

D. PRIORITIZATION

CORE REQUIREMENTS

A standardized Release of Information (ROI) is utilized by all HUD-funded providers to input data and VI-SPDAT information into HMIS. This ROI is based on a Michigan statewide adopted, HIPPA-compliant ROI. All assessments and VI-SPDAT information for HMIS agencies must be recorded in HMIS. See Appendix L for ROI. Domestic Violence providers use an approved ROI for DV clients.

Eaton County CoC has a sharing agreement which allows client data int~~o~~ HMIS to be shared. The Prioritization list is shared through a password protected spread sheet document and in person at the monthly Inter-Agency Case Review Team meetings. Individuals may be placed on the list even if they refuse the SPDAT and/or are receiving DV services and wish to remain anonymous. This special list is used updated at the Interagency Case Review Team meetings. As RR, TH, or PSH unit openings occur, the Prioritization team reviews these openings and selects candidates as dictated by the list HUD regulations only allow RR, TH and PSH programs to serve:

- people who are literally homeless (Category 1)
- people who are homeless because they are fleeing domestic violence (Category 4).

In addition, HUD mandates that communities prioritize literally homeless households who are chronically homeless (CH) for housing and services.

The protocols for this prioritization include:

- Prioritize homeless persons within Eaton County;
- Prioritization is based on a specific and definable set of criteria that are documented, made publicly available, and applied consistently throughout the CoC for all populations. (See appendix C for criteria)
- The CoC's prioritization procedures are consistent with CoC and ESG written standards under 24 CFR 578(a)(9) and 24 CFR 576.4.
- The CoC's CE procedures include the factors and assessment information with which prioritization decisions are made for all homeless assistance.

PRIORITIZATION LIST

Because the CoC manages its prioritization order using a "Prioritization List," the CoC extends the same HMIS data privacy and security protections prescribed by HUD for HMIS practices in the HMIS Data and Technical Standards. To meet this requirement, the Eaton CoC utilizes a password protected Google document for its Prioritization List, and as such it agrees to provide the data privacy and security protections prescribed by HUD. (See Appendix H)

In compliance with HUD standards, participants maintain their place on the Prioritization List even when the participant rejects referral options. Clients may stay on the list if they refuse the housing opportunity. (See Appendix C)

Prioritization Process

Annually, the CoC' Strategies/Grants Committee reviews the Prioritization Policy and updates the providers on the process for determining participant prioritization for available CoC housing and supportive services.

In order to assist the identified prioritization agencies, the Coordinated Case Plan may be used when considering aspects of the households to assist in the assessment of the appropriate housing type.

The Coordinated Case Plan may be reviewed, along with the Prioritization List, by the Prioritization Team so that in the event that two or more homeless households within the same geographic area are identically prioritized for the next available unit, and each household is also eligible for that unit, then Team may select the household that first presented for assistance in the determination of which household receives a referral to the next available unit. Observations by case managers on a case-by-case basis may also provide input for those not fitting typical prioritization such as not informing the process correctly or because of disability or trauma, or substance abuse issues.

The Eaton CoC's maintains its Prioritization List for housing placements immediately. (See Appendix C)

Additionally, YOUTH, under 18, are served by a non-HUD funded agency. Its prioritization process is in Appendix C.

E. MOVE-UP VOUCHERS

The Eaton CoC has been awarded "Move-Up Vouchers" from the MSHDA as a strategy to increase the availability of PSH units for both individuals and families. These special vouchers are to be used only by those coming out of PSH units after 1 year. The process is based on self-

referral using a self-assessment tool filled out by the participant after the one-year mark. Accepting these vouchers is completely voluntary. No client will be required to ever accept this voucher and may choose to stay on the PSH program.

1. The policy for using these vouchers was approved by the Eaton CoC on May 14, 2018 and is as follows: All PSH program participants will be provided with a Move Up Voucher Invitation and Self-Assessment form at annual renewal, beginning on the first annual renewal. At the time of the first renewal/review, the Case Manager will provide information on a Move Up Voucher and the differences between the voucher program and the PSH program at that time.

2. Clients will be eligible to complete the Pre Application, Release of Information, and Contact Person form if they meet the following requirements and desire to apply for the Move Up Voucher:
    A. Household must be on a PSH program for a period of no shorter than one year.
    B. Household must be current on all rent payments with HSMM.
3. Once the Pre Application documents are completed Case Manager will add the household to the waiting list on a first come first serve basis.
4. When the participant's name comes up on the Move Up Voucher waitlist, and decides to accept the voucher, the participant is then referred to MSHDA for the next steps to engage with the MSHDA HCV Housing Agent.

The documents used are in Appendix K including the letter to the client, self-assessment and the client agreement. (See Appendix K)

F. Referral

Referrals to Participating Projects

The CoC requires that all homeless providers ~~to~~ annually affirm the non-discrimination policy that participants are not screened out for assistance based on perceived barriers related to housing or services such as low or no income, disability, sobriety, or cooperation with any treatment plan.

Through the HARA, the CoC maintains and annually updates a list of all resources that may be accessed through referrals from the coordinated entry process by publishing its "Resource Directory" which is available both in paper version, free to the public and is published on its website. Other agencies are offered a hyper-link to publish these documents on their websites. Additionally, all CoC agencies participate with 211.

It is the policy of the COC that Providers and sub-recipients use the CE established by the CoC as the only referral source from which to consider filling vacancies in housing and/or services

funded by CoC and ESG programs. All of the agencies within the Eaton County COC have agreed to follow the established CE process which includes filling all vacancies in housing or services which includes the prioritization of RR, TH, and PSH units.

The Eaton CoC has adopted the use of the SPDAT tools to ensure that all clients are screened and referred to the appropriate Provider. The SPDAT score is then used to prioritize the household using the Eaton CoC Prioritization Policy and entered into the password protected Google document which holds the Prioritization List. (See Appendix C)

Each CoC project establishes and makes publicly available the specific eligibility criteria the project uses to make enrollment determinations. This information can be found on each agencies' website and on the CoC's website.

Although general non-compliance with program requirements will not be a barrier to referral, referral rejections may occur due to ineligibility or previous severe non-compliance with program requirements. The referral will be rejected and the referral will be sent back to the referring agency which will then make additional referrals to other agencies and services. Upon referral, CoC participants receive clear information about the project they are referred to, what participants can expect from the project, and expectations of the project through the program specific rules and guidelines.

The CoC will refer clients based its prioritization policy. (See Appendix C) The Eaton CoC does not have regions or referral zones. The CoC transmits participant referral information electronically, via the CoC's HMIS Coordinated Housing Plan.

Using a standardized referral form the CoC has established its minimum set of participant information associated with any referral to be shared by a referring agency/entity with the project receiving the referral. (See Appendix I)

The CoC employs the HARA to function as its "housing navigator" to ensure efficient and effective enrollment and subsequent enrollment from one CoC project to another. Typical duties include:

- Work closely with referral agencies regarding eligibility determination
- Develop a Housing Stability Plan
- Complete housing applications
- Perform housing search and placement
- Outreach to and negotiations with landlords
- Assisting with submitting rental applications and understanding leases
- Addressing barriers to project admissions

PARTICIPANT AUTONOMY

Eaton County CoC incorporates a person-centered approach into the referral process. Participant choice in decisions such as location and type of housing, level and type of services, and other project characteristics are offered. The CE assessment processes provides options and recommendations that guide and inform participant choice, as opposed to rigid decisions about what individuals and families' needs.

Should a participant decline referral, assessment staff, through the administration of the assessment tools and the assessment process (which includes the consumer input), will attempt to do what they can to meet each consumers needs while also respecting community wide prioritization standards.

The CoC has the right to limit the number of program refusals any consumer can make per episode of homelessness. Example: Two refusals of the same program type, the participants are no longer eligible for that program type.

G. PROGRAM FEES

Under MSHDA ESG, the HARA is required to pay the gross rent to the landlord. However, effective October 1, 2018, **participants are required to pay 30% of gross monthly projected income toward their monthly rent directly to the landlord**. Households with zero income qualify and have zero rental contribution. Income must be re-verified after three months of rental assistance, i.e., prior to paying the fourth month's rent.

However, the HARA are **not required to cancel** ESG rapid re-housing participants that do not make their monthly payment to landlord, **but meeting monthly with all rapid re-housing participants is required.**

H. VAWA REQUIREMENTS

The Violence Against Women Act (VAWA) protects victims of domestic, dating, stalking, human trafficking and sexual assault. VAWA applies to all federal funding, including the Emergency Solutions Grant (ESG), the CoC Program, and all other federal housing programs.

Effective May 1, 2019, all ESG programs will be required to ensure that all participants will be given FORM MSHDA -1A and that all landlords receiving deposits or rental assistance must be given FORM MSHDA – 1B. Further, all leases must contain the HUD form 91067 be signed by the tenant and landlord. These forms are available on the MSHDA and HUD websites. (See Appendix M)

I. DATA MANAGEMENT

CORE REQUIREMENTS

When using HMIS or any other data system to manage coordinated entry data, the CoC ensures adequate privacy protections of all participant information per the HMIS Data and Technical Standards at (CoC Program interim rule) 24 CFR 578.7(a)(8). It is the policy of the CoC that all of its providers use the Michigan Coalition Against Homelessness Release of Information Workflow to meet the 24 CFR 578.7(a)(8) standards.

PRIVACY PROTECTIONS

The CoC's uses the MCAH standardized form using the HMIS Release of Information Workflow for obtaining participant consent to share and store participant information for purposes of assessing and referring participants through the coordinated entry process, and only shares participant information and documents when the participant has provided written consent. The CoC prohibits denying services to participants if the participant refuses to allow their data to be shared unless Federal statute requires collection, use, storage, and reporting of a participant's personally identifiable information (PII) as a condition of program participation.

It is the policy of the CoC that all users of HMIS are informed and understand the privacy rules associated with collection. All HMIS users are required to complete privacy training with an annual refresher training on confidentiality.

The CoC does not import and export data to support collaboration between homeless service providers and mainstream resource providers (Medicaid, criminal justice re-entry programs, healthcare services, etc.).

The CoC does not integrate data between multiple data systems to reduce duplicative efforts and increase case coordination across providers and funding streams.

DATA SYSTEMS MANAGEMENT

The CoC uses the Michigan Balance of State HMIS system, which is managed through the Michigan Balance of State's contract with MCAH, as part of its coordinated entry process, for collecting, using, storing, sharing, and reporting participant data associated with the coordinated entry process.

J. EVALUATION

The Eaton CoC requires that the CE processes are evaluated at least annually. This evaluation is conducted to ensure that the processes of intake, assessment, and referrals associated with the coordinated entry are reviewed and refined as needed.

The CE review process takes place using two methods. First, the Strategies/Grants Committee formally reviews the CE process beginning in January. Changes to processes are made at that time as needed and all agencies are informed. However, refining the CE procedures is seen as an on-going process and all agencies are encouraged to bring concerns before the Strategies/Grants Committee for consideration. Changes are allowed to occur at any point once the Strategies/Grants Committee takes its recommendation to the entire CoC for approval.

Secondly, the CoC holds its annual focus groups at the Project Resource Connect where information is gathered to assist with planning and adaptations to processes. The results of the focus group are provided to the Strategies/Grants Committee for review and potential implementation changes of existing policies and procedures.

These focus groups (2) are made up of at least 20 self-selected volunteers who sign up at the annual Project Resource Connect. The CoC ensures adequate privacy protections of all focus group participant's information collected as the survey does not contain any personal information. Non-HUD funded agencies conduct these focus groups to ensure unbiased information is collected.

The information gathered is then evaluated by the CoC's Evaluation and Review Team and the results are then shared at the next CoC meeting where discussion can take place about the results and assignments can be made back to Strategies/Grants Committee for action.

Additionally, the CoC incorporates system performance measures or other evaluation criteria into their required annual coordinated entry evaluation plan. These performance measures are set using several processes. First, HUD requirements are reviewed and each program type is held accountable for meeting the requirements or benchmarks. These outcomes are collected during both the six-month and annual report and reported to the entire CoC and again during the funding cycles for scoring.

STAKEHOLDER CONSULTATION

The CoC ensures that ongoing evaluation is part of the implementation planning process from the inception of the CE.

To accomplish this standard, each funded project uses its own satisfaction surveys and provides annual HUD project reports to the entire CoC. The Strategies/Grants Committee solicits feedback from the Interagency Case Review Team about its processes, and the Focus Group

feedback is reviewed and analyzed to ensure that the CE processes are efficacious or they are realigned.

Adopted at a meeting of the Eaton County Continuum of Care on May 11, 2020.

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Claudine Williams, Secretary
Eaton County Continuum of Care