Toledo Lucas County Continuum of Care: Coordinated Entry Referral Process

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Referral Components

The referral process begins with Coordinated Entry and continues with the TLCHB Homelessness Board (TLCHB) making a referral to a housing program for assistance. There are numerous components to the CoC's housing referral process that occur within TLCHB.

The following is an overview that provides the referral components. Additional details can be found in the subsequent sections of this manual.

1. Initial Contact
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Initial Contact

Coordinated Entry: serving as the single, centralized point for access/entry

- 2-1-1 United Way
    a. Individual calls 2-1-1: they can call 24 hours a day.
    b. Community Navigation Specialist (CNS) assesses adult only household/households with children, determining their eligibility for shelter.
        i. If eligible, CNS will conduct the necessary pre-screen, and send information to CE. For this, the Refer database is utilized.

ii. If ineligible, CNS makes any other appropriate referrals.

c. CNS verbally confirms family is stable for the night.
    i. If so, they are told that CE will contact them within 1 business day.
    ii. If not, a 2-1-1 supervisor is contacted, and subsequently contacts the CE staff on call. If it is an adult only household, outside shelters are given, and CE staff contacts the client back as soon as possible.
d. When CE is given the information, CNS then transfers their information onto HMIS
e. A call is then made to the client in order to complete housing crisis assessment and explain shelter process
    i. If permission was previously given, CE staff will leave a message explaining the process.
    ii. If CE staff is able to speak with client, assessment is completed, and CE gives any other referrals clients may need.
    iii. If CE staff is unable to leave message, a follow-up is scheduled, and the client is contacted 3 times.
    iv. Clients remain on list, until they either have refused shelter, or CE staff has attempted contact twice after housing crisis assessment has been completed.

Determining Eligibility

In TLCHB, one of the tools that the CoC uses to determine level of housing assistance is the SPDAT. The SPDAT/housing assessment is completed with the person in a housing crisis.

- *The Service Prioritization Decision Assistance Tool (SPDAT)*
  Housed within all of participating shelters, as well as most of the Community Mental Health Centers, are Re-Housing Specialists. These specialized case managers are trained in the variations between Housing Programs within the community as well as the SPDAT.

  The SPDAT (for individuals) takes into account 15 different domains. The Family SPDAT (F-SPDAT) takes into account 20 domains to determine the family's housing acuity. The SPDAT/F-SPDAT prioritize both housing type as well as housing priority. This tool provides an evidence based assessment of the client's housing preparedness. TLCHB

also considers the amount of time spent in shelter or on the streets within the referral process; this ensures the community minimizes the duration of homeless.

Re-Housing Specialists utilize other case management expertise, case file documentation, and in depth interviewing techniques to complete the SPDAT or the F-SPDAT.

From the various remote access points for SPDAT re-housing assessments, all community SPDAT numbers and information are given to the TLCHB's Communication & Data Specialist to be compiled into a Community SPDAT list. Referrals to appropriate housing programs are coordinated from this list.

- *Community SPDAT List*
  The Community SPDAT List is another tool that is used to determine client eligibility. The TLCHB Communication & Data Specialist is responsible for monitoring and maintaining the Community SPDAT Lists. The entries on the Community SPDAT List represent those individual/families who have obtained their required re-housing documents, completed a SPDAT, and are currently homeless.
  The entries contain the head of household's HMIS number, the SPDAT score, the date the SPDAT was completed, and the number of weeks on the Community SPDAT List.

  The Community SPDAT List is distributed to all shelters, Community Mental Health Center, housing programs, CE staff, and outreach workers who have been SPDAT trained. This allows them to track their clients. When a person is referred to a housing program, the TLCHB Communication & Data Specialist documents the referral on spreadsheet and includes which agency and program the person is referred to. The TLCHB Communication & Data Specialist maintains two spreadsheets;
  1) the referral spreadsheet which includes agency and recommend programs;
  2) spreadsheet of all SPDAT Lists.

Referral Approach

The TLCHB CoC uses a cohesive referral approach. When a referral is made, an email is sent to all parties involved which allows each agency to see what other case managers and supports the referral may have. Case conferences occur frequently to ensure a warm handoff.

Case conferences should include every agency the referral is receiving services from. Examples may include the referring agency, the receiving agency, Children's Services, TLCHB, Community Mental Health Centers, etc. Utilizing case conferences allows all agencies to identify and discuss the referral's barriers and ultimately serve the person more efficiently.

Housing Program Eligibility & Level of Assistance

Within the TLCHB CoC, there is a range of housing programs available to persons experiencing homelessness. The programs range from offering short-term assistance to long-term assistance. The TLCHB CoC honors the referral's choice regarding a specific agency or program type, whenever possible. The TLCHB Communication & Data Specialist is advised when a referral requests alternate placement or program. Each program has eligibility requirements and provides a different level of assistance. Below are the eligibility requirements for each housing program:

- *Short-Term Rapid Re-Housing:*
    a. Currently homeless
    b. Obtained all required re-housing documents
    c. Completed SPDAT
    d. SPDAT score between 20-34 for single adults; 35-60 for families
- *Medium-Term Rapid Re-Housing:*
    a. Currently homeless
    b. Families only
    c. Obtained all required re-housing documents
    d. Completed SPDAT
    e. SPDAT score in the higher RRH range
    f. Cannot re-enter medium-term RRH for 9 months after exiting medium RRH
- *Tenant-Based Rental Assistance (TBRA):*
    a. TBRA is still considered a form of RRH
    b. Currently homeless
    c. Obtained all required re-housing documents
    d. Completed SPDAT

e. SPDAT score on the higher end of the RRH range
f. Cannot have been in the TBRA program previously

- *Permanent Supportive Housing (PSH):*
  a. Currently homeless
  b. Obtained all required re-housing documents
  c. Completed SPDAT
  d. SPDAT score between 35-60 for singles; 54-80 for families
  e. Have a disability documented on a housing impairment form

Below are the services provided by each type of program:

- *Short-Term Rapid Re-Housing (RRH):*
  a. Security deposit
  b. Outstanding utility debt (up to 6 months)
  c. $2,400.00 stipend for rent
  d. Ongoing case management and wrap around services
- *Medium-Term Rapid Re-Housing (RRH):*
  a. Security Deposit
  b. Up to 12 months of rental assistance
  c. Up to 6 months of past utility debt
  d. Ongoing case management and wrap around services
- *Tenant-Based Rental Assistance (TBRA):*
  a. Security deposit
  b. Utility deposits (for gas and electric)
  c. 12 months of rental assistance
  d. Utility allowance when housed
  e. Ongoing case management and wrap around services
- *Permanent Supportive Housing (PSH):*
  a. Security deposit
  b. Outstanding utility debt (up to 6 months)
  c. 12 months or more of rental assistance
  d. Ongoing case management and wrap around services

Disclosure: The Coordinated Entry Process complies with the non-discrimination requirements of the Fair Housing Act, which prohibits discrimination in all housing transactions on the basis of race, national origin, sex, color, religion, disability status and familial status. This also includes protection from housing discrimination based on source of income. Additional protected classes under state law include sexual orientation (including gender identity), marital status, military

discharge status, age (40+). Agencies cannot preference any protected class unless allowed by statute/regulation, or written waiver from their funding or regulatory body (i.e. U.S. Department of Housing and Urban Development).

All Authorized User Agencies who enter into an MOU for the Coordinated Entry Process agree to take full accountability for complying with Fair Housing and all other funding and program requirements. The MOU requires User Agencies to use the Coordinated Entry Process in a consistent manner with the statutes and regulations that govern their housing programs.

The TLCHB CoC will request from each Authorized User Agency their tenant selection plan and any funding contract that requires or allows a specific subpopulation of persons to be served. For instance, Housing Opportunities for Persons with AIDS (HOPWA) programs will show funding contract, or a single-gender program must produce its HUD waiver. The TLCHB CoC in accordance with the Fair Housing Act also recognizes that a housing provider may seek to fulfill its "business necessity" by narrowing focus on a subpopulation within the homeless population. The Coordinated Entry Process may allow filtered searches for subpopulations while preventing discrimination against protected classes.

Participating Project List

It is critical to determine housing program availability before making a referral. TLCHB's Communication & Data Specialist is responsible for monitoring housing program availability.

The TLCHB Communication & Data Specialist communicates weekly with the multiple housing programs to inquire about availability.

After the housing programs have communicated the availability for the week, the TLCHB Communications & Data Specialist enters that information into a spreadsheet. This spreadsheet includes the number of openings each week, the program type (RRH, TBRA or PSH) and the individual projects and any additional eligibility requirements.

A separate spreadsheet is created that has all of the Community SPDAT Lists that have been distributed complete with referral information.

Referral Communication & Monitoring

Referral Communication
After eligibility has been determined the TLCHB Communication & Data Specialist verifies that the person has all necessary documents and the SPDAT score. Then, when an opening has been identified, the TLCHB Communication & Data Specialist informs all parties involved of the referral. This is done via email as all parties can keep electronic records.
The referral email contains the following information:

- The referral date and time
- The person (identified by an HMIS number for confidentiality)
- The program type the person is being referred for
- Any relevant information or disabilities (family size, wheel chair access, etc.)
- A timeframe for the referral agency to contact the person
- How to locate the person's required documents and SPDAT

The referral email is sent from the TLCHB Communication & Data Specialist to the following parties:

- The agency currently serving the person (shelter and/or mental health provider)
- The agency receiving the referral
- The Coordinated Entry Specialist

When the referral agency receives the referral, they are given access to the client's documents and SPDAT score to verify eligibility.

Referral Monitoring
The TLCHB CoC has the ability to monitor referral progress. The TLCHB Communication & Data Specialist using electronic documentation and the HMIS data system monitors the referrals.
When a referral is made, the TLCHB Communication & Data Specialist sends an email notifying all parties of the referral. In that email there is a timeframe by which the receiving agency must contact the client, generally it is a 7-10 day timeframe. After the receiving agency completes an intake with the person, an entry is made in the HMIS data system. Additionally, there is an option in HMIS for the referral agency and the receiving agency to leave case notes documenting progress.

After 10 days the TLCHB Communication & Data Specialist will verify that the person's documents were shared correctly and check for an entry in HMIS. If the documents have been shared and there has been, confirmation that the person has not been contacted the TLCHB Communication & Data Specialist will contact the receiving agency to inquire about the status of the referral. If the receiving agency is unable to take the referral, an alternative referral is identified.
If the receiving agency is unable to locate a person after 7-10 days the case will closed. The person will have the opportunity for another referral if they present as homeless again in the future.

Referral Rejection Protocol

Receiving Agency
In the TLCHB CoC, receiving agencies are permitted to reject a referral if the referral violates the agency's program policies. If a referral is rejected the person, the agency serving the person and the TLCHB Communication & Data Specialist is notified in writing of the rejection and the rationale. A rejection letter also contains that agency's grievance procedure. The person has the right to file a grievance and go through the grievance procedure within that agency. If the person wishes to escalate the grievance it is brought to either TLCHB's Executive Director or Grants Administrator.

If a solution cannot be reached and the person is still in need of housing assistance, the TLCHB Communication & Data Specialist makes every effort to identify an alternate referral agency.

Client
As mentioned previously, the TLCHB CoC does adhere to a person's choice when it comes to referrals. At the beginning of the process, the person is made aware of what program types are available for them and the eligibility requirements associated with each one. If the person has a preference for program type or agency and the person is eligible for that program or agency, the TLCHB CoC does honor that. If the person has a preference, they are informed that by limiting their referral options they may be prolonging the referral process, however if the person still has a certain preference, the TLCHB CoC honors it.

Referral Process for DV Victims

The TLCHB CoC has a process for serving a person that is fleeing from domestic violence. There are two options, one is used if the client is willing to have their

information entered into the secure HMIS data system, and the other is used if the client refuses to have their information entered into the secure HMIS data system.

Allow Information in HMIS
If a person consent to be entered into the HMIS system, they are given a consent form that they must sign. Then, the process proceeds as it usually does; a SPDAT is completed, the person is placed on the Community SPDAT List, a referral is made and agencies work together to assist the person obtaining housing.

Refuse Information in HMIS
No person is required to be entered into HMIS. If a person does consent to being entered into the HMIS system, they can be entered anonymously without providing any identifying information. In this case, either the DV shelter or the TLCHB Communication & Data Specialist will give the person an ID number, not an HMIS number. The person will have the SPDAT completed and be placed on the Community SPDAT List, using the client ID number.

When a referral is made, the TLCHB Communication & Data Specialist or the agency serving the person will fax the person's documents and SPDAT to the agency receiving the referral. This will only be communicated via fax for security. The person will be identified by the client ID number in any electronic correspondence.

If a case manager enters, a person anonymously in HMIS that case manager is responsible for tracking that person in the system.

If a person has had their information entered into HMIS and then chooses to be anonymous in that system, the HMIS Administrator is contacted to allow that person to be anonymous.

Housing Referrals for DV Victims
The agency receiving the referral is informed if the person is a DV victim or residing in a DV shelter. This allows the receiving agency to prepare a housing plan specific to that person.

Referral Process for Veterans

In order to identify all veterans in the Toledo Lucas County Continuum of Care, the Community Veterans Committee Master List Sub-group will use various sources of relevant data to compile and maintain a Master (by name) list. The following sources of relevant veterans' data have been identified. Sources shall be polled no less than every two weeks:

1. Toledo HMIS (Toledo Lucas County Homelessness Board), including data from Open Door Ministries, NPI Veterans Program (GPD), Beach House, St Pauls' Community Center Shelter & Family House Shelter
2. WSOS Community Action, including data from Outreach Sources i.e., Cherry Street Mission Ministries and Toledo Gospel, & National Church Residences (via ineligible referrals)
3. Veterans Affairs of Ann Arbor, including data from VA referrals to ADAMS House, VASH referrals and all outreach activities.
4. Verification of Permanent Housing Offer forms should be polled.

The Toledo Lucas County Homelessness Board's HMIS administrator will be responsible to maintain the Veterans' Master List. The HMIS Administrator will poll the sources of veteran data no less than every two week and update the Master List accordingly. Once updated the Master List will be securely distributed to members of the Master List Subgroup for the bi-weekly case conferencing meeting.

Not less than every two weeks, all veterans on the Master List will be discussed in the Master List Sub-group with the goal to identify barriers to permanent housing and facilitate solutions to those barriers. The HMIS administrator will lead the Sub-group through the Master list. All parties with relevant data will share updates to the veteran's status. The sub-group will identify next steps to the goal of the veteran's obtaining permanent housing and assign the next steps to a Sub-group member. The HMIS administrator will note all updates, next steps and responsible parties in the Master list.

The Master List Sub-group will report out aggregate statistics and benchmarks regularly. The HMIS Administrator will process the statistics and benchmarks no less than once monthly and report them to the Community Veterans Committee Planning Group. And the Master List Policies and Procedures will be reviewed no less than annually based on case conferencing performance.

Referral Process for Unaccompanied Youth

Currently, there are two processes for serving unaccompanied youth, the determinant being the age of the youth. For those youth between the ages of 18 to 24 years old, these youth are entered into the coordinated entry referral process described on pages 1 to 9. For unaccompanied youth under 18 years old, the youth are referred to Safety Net, a youth shelter for youth from 12 to 17 years old.

Safety Net provides temporary shelter, supportive services and life skills development lessons to youth who have left home without permission of their parents or guardians or to other homeless youth who might otherwise end up in the child welfare, mental health, or juvenile justice systems in Lucas County (Toledo), Ohio. Safety Net is designed to increase youth's safety, social and emotional well-being, self-sufficiency, and to help them build permanent connections with families, communities, schools and other positive social networks.

Youth ages 12-17 may stay (become a resident at Safety Net) if they meet one or more of the following criteria:

1. Youth are experiencing a family crisis to the point where safety, physical health or emotional health is at risk;
2. Youth who have run away;
3. Youth who have been asked to leave their residence;
4. Youth who are homeless or couch hopping from place to place;
5. Youth who are stranded in the area;
6. Youth who are being physically, sexual, or emotionally abuse and need to get help; or
7. Other situations that are a crisis for the resident (i.e. resident is lost, resident's guardians cannot be located, etc.).

Custodial consent is required for minor residents who remain in the Shelter for more than twenty-four hours. Staff will attempt to obtain constant at admission or as soon as possible unless there are reasons to delay contact with guardian.

Referrals may come from a variety of sources. Youth may just appear at Safety Net and will be assessed.

While at Safety Net, the youth will be provided with:

- **Gateway services**, providing food, shelter, clothing, transportation and hygiene-related items;

- **Assessment services and intensive coordinated case management**, ensuring youth receive assistance with emotional and behavioral health challenges while developing a plan for permanency;
- **Continuum service linkages**, ensuring the ability to provide services as a community to the target population; and
- **Follow-up/aftercare services**, providing three months of follow-up services to youth, including a plan to exit, permanent placement and personal goals.

Youth will be screened within their first two days in the shelter by staff; the results of these screens will be used to inform the service planning process, including the need for further assessment. Clinical assessment for behavioral health will be provided by staff within Zepf Center's youth services department.

Shelter staff will collaborate with the youth to develop an exit plan. Part of the exit planning process will be to ask the youth to discuss their plans for either reunification with the parents/ guardian or to consider options for a safe and stable living situation if reunification is not possible. 90 days of follow up/aftercare services will be provided for youth who receive shelter services or are provided alternative living arrangements, regardless of their length of stay in the shelter.