"Community Connect"
Coordinated Entry System

Policy No.:	578.7a-OR506CoC	Approved By:	HSSN (the CoC)
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Prepared By:	Washington County Department of Housing Services		
	503-846-4760 http://www.co.washington.or.us/Housing/EndHomelessness		

Policy Authority: This policy is adopted under the authority of the local Continuum of Care (CoC) in Washington County, commonly referred to as the Housing and Supportive Services Network (HSSN).

Purpose: Grant recipients and subrecipients under the Continuum of Care (CoC) Program and the Emergency Solution Grant (ESG) Program must use the Coordinated Entry System (CES) established by the HSSN, in accordance with requirements established by HUD, to ensure the screening, assessment and referral of program participants is consistent with the written standards established.

Standard: The HSSN, in consultation with the CoC Program and ESG Program recipients and subrecipients, is responsible for determining how to allocate the CoC and ESG funds; for developing the performance standards and evaluating the outcomes of the local Coordinated and Centralized Assessment System (CCAS) system and projects assisted by the CoC and ESG Program funds; and coordination and integration, to the maximum extent practicable, with other mainstream resources and programs targeted to homeless people in the area covered by the Continuum of Care to provide a strategic, community-wide system that will prevent and end homelessness for that area.

Scope: HSSN, recipients and subrecipients of CoC and ESG Program funds, the CoC Collaborative Applicant, and the HMIS Lead.

Authority For Code: Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act Code of Federal Regulation (CFR) for the CoC Program 24 CFR Part 578.3, Part 578.7, Part 578.23(c), Part 578.93(c), the ESG Program Part 576.400 and Part 576.407, the Homeless Definitions 24 CFR Part 91.5, Part 582.5 and Part 583.5, and Equal Access in Accordance With an Individual's Gender Identity in Community Planning and Development Programs 24 CFR Part 5.105 and 5.106.

Responsibilities:

1. DEFINITIONS

1.1 **Assessment Specialist** is defined to mean any job description that performs assessment duties, as outlined by this policy. The Assessment Specialist may include housing

specialist, outreach worker, and case management positions with Homeless Provider Agencies identified in this policy.

1.2 **Collaborative Applicant** is defined to mean an instrumentality of state or local government, local government, nonprofit, state, or public housing authority that has been designated by the Continuum of Care to collect the required Continuum governance planning activities, data and information from all projects within the geographic area of the Continuum to prepare and apply for a grant.

1.3 *Community Connect* is the name given to the coordinated entry system for the Continuum of Care jurisdiction in Washington County, Oregon.

1.4 **Equal Access Rule** 24 CFR Part 5 ensures access for individuals in accordance with their gender identity in programs and shelter. This rule builds upon HUD's 2012 rule entitled Equal Access to Housing in HUD Programs Regardless of Sexual Orientation or Gender Identity.

1.5 **Homeless Provider Agency (HPA)** is defined as CoC Program and ESG Program recipients and subrecipients, and other homeless prevention and assistance programs that provide housing and/or services.

1.6 **McKinney-Vento Act Local Education Agency (LEA)** is defined as a public board of education or other public authority legally constituted within a State for either administrative control or direction of, or to perform a service function for, public elementary schools or secondary schools in a city, county, township, school district, or other political subdivision of a State, or for a combination of school districts or counties that is recognized in a State as an administrative agency for its public elementary schools or secondary schools.

1.7 **Mobile Assessment** is defined to mean an agency that performs screening and assessment of at-imminent-risk or homeless individuals using the written standards and tools adopted in this policy.

1.8 **Recipient** is defined to mean an applicant that signs a grant agreement with the U.S. Department of Housing and Urban Development (HUD), as defined in Section 424 of the McKinney-Vento Act.

1.9 **Subrecipient** is defined to mean a private nonprofit organization, State or local government, or instrumentality of a State or local government that receives a subgrant from the recipient to operate a project. The definition of "subrecipient" is consistent with the definition of "project sponsor" found in Section 401 of the McKinney-Vento Act.

1.10 **Domestic violence** (DV) is defined as a pattern of abusive behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate

partner. Domestic violence can be physical, sexual, emotional, economic, or psychological actions or threats of actions that influence another person. This includes any behaviors that intimidate, manipulate, humiliate, isolate, frighten, terrorize, coerce, threaten, blame, hurt, injure, or wound someone. https://www.justice.gov/ovw/domestic-violence.

1.11 **Fleeing domestic abuse or violence** is defined as any individual or family who: (i) Is fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, trafficking, 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, faith-based or other social networks, to obtain other permanent housing (24CFR 578.3).

1.12 **Phased Assessment** is defined as the multiple Community Connect Assessments utilized within Washington County. A phased assessment only collects the relevant and least amount of data from a household at each step from homelessness to permanently housed. The phased assessment is broken into four (4) assessments.

    1.12.1 **Phase One Assessment** is the Initial Access and Eligibility Tool. This assessment gathers basic eligibility data necessary to connect a household to eligible housing interventions.

    1.12.2 **Phase Two Assessment** is the Housing Placement Assessment. This assessment is completed at program enrollment. It gathers basic HUD required data as well as housing barriers, such as eviction and criminal history. It encompasses a tenant screening report. It also prioritizes high barrier households to project-based units.

    1.12.3 **Phase Three Assessment** is the Housing Stabilization Plan. This assessment is completed after a household moves into a housing unit. It encompasses housing needs such as physical and behavioral health, education, employment, social supports; and creates referrals to resources based off those needs.

    1.12.4 **Phase Four** is the Housing Needs Review. This assessment is still in development and will not be included in this policy.

1.13 **Dynamic Prioritization** is a loose term for a specific prioritization process wherein all available housing resources for households experiencing homelessness are flexibly and immediately offered to the households who need them most acutely in that moment, regardless of whether the household might be better-served in the future by a type of program not presently available.

1.14 **Progressive Engagement** is a person-centered approach to ending a household's homelessness. It is based on tailored assistance to each individual or household's needs and assessing what works best for them, with their specific strengths, and in their specific situation.

2. **COMMUNITY CONNECT OVERVIEW**

A coordinated assessment system, hereafter called *Community Connect*, is a system designed to provide people at imminent risk of homelessness (within 14 days) or experiencing homelessness, with a centralized access point, coordinated intake, assessment and referral process to housing and supportive services. *Community Connect* operating standards are established in this policy, to include evaluation of *Community Connect* system performance by the HSSN. The same assessment is performed at all access points and utilizes a standardized decision-making process.

Community Connect will:

2.1 Cover the geographic area of Washington County, Oregon.

2.2 Be easy to access by individuals and families, including people fleeing domestic violence, via walk-in to any HPA or by calling (503) 640-3263, a phone number managed by Community Action Organization, a nonprofit agency selected by the HSSN to operate as the community-wide access point to the coordinated entry system.

2.3 Provides as a component of outreach, mobile screening and assessment to address the safety and special needs of subpopulations (e.g. chronically homeless, those fleeing domestic violence, people with serious and persistent mental illness) that will operate in compliance with the written standards identified in this policy to ensure equity for people receiving screening, assessment and referral to community resources whether people enter the centralized assessment system through *Community Connect* or any HPA.

2.4 Use comprehensive and standard assessment tools with written standards to evaluate the eligibility of households for assistance and make appropriate housing placement referrals.

2.5 Be well advertised to the public.

2.6 Be data driven using HMIS, and as available, other data sources to compliment planning and evaluation activities of the HSSN.

2.7 *Community Connect* is the only referral source for CoC Program and ESG funded projects and activities, and will include other local, state and federal housing programs in coordination with mainstream resources serving homeless populations.

2.8 Provide placement and accommodation of individuals in a manner that supports the individual's gender identity, to include Lesbian, Gay, Bisexual, Trans, Questioning or Queer, Intersex, Asexual, and Two Spirit. (LGBTQIA + 2S).

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2.9 Provide culturally and linguistically responsive services to every extent possible.

2.10 The screening and assessment process is defined in Section 6 and Section 7 of this policy.

3. **ALIGNMENT WITH HOUSING AND SERVICES**
   Community Connect will align with prevention and homeless assistance programs targeted to serve the homeless, to include:
   3.1 All CoC Program projects funded under 24 CFR Part 578.23(c)(9).

   3.2 All Emergency Solution Grant projects and activities funded under 24 CFR Part 576.400(a).

   3.3 Coordination, and to the extent possible, system alignment with other targeted homeless services:
   a) HUD-VASH or Veteran Affairs Supportive Housing;
   b) Education for Homeless Children and Youth (EHCY) Grants under title VII-B of the McKinney-Vento Act;
   c) Grants for the Benefit of Homeless Individuals (Section 506 of the Public Health Services Act);
   d) Healthcare for the Homeless (42 CFR Part 51c);
   e) Programs for Runaway and Homeless Youth (Runaway and Homeless Youth Act);
   f) Projects for Assistance in Transition from Homelessness (Part C of title V of the Public Health Service Act);
   g) Services in Supportive Housing Grants (Section 520A of the Public Health Service Act);
   h) Emergency Food and Shelter Program (title III of the McKinney-Vento Act);
   i) Transitional Housing Assistance Grants for Victims of Sexual Assault, Domestic Violence (DV), Dating Violence, and Stalking Program (Section 40299 of the Violent Crime Control and Law Enforcement Act);
   j) Homeless Veterans Reintegration Program (section 5(a)(1) of the Homeless Veterans Comprehensive Assistance Act);
   k) Domiciliary Care for Homeless Veterans Program (38 U.S.C. 2043);
   l) Veteran Affairs Homeless Providers Grant and Per Diem Program (38 CFR Part 61);
   m) Health Care for Homeless Veterans program (38 U.S.C. 2031);
   n) Homeless Veterans Dental program (38 U.S.C. 2062);
   o) SSVF or Supportive Services for Veteran Families Program (38 DFR Part 62); and
   p) Veteran Justice Outreach Initiative (38 U.S.C. 2031).

   3.4 Coordination and integration with other program resources:
   a) Public housing programs (Section 9);
   b) Housing programs receiving tenant-based or project-based assistance (Section 8);
   c) Supportive Housing for Persons with Disabilities (Section 811);
   d) HOME Investment Partnerships Program;

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    e) Temporary Assistance to Needy Families;
    f) Health Center programs;
    g) State Children's Health Insurance program;
    h) Head Start;
    i) Mental Health and Substance Abuse Block Grants;
    j) Services funded under the Workforce Investment Act;
    k) McKinney-Vento School District Liaisons in Washington County; and
    l) Metro Supportive Housing Services program.

4. HOMELESS MANAGEMENT INFORMATION SYSTEM (HMIS)

4.1 The Continuum's HMIS will operate as a semi-open system and comply with data privacy and security standards (24 CFR 580.35) to support assessment and referral activities of the system.
    a) Compliance with the HSSN Governance Charter adopted by the HSSN; and
    b) HMIS Data Sharing Addendum to the Agency Participation Agreement.

4.2 To protect the privacy of the homeless participant, the homeless provider agency (HPA) may apply confidentiality filters to the Client Record in the HMIS system upon intake and enrollment into the HPA's program.

4.3 Community Action Organization is the lead agency to develop and maintain the assessment tools, as approved by the HSSN and in consultation with the HMIS Lead Agency. Community Action Organization will ensure fidelity to the system standards through:
    a) Training provided to positions performing Assessment (e.g. homeless outreach workers and site-based Assessment Specialist) on use of policy and procedures as outlined in Section 10; and
    b) Training provided to HMIS Users who will perform Assessment in HMIS.

4.4 Washington County Department of Housing Services is the HMIS Lead Agency, and will ensure fidelity to the system standards through:
    a) Technical assistance provided to Community Action Organization, as necessary;
    b) Implementation and monitoring of HMIS CoC Participation Agreements;
    c) Prepare and provide daily housing inventory availability report to *Community Connect* and housing providers aligned with *Community Connect*;
    d) Implementation of reporting in support of the system performance measurements, and training to Community Action Organization and the CoC Collaborative Applicant on use of the HMIS reporting tools;
    e) Monitoring of HMIS data quality; and
   f) Testing the *Community Connect* system and workflows in HMIS.

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5. OUTREACH AND MARKETING PROCESS

Community Connect is a publicly marketed system that aligns with the communitywide outreach activities targeted to serve unaccompanied youth, adults and families with children experiencing homelessness and those at imminent risk of homelessness.

5.1 Outreach activities and marketing aligned with the system include:

a) A wallet-sized outreach information card printed in English and Spanish directing access to *Community Connect* via telephone at (503) 640-3263 or text telephone TTY via 711.

b) Family Shelter Network Intake Line administered by Community Action Organization.

c) Outreach staff and outreach activities administered by Forest Grove Foundation, New Narrative, HomePlate Youth Services, Just Compassion of East Washington County, Open Door Counseling Center, The Salvation Army, and Veteran Affairs.

d) McKinney-Vento Local Education Agencies.

e) HSSN listserv (the CoC email distribution that includes community stakeholders to include homeless/formerly homeless consumers, private citizens, and providers of housing, supportive services, mainstream resources, faith-based meal sites, health, education, and employment programs).

f) Washington County website http://www.co.washington.or.us/Housing/EndHomelessness/index.cfm or https://www.co.washington.or.us/Housing/EndHomelessness/community-connect.cfm which includes information and referral instructions in Arabic, Bengali, Simplified and Traditional Chinese, English, Filipino, French, German, Gujarati, Hindi, Hmong, Indonesian, Japanese, Khmer, Korean, Malay, Marathi, Myanmar (Burmese), Persian, Polish, Pubnjabi, Russian, Somali, Spanish, Tamil, Telugi, Thai, Urdu and Vietnamese languages.
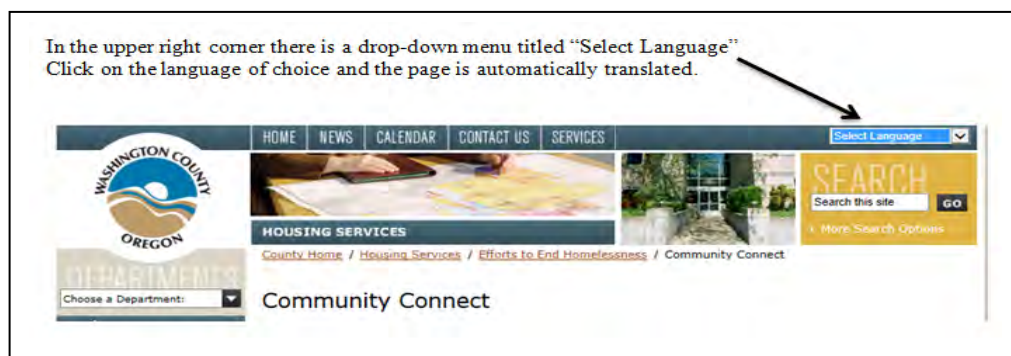
g) 211info, a statewide resource and information referral agency.

h) Winter Shelters.

i) Public safety officials; e.g. law enforcement, fire/EMS.

j) Most pages on the County website can be read by a screen reader and allow visually impaired users to zoom in and out of a page, and to increase and decrease font sizes displayed.

5.2 The Community Connect Modernization process workflow (Appendix 10.2) will educate and inform provider organizations and the public – including homeless households - on the flow of homeless individuals through the outreach, phased assessment, and referral/housing placement process.

6. **THE *COMMUNITY CONNECT* PHASED ASSESSMENT PROCESS**

6.1 The *Community Connect* Phased Assessment process focuses on relevant questions to connect a household to needed resources in each phase of their journey to housing stabilization. It utilizes a progressive engagement approach to gathering information from a household and targets its questions to what is relevant at multiple phases toward housing stability. Each phase is designed to be trauma informed in its delivery and approach and should never be completed in increments longer than 20 minutes in length. Phased assessments do not utilize an acuity-based prioritization schema. Resource connection is based on eligibility, need, and a household's desire to be connected to resources. The process relies on all resources being accessed within the *Community Connect* system. *Community Connect* will match households with resources beginning with housing, then moving to the full spectrum of wrap-around resources available within the homeless response system. The phased assessment process policy can be found in the *Community Connect* Modernization Policy & Procedures (Appendix 10.3).

6.2 Phase One Assessment – Initial Access and Eligibility Tool
Phase One: The **Initial Access Tool** of the phased assessment process is completed with all households seeking assistance experiencing a housing crisis and will determine imminent risk of homelessness or homeless status of the individual or families seeking assistance, also referred to as a "household." The tool focuses on eligibility questions, such as length of time homeless, disability status, and income level. It also incorporates race/ethnicity, gender, and preferred pronouns and verifies whether the household is part of a federally recognized tribe, a military veteran, a victim of domestic violence, or actively fleeing. Households will be required to meet the federal homeless definition defined in 24 CFR Part 91.5 to be eligible for McKinney-Vento homeless programs aligned with the *Community Connect*. Eligibility of homelessness for people with developmental disability will be in compliance with 24 CFR Part 582.5 and Part 583.5. Households meeting the State definition (doubled-up or shared-housing) are eligible for non-HUD funded program resources, as available. Responses will verify eligibility with all homeless assistance housing-based resources. Household's will then be offered, and if accepted, the available housing resource for which they were eligible.

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Determination – Eligible for Homeless Assistance

a) A household assessed with the Phase One assessment and determined to have met the homeless definition will be offered a referral to emergency assistance resources, to include prevention, diversion, rapid rehousing, permeant supportive housing, other housing interventions, and emergency shelter serving adults, youth or families, to the extent these resources are available.

b) Veterans meeting the HUD homeless definition will be offered an assessment with *Community Connect* Assessment Specialist for eligibility for veteran and other assistance, as well as contact referral to Washington County Disability, Aging and Veteran Services (DAVS) and Veteran Community Resource and Referral Center (CRRC).

c) Data collected during the Phase One assessment is entered into HMIS and will be used for housing and service need purposes and system performance evaluation.

Determination - Not Eligible for Homeless Assistance

a) A household that does not meet the homeless definition will receive information and referral to available community resources, to include 211info, mainstream resources serving people in poverty, and other systems of care.

b) Data collected during the Phase One assessment is entered into HMIS and will be used for tracking demographics on populations contacting *Community Connect*.

6.3 Phase Two Assessment – Housing Placement Assessment

The **Housing Placement Assessment** is completed with all households at or soon after housing program enrollment. Before the assessment is completed a tenant screening report will be requested to ensure accurate assessment input. The assessment focuses on barriers that a household might face while seeking housing. This includes legal and eviction histories, prior history with the housing authority, debt, and any other physical or behavioral health concerns which would warrant a need for project-based housing. *Community Connect* will offer, and if accepted, matched households to either legal or debt resolution resources. If households have barriers to acquiring tenant-based housing, *Community Connect* will prioritize project-based resources as they become available. This assessment also gathers all required HUD data elements for program enrollment, such as income source and medical insurance information.

6.4 Phase Three Assessment – Housing Stabilization Plan

The **Housing Stabilization Plan** is completed with all households as they are leasing up with a unit, and soon after move in. The plan first focuses on items a household will need while leasing a unit such as establishment of address through the post office, voter registration, connection of utilities, reasonable accommodations, lease rules, and rental amount. When the household has moved into the unit, the plan encompasses, employment history, education history, physical and behavioral health history, disability services, and social and community supports. Based on their needs, households will be asked if they wish to be connected to resources. If so, *Community Connect* with match

interested households to resources such as behavioral health services, SSI/SSDI application support, work force development, and other resources.

6.5 Phase Four Assessment – Housing Needs Review (Not Complete)
The **Housing Needs Review** is currently in development and is not included within the initial policy. The purpose of this phase of the assessment process will be to evaluate if the current housing resources meet the households needs or if another housing program referral is needed to support long term household stability.

7. ACCESS TO *COMMUNITY CONNECT*
7.1 Homeless households, or those at imminent risk, looking for housing resources can reach an Assessment Specialist by either calling the telephone number for *Community Connect*, or by walking in to a Homeless Provider Agency (HPA):
    1) *Community Connect* phone access is available 24 hours daily staffed by Community Action Organization at **(503) 640-3263.**
    2) Homeless Provider Agencies include agencies with site-based Assessment Specialists and mobile-based access points to *Community Connect*.

7.2 All households seeking housing services will complete a Phase One assessment with an Assessment Specialist:
    1) To determine the needs and eligibility of households seeking homeless assistance, and effectively match each household with the most appropriate resources available to address that household's needs.
    2) Households actively fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, and stalking will receive information on domestic violence resources to include:
        a. **Domestic Violence Crisis Line: 503-469-8620 or 1-800-469-8600 toll free**
        b. **Call To Safety Crisis Line: 503-235-5333 or 1-888-235-5333**
        c. **Family Justice Center of Washington County: (503) 430-8300**
    3) Individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking, who are seeking shelter or services will also receive information on non-victim specific providers.
    4) Households identifying as HIV/AIDS positive will receive information for the central intake at **Cascade AIDS Project**: **503-278-3834**.
    5) Veteran individuals and families will receive information for veteran services with:
        a. Washington County Disability, Aging and Veteran Services
          Phone contact: **503-846-3060**
        b. Veteran Community Resource and Referral Center
          308 SW 1st Avenue, Portland, OR 97204.
          Phone contact: **503-808-1256 or 1-800-949-1004, Ext. 51256.**

Participants 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.

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Community Connect <u>does not</u> maintain a prioritization list and provides individuals an opportunity for re-assessment in the future. Participants will never be turned away from services even if they reject referral options previously provided.

8. **PHASE ONE ASSESSMENT PROCESS AND PROCEDURE**

   8.1 <u>Assessment Procedure for Sheltered Households</u>
   Shelter staff in eight (8) emergency shelters in Washington County (Community Action, Family Promise, Centro Cultural del Condado de Washington, Greater Good Northwest, Good Neighbor Center (Family shelter and Aloha Inn), Monika's House for victims fleeing domestic violence, and Safe Place Youth Shelter) will:

   1. Complete the Phase One assessment of eligibility using HMIS Phase One Initial Access and Eligibility Tool (see Appendix 10.3a);
   2. With the exception of Monika's House, shelter staff will enter household data in HMIS:
   3. Have shelter guests sign *A Road Home*: Client Consent to Release of Information for Data Sharing form (see Appendix 10.5)

   The Assessment Specialist at Monika's House – a domestic violence shelter - will maintain data in the HMIS comparable database for victims of domestic violence data. The Assessment Specialist will compile hardcopies of the following documents that will be made available upon referral/housing placement with the *Community Connect* Assessment Specialist:

   1. A Road Home: Client Consent to Release of Information for Data Sharing form (see Appendix 10.5)
   2. Informed Consent Form

   8.2 <u>Assessment Procedure for Non-sheltered Households</u>
   1. The household can meet with an Assessment Specialist from any of the CoC's Homeless Provider Agencies who will first check to see if the household has completed a Phase One Assessment (See Appendix (10.3a) within the last 60 days. If so, a new Phase One assessment will not be done unless a major life change has occurred.
   2. If not, the homeless household, will complete an assessment of eligibility needs with the Assessment Specialist using the HMIS Phase One Assessment Tool (Appendix 10.3a) or if a mobile assessor, a paper Phase One Assessment Tool which is later entered into HMIS (Appendix 10.4).
   3. Assessment Specialist uploads homeless eligibility documentation to HMIS: *A Road Home*: Client Consent to Release of Information for Data Sharing form (see Appendix 10.5).

   8.3 <u>The Assessment Tool For All Households</u>
   Once the Phase One Assessment Tool is entered into HMIS, the Eligibility Tool will inform the Assessment Specialist of the housing programs the household is eligible for.

The Assessment Specialist will then choose the most appropriate intervention based on the households needs and wants. Acuity will not be utilized in the eligibility process.

8.4 <u>Privacy Protection</u>.
The assessment process does not require disclosure of specific disabilities or diagnosis. Specific diagnosis or disability information may only be obtained for purposes of determining program eligibility to make appropriate referrals.

8.5 <u>Referral and Housing Placement</u>
The Phase One assessment tool (Appendix 10.3a) determines the household referral by Program Type to the appropriate housing project. Referrals are made to open beds and/or programs with capacity to serve in low, moderate, and high housing needs. The referral and process to match households to programs is outlined in the Community Connect Modernization Policy & Procedures (Appendix 10.3)

8.6 <u>Prioritizing Populations for Permanent Housing Placement</u>
Prioritization can be found in Community Connect Modernization Policy & Procedures (Appendix 10.3).

a. <u>By-Name List (Single Prioritized List)</u>
The By-Name List is a real-time, up-to-date list of all people experiencing homelessness which can be filtered by subpopulation and most vulnerable based on eligibility and shared with participating case conference agencies.

All CoC Program-funded permanent supportive housing programs receive referrals through a single prioritized list (By-Name List) that is created using real-time data for all persons completing a Phase One Assessment Tool (Appendix 10.3a) and is inclusive of data provided in HMIS by street outreach. The By-Name List is updated monthly (or more frequently as needed) to reflect data on who remains homeless or is newly homeless and who has exited to housing or is no longer in contact with the homeless system – measuring the "inflow and outflow" of homelessness.

b. <u>By-Name List Case Conferencing Team</u>
The Case Conference Team meeting is a "multi-agency" coordination that focus on housing "our" homeless persons, rather than "my" homeless participant. The action-oriented meeting utilizes real-time By-Name List data to establish a move-in date for each person on the list.

The CoC has three By-Name List Case Conference Teams that coordinate housing access:
1. Veterans: Meetings occur monthly that include the US Department of Veteran Affairs and CoC Stakeholders.

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    2. Families with children and Youth: Meetings occur monthly that include the Oregon Department of Human Services and CoC Stakeholders.

    3. Chronic Homeless: Meetings occur twice monthly that include a representative from the Veteran and Family/Youth Case Conferencing, as well as CoC outreach, shelter, housing, and service providers. The Chronic Homeless By-Name List Case Conferencing follows the *Built For Zero* model – refer to Appendix 10.12 for process and procedures.

8.7 <u>Determining Housing Placement for Populations</u>

The housing referral and match process for the Phase One Assessment can be found in Community Connect Policy and Procedures (Appendix 10.3)

8.8 <u>Intake and Disposition of Referral/Housing Placement</u>

    1. Homeless Provider Agency (HPA) will schedule an Intake Briefing with the household referred by *Community Connect*.

    2. HPA will follow the Intake procedure found in the Community Connect Policy & Procedures (Appendix 10.3) and meet with the household, review the Phase One Assessment and related documentation uploaded into HMIS. The HPA will then complete a tenant screening report with the household, then complete the Phase Two Assessment (Appendix 10.3b). If, based off the Phase Two Assessment, it is determined the household needs project-based housing *Community Connect* will prioritize households for that resource. The policy for project-based unit matching can be found in the *Community Connect* Modernization Policy & Procedures (Appendix 10.3). The procedures establish the order of priority for obtaining evidence as (1) third-party documentation, (2) intake worker's observations, and (3) certification from the person seeking assistance. Records contained in an HMIS, or comparable database used by victim service providers, are acceptable evidence of third-party documentation if the HMIS retains, as does Washington County's HMIS, an auditable history of all entries in HMIS, to include the person who made the entry.

    3. HPA enrolls the new program participant into the program; <u>OR</u>

    4. HPA determines the household is not eligible for the program as a result of an inappropriate referral.

    5. HPA will contact *Community Connect* who made the initial referral and follow-up with an email documenting the reasons for not accepting the household referral; e.g. sending a non-chronic homeless individual to a program that can only serve persons who meet the federal definition of chronically homeless.

    6. The household is referred back to the *Community Connect* Assessment Specialist.

8.9 <u>Rapid Rehousing Rent Subsidy Determination</u>

Rapid Rehousing (RRH) is a community-based permanent housing model funded by the CoC Program and the ESG Program. The following outlines the standards adopted for the ESG-RRH program in consultation with the HSSN and the standards for the CoC-RRH program.

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Rapid Rehousing Assistance (Maximum)	CoC Program CoC-RRH 24 CFR 578.37(a)(1)(ii)	County ESG Program ESG-RRH 24 CFR 576.104	State ESG Program ESG-RRH 24 CFR 576.104
Tenant Briefing on Rights and Responsibilities	Washington County: • Participant • Subrecipient Agency Case Manager	Case Manager	Case Manager
U.S. HUD Homeless Definition Populations[1]	Category 1 and 4 • Literally Homeless • Fleeing Domestic Violence	Category 1 and 4 • Literally Homeless • Fleeing Domestic Violence	Category 1 and 4 • Literally Homeless • Fleeing Domestic Violence
Income Eligibility	Must have income at or below 30% AMI, and Lack resources and support network.	Must have income at or below 30% AMI, and Lack resources and support network.	Must have income at or below 30% AMI, and Lack resources and support network.
Housing Standard	Units must meet HUD Housing Quality Standards (HQS)	Units must pass HUD Habitability Standards	Units must pass HUD Habitability Standards
Percentage (%) of rent to be paid by program participant, with utility allowance	The greater of: 30% of the adjusted gross income, OR 10 percent of the monthly income	The greater of: 30% of the adjusted gross income, OR 10 percent of the monthly income	30% of the adjusted gross income
Income Calculation	24 CFR 578.77: TTP (Total Tenant Portion) will be calculated at program entry (lease signing)	To calculate the gross rent of a unit: total contract rent amount of the unit + allowable* fees (excluding late fees and pet fees) required for occupancy under the lease + monthly utility allowance established by local public housing authority = Gross Rent Amount	To calculate the gross rent of a unit: total contract rent amount of the unit + allowable* fees (excluding late fees and pet fees) required for occupancy under the lease + monthly utility allowance established by local public housing authority = Gross Rent Amount
Income Re-Calculation	24 CFR 578.77: • Re-calculate TTP annual income assessment at 12-month and 24-month • Loss of income recalculate down, with recalculation at 12-months from entry or 24-months • Move to new unit	Homelessness prevention reassessments are required every three months—must verify that a household continues to have an annual income at or below 30% of area median income	Homelessness prevention reassessments are required every three months—must verify that a household continues to have an annual income at or below 30% of area median income

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[1] Refer to eligible populations defined in the HUD NOFA. Addition resource, HUD Guidance released 3/12/2013 regarding Imminent Risk for CoC-RRH https://www.onecpd.info/resource/2889/rapid-rehousing-esg-vs-coc/

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Fair Market Rent Standard	24 CFR 578.51: • Rent reasonable for units • Subrecipient will serve at least as many participants as shown in application for assistance	Up to the FMR for a unit	Up to the FMR for a unit
Rent Reasonableness Standard	Units must comply with HUD Rent Reasonableness Standard	Units must comply with HUD Rent Reasonableness Standard	Units must comply with HUD Rent Reasonableness Standard
Move-in Standards	Security deposit not to exceed two (2) months rent	• Rent in Arrears • Security deposit	• Rent in arrears is a one time payment for up to 6 months of past due rent. • Security deposit not to exceed 2 months rent.
Number (#) of months	1 to 24 Months	1 to 24 Months	1 to 24 Months
Number (#) of times participant can enroll in RRH	Two (2) episodes of homelessness in five years, but total amount of assistance cannot exceed 24 months	No limit, but total amount of assistance cannot exceed 24 months	Cannot exceed 24 months during any 3-year period.
Supportive Service Limitation	No longer than 6 months after rent assistance stops	No limit, but total amount of assistance cannot exceed 24 months	Cannot exceed 24 months during any 3-year period.
Re-evaluate participant self-sufficiency	At least annually	At least annually	At least annually.
Participant and Case Manager meet to review progress	At least monthly	At least monthly	At least monthly.

9. ENROLLMENT: *COMMUNITY CONNECT* POST HOUSING PLACEMENT

1. Once the household has located a housing unit, HPA will complete the Phase Three Assessment Tool (Appendix 10.3c)

2. *Community Connect* will utilize the Phase Three Assessment to provide referrals to wrap around supportive services. This are outlined in the *Community Connect* Modernization Policy & Procedures (Appendix 10.3)

10. FAIR HOUSING AND EQUAL ACCESS
10.1 Affirmative Outreach

All individuals and their families, including transgender individuals and other individuals who do not identify with the sex they were assigned at birth, will receive equal access to programs, benefits, services and accommodations in accordance with their gender identity without being subjected to intrusive questioning or being asked to provide documentation, in accordance with the HUD final rule entitled "Equal Access in

Accordance with an Individual's Gender Identity in Community Planning and Development Programs."

Housing and service providers aligned with *Community Connect* will implement affirmative outreach written procedures in compliance with 24 CFR Part 578.93(c) to include marketing information, information provided to participants, and access to grievance process that informs persons with regard to rights and anti-discrimination based on race, color, ethnicity, religion, sex, gender, sexual orientation, age, national origin, familial status, or disability, and how to obtain access to facilities and services. Shelters and temporary facilities will not separate family members with the exception of facilities that require shared sleeping quarters or bathing facilities and that do not qualify as a dwelling under the Fair Housing Act may operate single-sex shelters unless doing so would violate some other Federal, State or local law. Reasonable accommodations for persons with disabilities must be available in order to ensure disabled participants have an equal opportunity to utilize housing, including shelters, and receive essential services. Greater levels of accessibility may be required for some shelters in compliance with The Americans with Disabilities Act. Shelter and housing providers shall document and maintain records of compliance with this requirement.

10.2 Nondiscrimination

Housing and service providers will comply with all state and federal statutes relating to nondiscrimination, including the Fair Housing Act, Section 504 of the Rehabilitation Act, Title VI of the Civil Rights Act, Title II of the Americans with Disabilities Act, and Title III of the American with Disabilities Act. Providers may not take any of the following actions based on race, color, national origin, religion, gender, familial status, disability, marital status, source of income, sexual orientation, including gender identity, honorably discharged veterans/military status, and survivors of domestic violence:

- Refuse to rent housing or provide services.
- Make housing or services unavailable.
- Deny a dwelling or services.
- Set different terms, conditions or privileges for rental of a dwelling or obtaining services.
- Provide different housing services or facilities or different services.
- Falsely deny that housing is available for inspection or rental or services are not available.
- Deny anyone access to a facility or service.
- Screen out individuals with 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/history of not being a leaseholder, or criminal record.
- Create or maintain priority lists.
- Turn participants away from services even if they rejected referral options previously provided.

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Community Connect'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, disability, or the presence of children.

10.3 Culturally and Linguistically Responsive

All staff administering assessments must use culturally and linguistically responsive practices, including the following:

- *Community Connect* incorporates cultural and linguistic responsiveness into the required annual training protocols for participating projects and staff members.
- Assessments use questions for all persons that reduce cultural or linguistic barriers to housing and services.
- Access points will take reasonable steps to offer materials and participant instructions in multiple languages to meet the needs of minority, ethnic, and groups with Limited English Proficiency. *Community Connect* materials will be offered in English and Spanish, and translation services will include the use of bilingual staff and/or other provider resources.
- Appropriate auxiliary aids and services necessary to ensure effective communication are available for individuals with disabilities. This may include the ability to enlarge text and TTY services. Access points are handicap accessible for those with physical disabilities, such as persons with wheelchairs.

10.4 Domestic Violence Emergency Safety Plan

a) All persons accessing *Community Connect* are asked, via the Phase One Assessment, if they are fleeing or attempting to flee domestic violence. If a person or persons are identified as fleeing or attempting to flee domestic violence, the provider, including non-victim service providers, must provide immediate referral to, and assistance accessing emergency services. The person or persons has the right to decline any and all referrals to, or assistance with access to, emergency services. **Declining referrals or assistance with access will not negatively impact the person's access to *Community Connect*.**

b) Assessment office areas are secure, safe and private to allow for individuals to identify sensitive information or safety issues in a private and secure setting.

c) Coordinated entry staff are trained in the Emergency Safety Plan procedures outlined in the CoC Program Administrative Plan, Chapter 2, Part 2: VAWA Notification, Documentation and Confidentiality, and use of HUD-5381 Model Emergency Transfer Plan for Victims of Domestic Violence, Dating Violence, Sexual Assault, or Stalking and HUD-5383 Emergency Transfer Request for Certain Victims of Domestic Violence, Dating Violence, Sexual Assault, or Stalking. The CoC Program Administrative Plan is online at https://www.co.washington.or.us/Housing/EndHomelessness/hssn.cfm.

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10.5 Grievance Policy

At the time of assessment with mobile outreach workers or site-based Assessment Specialist, persons will be advised of their right to file a non-discrimination complaint with the CoC Board.

- If less than 15 days to the next CoC Board meeting, the complaint will be added to the next regular business meeting agenda for review and act upon the complaint.
- If more than 15 days to the next CoC Board meeting, the Chair will call a special meeting to review and act upon the complaint.

11. ASSESSMENT SPECIALIST TRAINING

Mobile Assessment Specialists (outreach workers) and site-based Assessment Specialists performing *Community Connect* assessment are required to complete training to ensure fidelity to the centralized assessment policies and procedures and uniform decision-making and referrals.

11.1 New Hire Training and Orientation:

Prior to performing assessments, mobile and site-based Assessment Specialists will be required to read and acknowledge understanding of all *Community Connect* policies. Training will be provided on the policy and process to perform assessments, with additional training completed as follows:

a) Overview of the housing programs and resources aligned with *Community Connect*.
b) Training in how to perform an assessment using an equitable, person-centered approach.
c) Confidentiality that assessors will be trained on providing appropriate disclosures to center participant autonomy in providing personal information. [2]
d) Training on nondiscrimination and how to perform an assessment using a person-centered approach that is culturally and linguistically responsive.
e) Safety planning and training.
f) ServicePoint HMIS training.
g) Training on how to conduct a trauma-informed assessment. Enrollment and completion of Trauma Informed Care course required within 6 months of hire.
h) Enroll and complete within 6 months of hire, the Rent Well course, which provides information that is beneficial to serving people who are at risk of homelessness or have housing barriers.
i) De-escalation and Crisis Resource Training.

11.2 Annual Training: In the month of May, conduct annual training for Assessment Specialists. This will include:

a) Overview of the most recent CoC Housing Inventory Chart (HIC) submitted to HUD, with emphasis on new/future housing resources.

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[2] in compliance with HUD Coordinated Entry Notice: Section II.B.11

b) Review of the assessment and referral process to ensure fidelity to the *Community Connect* policies and procedures.
c) Confidentiality/privacy training that includes safety for persons fleeing domestic violence and how to determine program eligibility for appropriate referrals for persons with disabilities.
d) Mental Health First Aid training.
e) Safety planning and training.
f) Implicit Bias and Equity Training.

12. PERFORMANCE MEASUREMENTS AND SYSTEM EVALUTION
The HSSN will provide oversight to the *Community Connect* process to provide transparency for people working in the system and ensure consistency with how people access resources communitywide.

12.1 The HSSN will measure project and system performance outcomes based on seven criteria:
a) Reduction in the Average Length of Time Persons remain Homeless
b) Reduction in Recidivism
c) Reduction in First-time Homelessness
d) Reduction in Unsheltered Homelessness
e) Increase in Earned Income
f) Increase in Mainstream Benefits
g) Increase in Placement to Permanent Housing from Outreach, and Placement in or Retention of Permanent Housing

12.2 Measurement period will be on a federal fiscal year, to align with Annual Homeless Assessment Report submitted to HUD.

12.3 Semi-annually, the HSSN will review the outcomes of the system performance measurement.

12.4 Target goals for system performance will be measured annually beginning October 1 to September 30, with CoC goals:
a) Average length of homelessness $\leq$30 days, or a reduction by at least 10 percent from the preceding federal fiscal year.
b) Less than 5 percent recidivism within two-year period, or homeless again within two years decreased by at least 20 percent from the preceding year.
c) HMIS bed coverage rate is greater than 80 percent.
d) Outreach plan is comprehensive in identifying and referring homeless individuals and families to *Community Connect.*

12.5 An annual report will provide HSSN membership with results of consultations with participating project and project participants. The purpose of (at least) annual consultations will be to evaluate the intake, assessment, and referral processes associated

with coordinated entry. Solicitation methods to address the quality and effectiveness of the entire coordinated entry experience for both participating projects and households may include surveys, focus groups and interviews. All data obtained through surveys will be in anonymous paper form or conducted through *Survey Monkey* and will be stored by the CoC lead agency. Documents will be retained for no longer than one year after which time they will be destroyed through a secured process.

13 APPENDICES

Note: Appendix documents will retain their 10.x designation as CoC members have integrated into their daily language referring to these documents by their Appendix number; e.g. 10.3 is commonly known as the form that is the Community Connect Modernization Policy & Procedures.

10.1.	Inter-Agency Data Sharing Participating Agencies in Washington County
10.2	Community Connect Modernization - New Process Flow
10.3	Community Connect Modernization Policy & Procedures
10.3a	Phase One Assessment – Initial Access and Eligibility Tool
10.3b	Phase Two Assessment – Housing Placement Assessment
10.3c	Phase Three Assessment – Housing Stabilization Plan DRAFT
10.4	Phase Four Assessment Tool (ServicePoint HMIS – Client Profile Example)
10.5	A Road Home Client-Consent-to-Data-Sharing-form_10-2017
10.6	HMIS WashCo Occupied Beds Summary 08.24.21
10.7	Department of Veterans Affairs, Request For & Authorization To Release Health Information
10.8	By-Name List Case Conferencing Procedures for Chronic Populations

REVISION HISTORY

Revision Date	Description of Changes
1/17/2014	Original Version
6/6/2018	Section 5 add information in multiple languages; Section 9.4 add.
12/5/2018	Section 7: remove Homeless Verification and Self-Declaration of Housing form 10.6 as agencies submit 3rd party documentation as proof of homelessness. Proof of Community Connect assessment can be printed from HMIS and attached to program application; add A Road Home: Client Consent to Release of Information for Data Sharing form 10.6; Appendix 10.1 includes addition of Severe Weather Shelters who completed HMIS Agency Data Sharing Agreement.
2/14/2020	Section 8.1: Update prioritization matrix and add By-Name List Case Conferencing process. Add Appendix 10.12 By-Name List Case Conferencing Procedures for Chronic Populations. Section 8.4: Revise ESG Program re-evaluate participant from "At least every 3 months" to "At least annually".
9/9/2021	Definitions added: 1.8 Recipient, 1.9 Subrecipient, 1.10 Domestic Violence, 1.11 Fleeing domestic abuse or violence, 1.12 Phased assessment, 1.12.1 Phase One assessment, 1.12.2 Phase two assessment, 1.12.3 Phase three assessment, 1.12.4 Phase four assessment, 1.13 Dynamic Prioritization.

Section 2: Community Connect Overview – updated with current information and defined terms.

Section 6.2: Determinization of Eligible for Homeless Assistance – Updated with current information and removal of "b)"

Section 7: Most of the section was moved to Section 8 – added Community Connect Phased Assessment process. Added 7.1 Description of the Community Connect Phased Assessment process, Added 7.2 Phase I Assessment – Initial Access and Eligibility Tool, Added 7.3 Phase II Assessment – Housing Placement Assessment , Added 7.4 Phase III Assessment – Housing Stabilization Plan , Added Phase IV Assessment – Housing Needs Review (Not Complete)

Section 8: Changed title to "Access" – and following changes or updates were made - 8.1 updated, 8.2 updated shelter names and removal of d), 8.3 updated with Phase One Assessment, 8.4 Removal of scoring and scoring guide references, 8.6 "Referral and Housing Placement" Removal of all scoring references, 8.7 "Prioritizing Populations" updated to reference Appendix 10.3 and removal of a) Permanent housing prioritization matrix, 8.8 "Determining Housing Placement" Removed and updated to reference the Appendix 10.3, 8.9 "Intake and Disposition of Referral/Housing Placement" Updated to reference Phase Two Assessment Appendix 10.3b, Added 8.11 "enrollment: Community Connect Post Housing Placement" referencing Phase three Assessment 10.3c

Section 9: Added Enrollment: Community Connect Post Housing Placement

Section 10.3: terms updated to Culturally and Linguistically Responsive

Section 11: updated Confidentiality language in 10.1 New Hire Training - Added De-escalation and Crisis Resource Training and Annual Training - Added Implicit Bias and Equity Training

Section 13 Appendices – Updated

The following Appendixes were removed:
10.1 HMIS Data Entry Procedure for CRAs
10.2 *Community Connect* Screening and Intake Flow Chart
10.3 Screening Tool
10.4 Building Sustainable Partnerships for Housing Matrix
10.5 Assessment Tool (ServicePoint HMIS)
10.5.a Assessment Tool (Paper Form used by Outreach Staff)
10.7 Resource Eligibility and Housing Options form
10.8 Staff Affidavit Form
10.9 Assessment Scoring Guide
10.10 Program Eligibility Tool

The following Appendixes were added:
10.1 Inter-agency Data Sharing Agencies with executed agreements
10.2 Community Connect Modernization - New Process Flow
10.3 Community Connect Modernization Policy and Procedures
10.3a Phase I Assessment – Initial Access and Eligibility Tool
10.3b Phase II Assessment – Housing Placement Assessment
10.3c Phase III Assessment – Housing Stabilization Plan DRAFT
10.4 Phase IV Assessment Tool (ServicePoint HMIS – Client Profile Example)

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**NW Social Service Connections' HMIS/CMIS
Inter-Agency Data Sharing Participating Agencies in Washington County**

To ensure privacy and security of individual personal identifying information (PII) and to facilitate communication and collaboration between all programs participating in Community Connect - a coordinated entry system - certain data entered into the Homeless Management Information System (HMIS) will be shared with Community Connect participating agencies. HMIS data may be used to operationalize the CoC's rehousing focus through case conferencing of homeless individuals/households to provide rapid access to housing and person-centered services.

Agencies execute a *NW Social Service Connections' HMIS/CMIS HMIS Agency Participation Agreement and Inter-Agency Data Sharing Participating Agencies in Washington County* with the CoC HMIS Lead Agency (the Washington County Department of Housing Services). The *HMIS Agency Participation Agreement* is available in the CoC-HMIS Governance Charter policy.

Community Connect agencies included under this agreement are:
- ❖ ASSIST Program
- ❖ Bienestar Inc.
- ❖ Boys & Girls Aid
- ❖ Bridges To Change
- ❖ Cascade AIDS Project
- ❖ Catholic Charities
- ❖ Centro Cultural del Condado de Washington
- ❖ Community Action Organization of Washington County
- ❖ Community Partners for Affordable Housing
- ❖ Domestic Violence Resource Center
- ❖ Easter Seals Oregon
- ❖ Ecumenical Ministries of Oregon
- ❖ Family Promise of Tualatin Valley
- ❖ Family Promise of Greater Washington County
- ❖ Forest Grove Foundation
- ❖ Good Neighbor Center
- ❖ Greater Good North West
- ❖ HomePlate Youth Services
- ❖ Immigrant and Refugee Community Organization
- ❖ JOIN
- ❖ Just Compassion of East Washington County
- ❖ LifeWorks Northwest
- ❖ New Narrative
- ❖ Open Door Counseling Center
- ❖ Project Homeless Connect
- ❖ Sequoia Mental Health Services, Inc.
- ❖ St. Vincent dePaul – Tigard
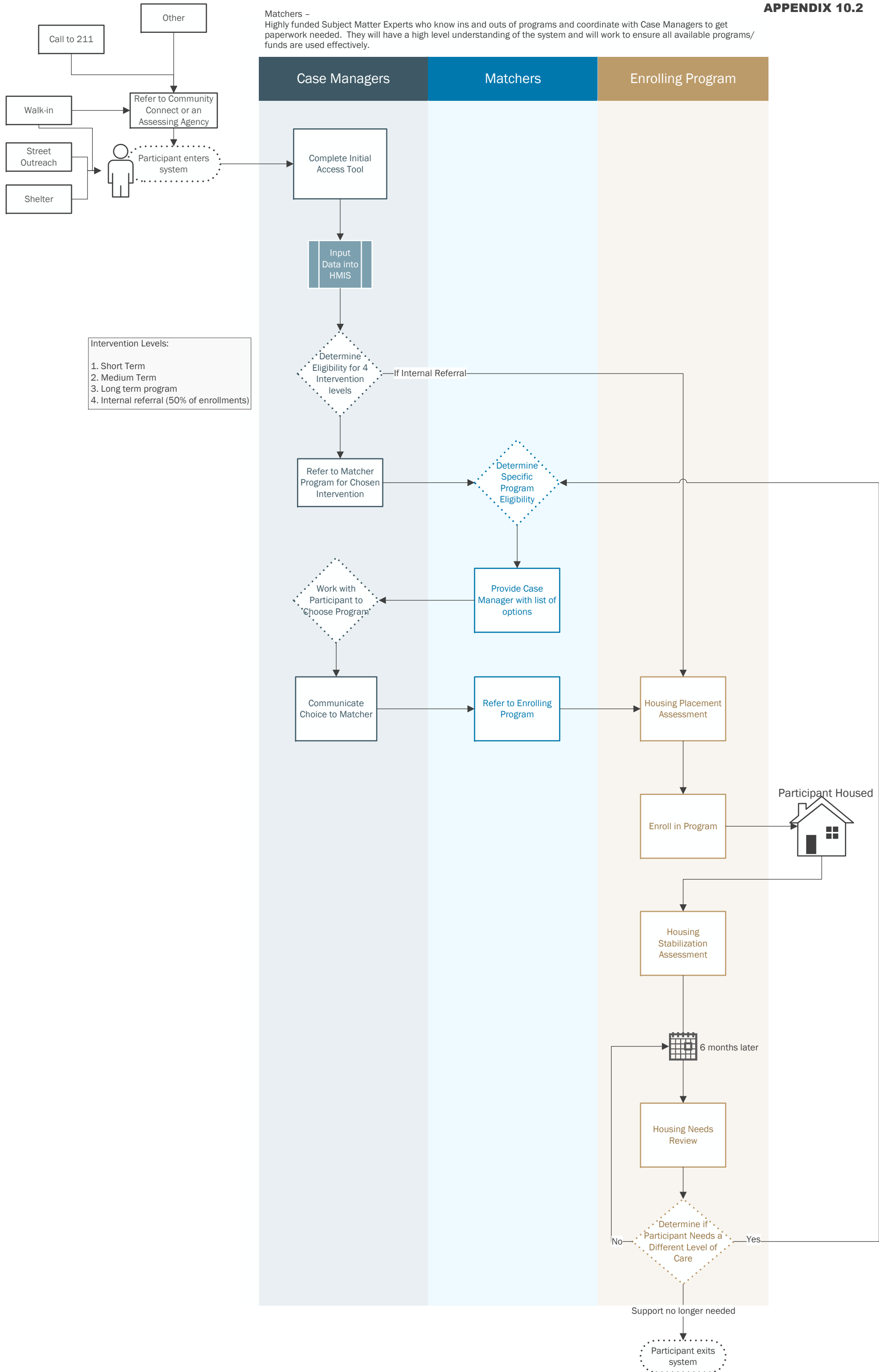- ❖ The Salvation Army

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- ❖ Urban League of Portland
- ❖ Washington County Department of Housing Services, the CoC HMIS Lead Agency
- ❖ Washington County Disability, Aging and Veteran Services (DAVS)

Executed copies of the HMIS Agency Participation Agreement and individual HMIS User Agreements are on file at Washington County Department of Housing Services Business Office. For information, contact HMISinfo@co.washington.or.us.

Case Managers –
Work directly with participants to get all the information needed to enroll in programs and to coordinate other care needs.

Matchers –
Highly funded Subject Matter Experts who know ins and outs of programs and coordinate with Case Managers to get paperwork needed. They will have a high level understanding of the system and will work to ensure all available programs/ funds are used effectively.

Call to 211

Other

Walk-in

Street Outreach

Shelter

Refer to Community Connect or an Assessing Agency

Participant enters system

Case Managers

Matchers

Enrolling Program

Complete Initial Access Tool

Input Data into HMIS

Determine Eligibility for 4 Intervention levels

Intervention Levels:

1. Short Term
2. Medium Term
3. Long term program
4. Internal referral (50% of enrollments)

If Internal Referral

Refer to Matcher Program for Chosen Intervention

Determine Specific Program Eligibility

Work with Participant to Choose Program

Provide Case Manager with list of options

Communicate Choice to Matcher

Refer to Enrolling Program

Housing Placement Assessment

Enroll in Program

Participant Housed

Housing Stabilization Assessment

6 months later

Housing Needs Review

Determine if Participant Needs a Different Level of Care

No

Yes

Support no longer needed

Participant exits system

Community Connect Modernization

POLICY & PROCEDURE

Applies To: All funded homeless assistance housing programs within Washington County Continuum of Care (CoC)

Approved Date: 9/9/2021

Relevant Documents

❑ Phase I Assessment – Initial Access and Eligibility Tool

❑ Phase II Assessment – Housing Placement Assessment

❑ Phase III Assessment – Housing Stabilization Plan

❑ Phase IV Assessment – Housing Needs Review (Not Complete)

Purpose

The purpose of this document is to provide a formalized policy for the Washington County Community Connect System. This document encompasses the new Community Connect Phased Assessment. This policy will take effect on October 9, 2021.

Background

With the passage and launch of the Metro Supportive Housing Services tax levy. Washington County reviewed its current Community Connect policy and procedures. The original Community Connect system was designed based within a continuum of scarce housing resources. Policies and procedures needed to be updated to account for a large influx of new housing resources into the Washington County CoC. with a process that matches eligible households to resources in an efficient, equitable, and timely manner at each phase in their housing process.

Definitions

Community Connect is the name given to the coordinated entry system for the Continuum of Care jurisdiction in Washington County, Oregon.

Phased Assessment is defined as the multiple Community Connect assessments utilized within Washington County. A phased assessment only collects the relevant and least amount of data from a household at each step from homelessness to stably housed. The phased assessment is broken into four (4) assessments.

Phase One Assessment or the Initial Access and Eligibility Tool. This assessment gathers basic eligibility data necessary to connect a household to eligible housing interventions.

Phase Two Assessment or the Housing Placement Assessment. This assessment is completed at program enrollment. It gathers basic HUD required data as well as housing barriers, such as eviction and

criminal history. It encompasses a tenant screening report. It also prioritizes high barrier households to project-based units.

Phase Three Assessment or the Housing Stabilization Plan. This assessment is completed after a household moves into a housing unit. It encompasses housing needs such as physical and behavioral health, education, employment, social supports; and creates referrals to resources based off those needs.

Phase Four or the Housing Needs Review. This assessment is still in development and will not be included in this policy.

Dynamic Prioritization is a loose term for a specific prioritization process wherein all available housing resources for households experiencing homeless are flexibly and immediately offered to the households who need them most acutely in that moment, regardless of whether the household might be better-served in the future by a type of program not presently available.

Progressive Engagement is a person-centered approach to ending a household's homelessness. It is based on tailored assistance to each individual or household's needs and assessing what works best for them, with their specific strengths, and in their specific situation.

Phased Assessment

The Community Connect Phased assessment process focuses on relevant questions needed to connect a household to needed resources in each phase of their journey to housing stabilization. The phased assessment process utilizes a progressive engagement approach to gathering information from a household and targets its questions to what is relevant at multiple phases toward housing stability. Each phase is designed to be trauma informed in its delivery and approach and should never be completed in increments no longer than 20 minutes in length. The phased assessment does not utilize an acuity-based prioritization schema. Resource connection is based off eligibility, need, and a household's desire to be connected to resources. The phased assessment process relies heavily on all resources being accessed within the Community Connect referral process. Community Connect will match households with resources beginning with housing, then moving to the full spectrum of wrap around resources that are available within the homeless response system.

The **Initial Access Tool** is completed with all households seeking assistance with a housing crisis. The tool focuses on eligibility questions, such as length of time homeless, disability status, and income level. It also incorporates Race/ethnicity, gender, and preferred pronouns. Finally, the tool, verifies if the household is a part of a federally recognized tribe, a military veteran, or is a victim of domestic violence, or actively fleeing. The responses will verify eligibility with all homeless assistance housing-based resources. Household's will then be offered, and if accepted, matched to the available housing resource for which they are eligible.

The **Housing Placement Assessment** is completed with all households at or soon after housing program enrollment. Before the assessment is completed a tenant screening report will be requested to ensure accurate assessment input. The assessment focuses on barriers that a household might face while seeking housing. This includes legal and eviction histories, prior history with the housing authority, debt, and any other physical or behavioral health concerns which would warrant a need for project-based housing. Community Connect will offer, and if accepted, match households to either legal or debt resolution resources. If households have barriers to acquiring tenant-based housing, Community Connect will prioritize project-based resources as they become available. This assessment also, gathers

all required HUD data elements for program enrollment, such as income source and medical insurance information.

The **Housing Stabilization Plan** is completed with all households as they are leasing up a unit, and soon after move in. The plan first focuses on items that a case worker will need to work with a household while leasing a unit. These include establishment of address through the post office, voter registration, connection of utilities, reasonable accommodations, lease rules, and rental amount. When the household has moved into the unit, the plan encompasses, employment history, education history, physical and behavioral health history, disability services, and social and community supports. The households are asked in the plan if they have a want to be connected to resources based off their needs. If so, Community Connect with match interested households to resources such as behavioral health services, SSI/SSDI application support, work force development, and other resources that become available to the Community Connect system.

The **Housing Needs Review** is currently in development and is not included within the initial policy. The purpose of this phase of the assessment process will be to evaluate if the current housing resources are meeting the households needs or if another housing program referral is needed to support long term household stability.

Prioritization

Prioritizing Populations for Permanent Housing Placement

Housing is prioritized in alignment with HUD CPD-16-11 *Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless persons in Permanent Supportive Housing* (supersedes CPD-14-12) through new resources and turn-over of housing units not dedicated and/or prioritized for specific target populations.

As new local funding significantly increases resources for serving chronically homelessness, and Literally or imminently at-risk of experiencing long-term or frequent episodes of homelessness households. The infusion of local resources allows the Continuum to deploy short-term and medium-term resources for households experiencing homelessness or needing eviction prevention support. This will allow the Washington County CoC to effectively serve all three priority levels while still prioritizing priority one chronically homeless households.

When Permanent Supportive Housing Resources are fully exhausted the Community Connect System will utilize **dynamic prioritization** and utilize rapid rehousing or other medium-term housing resources for the needs of the chronically homeless population.

Priority one; For all permanent supportive housing resources Community Connect will prioritize housing resources first to chronically homeless, and literally or imminently at-risk of experiencing long-term or frequent episodes of homelessness households. These households can be separated into the following populations in order of priority. Families who are either pregnant or have minor children, transitional age youth, adults over the age of 55, and adults. If a secondary level of prioritization is needed, households will be prioritized in the following order: length of time homeless, a needed program transfer due to dynamic prioritization, lowest income.

Priority two; For rapid rehousing resources Community Connect will prioritize housing resources first to chronically homeless households through dynamic prioritization. If dynamic prioritization is not needed, the Community Connect system will prioritize literally homeless households based off population type. These households can be separated into the following populations in order of priority. Families who are either pregnant or have minor children, transitional age youth, adults over the age of 55, and adults. If a secondary level of prioritization is needed, households will be prioritized in the following order: length of time homeless, disability status.

Priority three; For homeless prevention and eviction prevention resources Community Connect will prioritize households imminently at risk of homelessness. These households can be separated into the following populations in order of priority. Families who are either pregnant or have minor children, transitional age youth, adults over the age of 55, and adults. If a secondary level of prioritization is needed, households will be prioritized in the following order: lowest income, highest rent burden, disability status.

Housing Intervention	Target Population	Priority Level	Primary Prioritization	Secondary Prioritization
Permanent Supportive Housing, Or Long-Term supportive housing	Chronically Homeless, Or Literally or imminently at-risk of experiencing long-term or frequent episodes of homelessness	1	Families - Pregnant or with minor children Transitional Age Youth Adults over 55+ Adults	1. Length of time homeless 2. Program Transfer 3. Income
Rapid Rehousing, or medium-term supportive housing	Literally Homeless	2	Families - Pregnant or with minor children Transitional Age Youth Adults over 55+ Adults	1. Priority Level One 2. Length of time homeless 3. Disability status
Homeless and Eviction Prevention	Imminently at Risk of Homelessness	3	Families - Pregnant or with minor children Transitional Age Youth Adults over 55+ Adults	1. Lowest income 2. Highest rent burden 3. Disability Status

Washington County Community Connect
Initial Access and Eligibility Tool

INSTRUCTIONS

- Assessment should be conducted face to face and in a space comfortable to the participant whenever possible
- Time spent on assessment should never exceed 20 minutes
- Once completed tool administrator must input data into the HMIS and refer the participant to the most appropriate housing intervention they are eligible for
  - Tool administrator should always explore accessing the least amount of assistance necessary to resolve the housing crisis when making a housing referral
  - Housing options include, but are not limited to three paths:
    1. Brief one-time financial Assistance
    2. Short to medium term assistance ranging from two months to twenty-four months
    3. Long Term assistance

By completing this assessment, the tool administrator agrees to be the participants primary contact with Community Connect in the matching process.

Please begin with the following questions to determine whether to proceed with the assessment.

1. **What type of information or assistance are you seeking today?**
If the household is not seeking housing or homelessness related needs, discontinue tool and ask additional questions to make appropriate referral to needed resource.

2. **Are you, or anyone in your household, currently working with any organizations or housing programs?**
If the household is working with another housing program, discontinue tool and assist in connecting household back to organization they are working with.

Washington County Community Connect
Initial Access and Eligibility Tool

Tool Administrator:	Date:
Agency/Program:	Location: ☐ OR-506 ☐ OR-501

PARTICIPANT DEMOGRAPHIC INFORMATION	
Participant Name:	Nickname or Alias:
Participant DOB:	Full DOB Reported? ☐ Yes ☐No

Relationship to the head of household? _____
If the participant is the HOH, please write "self"

HOH Name:	Household Member ___ of ___

1. What language are you the most comfortable with us working with you in? _____

2. Are you comfortable with sharing your gender?
☐ Male
☐ Female
☐ A gender that is not singularly 'Female' or 'Male' (e.g. gender non-conforming, non-binary, genderqueer, bi-gender)
☐ Transgender (e.g. trans female, trans male, trans femme, trans masc, FTM, MTF)
☐ Questioning
☐ Declined

3. What are your pronouns? _____

4. What best describes your racial or ethnic identity? (*Check all that apply*)

Asian	African American or Black	American Indian or Alaskan Native	Native Hawaiian and Pacific Islander
☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Hmong ☐ Japanese ☐ Korean ☐ Laotian ☐ Vietnamese ☐ South Asian ☐ Other Asian	☐ African (Black) ☐ American African ☐ Caribbean (Black) ☐ Other Black	☐ American Indian ☐ Alaskan Native ☐ Canadian – Inuit, Métis, and First Nation ☐ Indigenous Mexican, Central American, and South American	☐ Native Hawaiian ☐ Guamanian ☐ Chamorro ☐ Marshallese, Micronesian, Palauan ☐ Samoan ☐ Tongan ☐ Other Pacific Islander
Middle Eastern and North African ☐Middle Eastern ☐North African	**White** ☐ Slavic ☐ Eastern European ☐ Western European ☐ Other White	**Hispanic and Latino/a/x** ☐ Mexican ☐ Central American ☐ South American ☐ Other Hispanic or Latino/a/x	**Other Categories** ☐ Other _____ ☐ Don't Know ☐ Decline

PARTICIPANT CONTACT INFORMATION	

Phone Number:

Voicemail Preference: ☐No Voicemail ☐ Voicemail without agency information ☐Voicemail with agency information

E-mail address:

Emergency Contact Name:	Emergency Contact Phone Number:
Current Primary Case Manager:	Case Manager Phone Number:

Preferred/best way to contact participant? ☐Phone ☐E-mail ☐Emergency Contact ☐Case Manager

Contact information is collected so that we can reach you regarding housing and resources. If you do not wish to be contacted, please let us know:
☐ I decline to be contacted by phone or email
☐ I decline to be contacted by phone
☐ I decline to be contacted by email

PROGRAM INTEREST AND CONNECTIONS

5. Are you or anyone in your household currently experiencing domestic violence or trying to leave a situation where you feel unsafe?
☐ Yes*
☐ No
*If YES, assess for safety and immediate needs. Then connect Household to Domestic Violence provider.

6a. Have you served in the active U.S. military?
☐ Yes*
☐ No

6b. *If YES, are you interested in being connected with a Veteran service provider to see if you may be eligible to access resources specifically for Veterans?
☐ Yes
☐ No

7a. Are you a member of a Federally Recognized Tribe?
☐ Yes*
☐ No

7b.*If YES, are you interested in being connected with tribal assistance resources?
☐ Yes
☐ No

8a. Would you be interested in being connected with a shelter?
☐ Yes
☐ No

8b. *If YES, and if there isn't space today would you like to be placed on the waiting list?
☐ Yes
☐ No

9a. Are you interested in being connected with a culturally specific provider for housing?
☐ Yes
☐ No

9b. *If YES, please elaborate:
_____
_____

10. Are you currently being assisted through an intensive case management program such as ACT?
☐ Yes
☐ No

11a. Do you have any pets?
☐Yes*
☐ No

11b. *If YES, how many pets are in the household?
☐1 ☐ 2 ☐3 ☐ 4 ☐More

11c. *If YES, are the pets service animals?
☐Yes
☐ No

11d. *If YES, are the pets emotional support animals?
☐Yes
☐ No

12. What city or region do you spend most of your time in?
_____

HISTORY

13a. Where did you sleep last night? (Prior Living Situation)

Homeless Situations	Institutional Situations	Temporary and Permanent Housing Situations	Other
☐Place not meant for habitation ☐Emergency shelter ☐Safe haven	☐Foster care ☐Hospital/medical facility ☐Jail/prison ☐Long term care/nursing home ☐Psychiatric hospital/facility ☐Substance treatment program	☐Residential project/halfway house ☐Hotel/motel (no voucher) ☐Transitional housing ☐Host home ☐Friend's place ☐Family member's place ☐Rental by participant (GPD TIP) ☐Rental by participant (VASH) ☐Permanent housing for formerly homeless (not RRH) ☐Rental by participant (RRH) ☐Rental by participant (HCV) ☐Rental by participant (public housing unit) ☐Rental by participant (no subsidy) ☐Rental by participant (with other subsidy) ☐Owned by participant (no subsidy) ☐Owned by participant (with other subsidy)	☐Unsure ☐Declined ☐Other:_____ _____ _____ _____

13b. How long have you been at the location you stayed last night?
_____

13c. If currently homeless, what is the approximate date this episode of homelessness started?
_____

13d. If in an Institutional Situation, on the night prior to entering the intuitional situation, did you stay on the streets, ES or SH?
☐ Yes
☐ No
☐ Has not been in an institutional situation (HUD – refused)

13e. If not currently homeless, would you describe your living situation as either of the following?
☐Imminent risk of literal homelessness (i.e. the participant will become literally homeless in fewer than 14 days)
☐Involuntarily doubled up (i.e. sharing housing of others due to loss of housing or economic hardship)

14a. Have you experienced literal homelessness in the last 3 years?
☐ Yes*
☐ No
☐ Unsure
☐ Decline

14b. *If Yes, How many separate times have you been literally homeless in the past three years?
☐ One time ☐ Two times ☐ Three times ☐ Four or more times ☐ Unsure ☐ Decline
☐ Has not been literally homeless (HUD – refused)

14c. *If Yes, What is the total number of months you have experienced literal homelessness in the past three years?
_____
☐ Unsure
☐ Decline
☐ Has not been literally homeless (HUD – refused)

15a. Have you resided in an institution or publicly funded system of care in the past 3 years? (e.g. medical center, prison etc.)
☐ Yes*
☐ No
☐ Unsure
☐ Decline

15b. *If YES, how many months have you resided in an institution or publicly funded system of care in the past 3 years?
☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12+ ☐ Unsure ☐ Decline

16a. Have you experienced a housing situation in which you were involuntary doubled up in the past 3 years?
☐ Yes*
☐ No
☐ Unsure
☐ Decline

16b. *If YES, how many months have you experienced a housing situation in which you were involuntary doubled up in the past 3 years?
☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12+ ☐ Unsure ☐ Decline

17. *For Assessor Only* – Does the total number of months homeless (14c), institutionalized (15b), or involuntarily doubled up (16b) add up to 12 months or more?
☐ Yes
☐ No

18. Have you previously been in housing through a houseless assistance program in the last three years?
☐ Yes
☐ No
☐ Unsure
☐ Decline

19a. Do you have any long-term disabilities or chronic health issues? e.g. chronic illness, cancer, HIV, mental health issues, substance use, developmental disabilities, etc.
☐ Yes*
☐ No
☐ Unsure
☐ Decline

19b. *If YES, would you like to be connected to a provider that specializes in chronic illness or disabilities if available?
☐ Yes
☐ No

19c. *If YES, to better connect you with resources, please select the category that best describes your condition:
☐ Physical disability or illness
☐ Mental disability or illness
☐ Substance use
☐ HIV/AIDS

20. Do you have any acute medical issues that need immediate attention?
☐ Yes
☐ No
☐ Unsure
☐ Decline

CURRENT LIVING SITUATION

21. Where will you sleep tonight?

Homeless Situations	Institutional Situations	Temporary and Permanent Housing Situations	Other
☐Place not meant for habitation ☐Emergency shelter ☐Safe haven	☐Foster care ☐Hospital/medical facility ☐Jail/prison ☐Long term care/nursing home ☐Psychiatric hospital/facility ☐Substance treatment program	☐Residential project/halfway house ☐Hotel/motel (no voucher) ☐Transitional housing ☐Host home ☐Friend's place ☐Family member's place ☐Rental by participant (GPD TIP) ☐Rental by participant (VASH) ☐Permanent housing for formerly homeless (not RRH) ☐Rental by participant (RRH) ☐Rental by participant (HCV) ☐Rental by participant (public housing unit) ☐Rental by participant (no subsidy) ☐Rental by participant (with other subsidy) ☐Owned by participant (no subsidy) ☐Owned by participant (with other subsidy)	☐Unsure ☐Declined ☐Other:_____ _____ _____ _____

HEAD OF HOUSEHOLD ONLY

22a. Does your household currently have any source of income?

☐ Yes*

☐ No

☐ Unsure

☐ Decline

22b. *If YES, what is the total monthly income for the household?
_____

23. Where does the household's income fit within the Area Median Income (AMI)?

☐ 30% or below ☐ 31% - 50% ☐ 51% - 79% ☐ 80% or more

2021 Income Limit	1 Person	2 People	3 People	4 People	5 People	6 People	7 People	8 People
30% AMI	$20,300	$23,200	$26,100	$29,000	$31,350	$35,580	$40,120	$44,660
50% AMI	$33,850	$38,700	$43,550	$48,350	$52,250	$56,100	$60,000	$63,850
80% AMI	$54,150	$61,900	$69,650	$77,350	$83,550	$89,750	$95,950	$102,150

Coordinated Entry Assessment

Assessment Location: ☐Phone/Main Call-in/211 ☐ Outreach Non-Youth ☐ Walk-In/Service Provider ☐ Youth Outreach

Assessment Type: ☐Phone ☐ Virtual ☐ In Person

Assessment Level: ☒ Housing Needs Assessment

Prioritization Status: ☒ Not Placed on Prioritization List

Washington County Community Connect
Phase II Housing Placement Assessment

INSTRUCTIONS

- Before completing assessment, first review the Initial Access and Eligibility Tool in HMIS for participant information, then complete a tenant screening report.
- Once the report has been returned, use the results from the report to assist participant in the Housing Placement Assessment.
- This assessment should be conducted face to face and in a space comfortable to the participant whenever possible.
- Time spent on assessment should never exceed 20 minutes.
- Once completed, tool administrator must input data into the HMIS.
- Community Connect Matcher will reach out to with any questions or provide connections and referrals for additional services the Participant might need or is eligible to receive.
- Administrator should next complete an action plan with participant utilizing the information provided.

Please begin with the following question before proceeding with the assessment.

1. **How are you (and your family) doing today? Is there anything that you need addressed right away before we begin asking some questions to assist you in finding housing?**

    If yes, please take the time right then and there to assess the current concerns or needs and attempt to address them before moving forward with the Housing Placement Assessment.

Washington County Community Connect
Phase II Housing Placement Assessment

Tool Administrator:	Date:
Agency/Program:	

PARTICIPANT INFORMATION	
Participant Name:	**Nickname or Alias:**
Participant DOB:	**Full DOB Reported?** ☐ Yes ☐No

PARTICIPANT DOCUMENTS

1a. Do you have a photo ID?
☐ Yes*
☐ No

1b. *If YES, may we scan a copy of your photo ID?
☐ Yes
☐ No

2a. Do you have a social security number? *A social security number is **not** always required for housing.*
☐ Yes*
☐ No
☐ Unsure
☐ Decline (HUD - doesn't know)

2b. *If YES, and if you are comfortable, please provide your full or partial social security number:
_____

3a. If you have any minor children, do you have their birth certificate(s)?
☐ Yes*
☐ No

3b. *If YES, may we scan a copy of their birth certificate(s)?
☐ Yes
☐ No

4a. If you have any minor children, are they enrolled in school, Head Start, or Early Intervention?
☐ Yes*
☐ No

4b. If yes, what school or program?
_____

PARTICIPANT CONTACT INFORMATION	
Phone Number:	
Voicemail Preference: ☐No Voicemail ☐ Voicemail without agency information ☐Voicemail with agency information	
E-mail address:	
Emergency Contact Name:	**Emergency Contact Phone Number:**
Current Primary Case Manager:	**Case Manager Phone Number:**
Preferred/best way to contact participant? ☐Phone ☐E-mail ☐Emergency Contact ☐Case Manager	

Contact information is collected so that we can reach you regarding housing and resources. If you do not wish to be contacted, please let us know:
☐ I decline to be contacted by phone or email
☐ I decline to be contacted by phone
☐ I decline to be contacted by email

EMPLOYMENT & FINANCES
4. Do you currently have a job, or would you like to being working while seeking housing? ☐ Yes ☐ No
5. Have you ever been unable to work because of a medical or mental health issue? ☐ Yes ☐ No
6a. Are any of your wages currently being garnished? ☐ Yes* ☐ No ☐ Unsure ☐ Decline
6b. *If YES, what type of garnishment? _____
6c. *If YES, what amount is garnished per month? _____
7a. Do you have a conservator that receives and handles your income? ☐ Yes* ☐ No ☐ Unsure ☐ Decline
7b. * If YES, what is your conservator's name and contact info? _____ _____
7c. * If YES, is your conservator responsive to your needs and requests? ☐ Yes ☐ No
HOUSING HISTORY
Please inform the participant that nothing disclosed in this section will impact their ability to find housing. This information is used to identify where to start housing assistance.
8. Have there been any changes to your living situation since we initially collected this information? ☐ Yes* ☐ No *If YES, please proceed to the CURRENT LIVING SITUATION Addendum on the last pages of this assessment. If no, confirm that there are auto-populated responses in the HMIS version of this assessment and skip the CURRENT LIVING SITUATION sections.*
9a. Have you had a lease for housing anywhere in the last 60 days? ☐ Yes ☐ No
9b. *If YES, please provide an address. _____
10a. Have you ever been evicted from housing? ☐ Yes ☐ No

10b. *If YES, please provide an address or addresses.

_____
_____
_____

10c. *If YES, how many times have you been evicted?

_____

10d. *If YES, was the location you were evicted from subsidized housing?
☐ Yes
☐ No

11a. Do you owe any landlord or housing program money for back rent or damages?
☐ Yes
☐ No

11b. *If YES, how much do you owe?

_____

11c. *If YES, please provide contact information for the property you owe money for.

_____
_____
_____

12a. Do you owe a public Housing Authority any money?
☐ Yes
☐ No

12b. *If YES, how much do you owe?

_____

13a. Do you owe back payments to local utility companies?
☐ Yes
☐ No

13b. *If YES, how much do you owe?

_____

13c. *If YES, please provide information for the utility company.

_____
_____
_____

14a. Do you have or have you ever had a housing voucher?
☐ Yes
☐ No

14b. *If YES, please describe.

_____

15a. Do you have preference on housing type?
☐ Yes
☐ No

15b. *If YES, please check all that apply.
☐ Shared Housing/Roommate
☐ Single Room Occupancy
☐ One bedroom
☐ Two bedroom
☐ Three bedroom
☐ Four or more bedroom
☐ Relocate with Family/Friends
☐ Other Housing Type _____

16a. Are there any restrictions on where you or any family member of your household can live?
☐ Yes
☐ No

16b. *If YES, please explain.
_____

17a. Do you or your household members have any preferences regarding location?
☐ Yes
☐ No

17b. *If YES, please explain.
_____

LEGAL HISTORY

Please inform the participant that the information collected in this section will not impact their ability to access housing.

18. Are you a registered sex offender?
☐ Yes
☐ No

19. Have you ever been convicted of arson?
☐ Yes
☐ No

20. Have you ever been convicted of manufacturing methamphetamines?
☐ Yes
☐ No

21a. Have you ever been convicted, pleaded guilty, no-contest, or have current pending charges for any felony or misdemeanor?
☐ Yes
☐ No

21b. *If YES, please describe.
_____
_____

HEALTH AND WELLNESS
22. Do you or anyone else in your household need any assistance with getting your needs met? *e.g. seeing a doctor, dentist, getting a prescription filled or getting mental health or substance use support.* ☐ Yes ☐ No
OBSERVATIONS (Optional) *For Long Term Housing Enrollment Only*
Please use this space to make observations. DO NOT ask these question to the participant.
23a. Is the participant showing symptoms or challenges that might indicate a physical or behavioral health support need that would warrant a need for project-based housing with onsite support? ☐Yes* ☐ No
23b. *If YES, what best applies: ☐ Physical disability ☐ Behavioral Health ☐ Mental Health ☐ History ☐ Other circumstance_____

CURRENT LIVING SITUATION ADDENDUM			
Where will you sleep tonight?			
Homeless Situations ☐Place not meant for habitation ☐Emergency shelter ☐Safe haven	**Institutional Situations** ☐Foster care ☐Hospital/medical facility ☐Jail/prison ☐Long term care/nursing home ☐Psychiatric hospital/facility ☐Substance treatment program	**Temporary and Permanent Housing Situations** ☐Residential project/halfway house ☐Hotel/motel (no voucher) ☐Transitional housing ☐Host home ☐Friend's place ☐Family member's place ☐Rental by participant (GPD TIP) ☐Rental by participant (VASH) ☐Permanent housing for formerly homeless (not RRH) ☐Rental by participant (RRH) ☐Rental by participant (HCV) ☐Rental by participant (public housing unit) ☐Rental by participant (no subsidy) ☐Rental by participant (with other subsidy) ☐Owned by participant (no subsidy) ☐Owned by participant (with other subsidy)	**Other** ☐Unsure ☐Declined ☐Other:- _____ _____ _____ _____

Are you going to leave your current living situation within 14 days?
- ☐ Yes*
- ☐ No
- ☐ Unsure
- ☐ Decline

*If YES, do you know where you are going to live?
- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ Decline

*If YES, do you and your household have resources or support networks to obtain other permanent housing?
- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ Decline

*If YES, have you had a lease or interest in home ownership in a permanent housing unit in the last 60 days?
- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ Decline

*If YES, have you moved two or more times in the last 60 days?
- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ Decline

Washington County Community Connect
Phase III Assessment Tool

Tool Administrator:	**Agency/Program:**
Participant Name:	**Nickname or Alias:**
Date Administered:	

PARTICIPANT INFORMATION

1. How are you (and your family) doing today? Is there anything that you need addressed right away, before we begin asking some questions so we can help you develop your housing plan?

If yes, please take the time right then and there to assess the current concerns or needs and attempt to address them before moving forward with the Phase III Assessment.

EXPLAIN that this discussion is going to help determine what will be most important to work on for their housing stability. Reassure them that the housing stability plan is their plan, participant led, and that you will work together to make it successful.

HOUSING MOVE IN

2. Have you established your new address with the post office? ☐Yes ☐ No*
  If No, offer to support

3. Have you transferred or connected your utilities? ☐Yes ☐ No*
  If No, offer to support

4. Do you need any support with internet, cable, or phone set up? ☐Yes ☐ No

5. Are you interested in registering to vote? ☐Yes ☐ No

6. Is there anything that you need help with to enjoy the apartment better? ☐Yes* ☐ No
  (reasonable accommodation)
  If YES, please describe _____

7. Do you know where to pay your rent to each month and how much it is? ☐Yes ☐ No
  Rental amount each month _____

8. Would you like any assistance reviewing your lease and rules you need to keep in mind? ☐Yes ☐ No
  Offer to do a unit walk through and take pictures of the unit's condition.

9. Do you have all the household or hygienic items you need to get started? ☐Yes ☐ No*
  *If NO, what items do you need support with? _____

INCOME SOURCES

10. Have there been any changes to your income since the last assessment? ☐Yes* ☐ No
  If YES, what changes? _____

EMPLOYMENT

11. Now let's talk about your employment history. Do you currently have a job even if it's under the table? ☐Yes* ☐ No

12. Are you interested in finding a job or changing your current job? ☐Yes* ☐ No
  If YES, what type of employment are you interested in? _____
  If YES, lets gather your employment history
  Employment History:

Start Date	End Date	HH Member	Position	Employer	Hourly Wage	Reason for leaving	Good Reference?

						☐Yes ☐ No
						☐Yes ☐ No
						☐Yes ☐ No
						☐Yes ☐ No
						☐Yes ☐ No

EDUCATION

13. Are you interested in continuing your education?   ☐Yes* ☐ No

If YES, what type of education have you completed? High school diploma ☐, GED ☐, Associates degree ☐, Bachelor's degree ☐, Master's Degree ☐, Other advanced level degree ☐, Trade School certification ☐, Other type ☐ _____, partial degree not completed ☐ _____

If YES, what type of education or skill training are you interested in pursuing? _____

14. Would you be interested in an internship or volunteering that is geared towards employment?   ☐Yes   ☐ No

15. Are you interested in being connected to a work force development program?   ☐Yes* ☐ No

If YES, are you interested in peer work? ☐**Yes*** ☐ **No**

HEALTH SUMMARY

Take time to let participant know that we will be asking health related questions that may bring up certain emotions or feelings. If at any point, we need to take a break or revisit questions, we can. The purpose of gathering this information is to provide better supports to help them achieve their housing goals.

16. Where do you go for services when you are sick or not feeling well? _____

17. Do you have a primary care physician?   ☐Yes* ☐ No

If YES, who is your primary care physician? _____

If NO, can I support you in getting a primary care physician?   ☐Yes   ☐ No

18. Are you currently pregnant?   ☐Yes* ☐ No

If YES, Due Date: _____   Receiving Prenatal Care?   ☐Yes ☐ No

19. Do you have any physical health concerns that you would like to see a physician for?   ☐Yes* ☐ No

*If YES would you be comfortable with sharing the health concern? _____

20. Do you received any treatment for behavioral health concerns currently or in the past?   ☐ Yes* ☐ No

21. Are you interested in a connection with someone to speak with about behavioral health or to just talk?
☐ **Yes***   ☐ **No**

If YES who? Psychiatrist ☐, Counselor ☐, Peer support ☐, someone within you community ☐, Other ☐, Who? _____

22. Are you interested in reducing your substance or alcohol use? Do you need support doing that?   ☐ Yes*   ☐ No

23. Are you interested in getting connected with a support or culturally responsive group?
☐ **Yes***   ☐ **No** If YES, what kind of support group? _____

Current Heath Care Service Providers	

Household Member	Start Date	Provider/Hospital Name & Phone	Physical or Behavioral Health

OTHER SERVICES

24. Have you ever applied for social security disability benefits before and been denied? ☐Yes* ☐ No
If YES, do you remember when? _____

25. Would you like a free consultation with a disability specialist to see if you should apply? ☐Yes* ☐ No

26. Have you been denied employment or discouraged from seeking employment because of an arrest or conviction? ☐Yes ☐ No

27. Do you have debt that will make it challenging to maintain housing? ☐Yes* ☐ No
If YES, what is the debt amount? _____
If YES, whom do you owe the debt to? _____

SOCIAL AND COMMUNITY SUPPORTS

Complete the following mini-assessment of the person's Social/Natural Supports. Do this by asking him/her/them about how they feel about their relationships with family (first) and friends. Mark the level as indicated below.

28.	1. In-Crisis	2. Vulnerable/At-Risk	3. Stable	4. Capable/Safe	5. Thriving
Family	*Isolated, no social network. Experiencing high levels of rejection and/or conflict (could include sexual or gender identity as "reason"). Kicked out of family.* ☐	*Family are not supportive or accepting (including sexual and gender identity). Only one family member has retained contact. Has little/no social network.* ☐	*Family are neutral or silent about sexual/gender identity. Has positive relationship with one or more member of the family.* ☐	*Family are supportive of sexual/gender identity. Has healthy attachments with family. Family are mostly consistently supportive and able to meet some of their needs.* ☐	*Family are accepting and supportive. He/she/they has healthy attachments to family and finds supports and a positive social network.* ☐
Friends	*Isolated, no social network. Experiencing high levels of rejection, conflict, violence (could include sexual or gender identity as reasons). Engaged in harmful relationships with others.* ☐	*Has little/no social network with supportive adults. Lack of supportive friends in current community. Friends are not accepting of sexual or gender identity.* ☐	*Friends are people from the streets who are neutral or silent about gender/sexual identity. Has strong social network of peers who accept them.* ☐	*Friends are supportive of sexual/gender identity, and is generally solidly attached. Friends offer mostly consistent support and may try to meet needs.* ☐	*Friends are accepting and supportive. He/she/they has healthy attachments to family and finds supports and a positive social network.* ☐

29. Based on our discussion, are you interested in getting reconnected with any friends or family? ☐Yes* ☐ No
If YES, who? _____

30. Are you interested in getting connected/reconnected with a faith-based organization or culturally specific services? ☐Yes* ☐ No

If YES, what type of faith, organization, or culturally specific practice? _____

31. Are you interested or getting involved in the community or volunteering in some way?	☐**Yes*** ☐ **No**
If YES, what interests you? _____	
32. Do you have any hobbies that you enjoy, used to enjoy, or are interested in trying?	☐**Yes*** ☐ **No**
If YES, what is the hobby? _____	

PARTICIPANT CONTACT INFORMATION	
Name:	Date of Birth:
Phone Number:	Permission to call or leave voicemail? ☐Yes ☐ No
E-mail address:	Permission to e-mail? ☐Yes ☐ No
Home address:	
Preferred/Best way to contact participant? ☐Via Phone ☐ Via E-mail ☐Via Emergency Contact ☐Via Case Manager	
Emergency Contact Name Phone Number:	Permission to call or leave voicemail? ☐Yes ☐ No
Current Primary Case Worker:	Phone Number:
E-mail address:	

INSTRUCTIONS
Assessment should be conducted face to face and in a space comfortable to the participant whenever possible. Time spent on assessment may take a longer time than the other assessments. While you are completing this, you should be thinking about what aspects of the answers may be best resolved through your housing plan as well as what kinds of referrals would be most helpful. Remember, however, that you will be conducting this early enough in your relationship with the person that they may still be traumatized and overwhelmed and therefore not ready or able to make decisions about what they want to prioritize for action. You can keep referring back to this assessment in future meetings to allow you to bring up items that have not yet surfaced. . Once completed, tool administrator must input data into the HMIS. *By completing this assessment tool, administrator agrees to be the participants' primary contact with Community Connect in the matching process.*

A Road Home

NW Social Service Connections' HMIS/CMIS
Client Consent to Release of Information for Data Sharing in Washington County, Oregon

Northwest Social Service Connections' Homeless Management Information System/Client Management Information System (HMIS/CMIS) is a computer system that is used to collect and share information on homelessness and social services throughout Washington County. The information gathered by HMIS/CMIS allows agencies to plan and deliver services that help people in need. By sharing information with each other, agencies are able to simplify service delivery by coordinating services and referrals across agencies.

Maintaining the privacy and safety of those using our services is very important to us. The HMIS/CMIS runs in compliance with all Federal and State laws and codes, including Health Insurance Portability and Accountability Act (HIPAA). Every person and agency that is authorized to read or enter information into the database has been trained on client confidentiality policies and has signed an agreement to maintain the security and confidentiality of the information. Any person or agency that is found to violate their agreement may have their access rights ended and may be subject to further penalties.

Services will not be denied should you choose not to share information. Information will still be collected and entered because of our federal and state requirements. **Certain minimum client information is shared throughout our HMIS/CMIS in order to avoid creating duplicate client records.** Authorized HMIS/CMIS persons at participating community agencies will be able to see the following data elements of all client records:

•First Name	•Veteran Status
•Last Name	•Gender
•Date of Birth	•Social Security Number (required for specific services)

Please read the following statements and consult with your agency staff if you have any questions:

I UNDERSTAND THAT:
- I will not be denied services if I decline to share my data beyond the minimum requirements.
- The release of my information does not guarantee that I will receive assistance.
- The partner agencies will share my basic identifying information (Name, DOB, Veteran Status, Gender, SSN) in order to improve service delivery and reduce duplicate data collection.
- Any details about the programs I participate in or information I share with agency staff will not be disclosed to any third party unless I give written authorization or it is otherwise required by law. We must still report some information because our federal, state or funder requirements.
- This authorization will remain in effect for 7 years unless I revoke it in writing by signing a written statement or Revocation form.
- I understand that I may cancel my consent to data sharing at any time. However, doing so will not change information that has already been given out or actions already taken. Revocation will be effective as of that date.
- I have the right to see my HMIS/CMIS record, ask for changes, and to have a copy of my record from this agency upon written request.
- I have the right to file a complaint if I feel I have been harmed in some way by the use of HMIS/CMIS.
- I have the right to receive a copy of the HMIS/CMIS Notice to Clients of Uses and Disclosures.

Maintaining the privacy and safety of those using our services is very important to us. Your record will only be shared if you give us permission to do so. There may be risks and/or benefits for you to consider before you decide whether or not to consent to the release of information.

By writing your initials below, you agree to share the following level of information for yourself and all household members listed below with other Northwest Social Service Connections' HMIS/CMIS partner agencies:

_____ 1) In addition to the minimum required data elements (Name, DOB, Gender, Veteran Status, SSN), **I agree to share** additional demographic information (including Race and Ethnicity), program enrollment and exit information, information about the nature of my situation, services and referals I receive, and contact information via the Northwest Social Service Connections' HMIS/CMIS with other Northwest Social Service Connections' HMIS/CMIS partner agencies.

_____ 2) Beyond the minimum required data elements (Name, DOB Gender, Veteran Status, SSN), **I DO NOT agree to share** any additional information through the Northwest Social Service Connections' HMIS/CMIS with other Northwest Social Service Connections' HMIS/CMIS partner agencies.

Please list the names and dates of birth of all household members participating in services:

_____
_____
_____
_____
_____
_____

_____   _____   _____
Client/Parent or Guardian Name (please print)   Client/Parent or Guardian Signature   Date

_____   _____   _____
Agency Personnel Name (please print)   Agency Personnel Signature   Date

☐   Secure Electronic File: HMIS ROI

Community Connect - Occupied Beds Summary
10/15/21

Emergency Shelter

Provider	Max HH (worksheet)	HMIS Households	Max Persons (worksheet)	HMIS Persons
BGA - Safe Place Youth Shelter (BCP) (WC)(2533)	5	6	5	6
CAO - Family Shelter - ESG(2385)	5	5	20	17
Family Promise of GWC (WC) - Beaverton(8116)	10	11	27	30
Family Promise of GWC (WC) - Hillsboro(8115)	10	6	27	25
Family Promise TV Shelter (WC)(7010)	15	15	65	40
GG - Bridge Shelter - Econolodge (WC)(8136)	60	42	79	43
GNC - Bridge Shelter - Aloha Inn (WC)(8211)	22	20	25	23
Good Neighbor Center (GNC - WC) (OHCS ESG) (SHAP)(2285)	9	9	36	27
SWS-PHC Forest Grove Winter Shelter(7767)	38	18	40	18

Homelessness Prevention (HUD)

Provider	Max HH (worksheet)	HMIS Households	Max Persons (worksheet)	HMIS Persons
CAO - State - Rent Assistance HSP Prevention(3962)	15	1	48	2

Permanent Supportive Housing

Provider	Max HH (worksheet)	HMIS Households	Max Persons (worksheet)	HMIS Persons
CAO - SPC WashCo(5136)	3	1	11	6
Housing Independence SPC WashCo(5269)	6	6	7	7
HUD VASH Vouchers Washington County(8233)	10	2	20	3
LifeWorks Northwest - Washington/Multnomah County SPC Program - SP(2282)	59	58	81	81
New Narrative Clover Court(7275)	6	6	6	6
New Narrative Graduated Independent Living (HGILP)(2651)	7	5	7	5
New Narrative Smith House(7274)	6	4	6	4
New Narrative SPC WashCo(2549)	10	9	10	9
ODCC - Shelter Plus Care Vouchers (SPC)(2439)	18	17	26	26
Sequoia Mental Health - SPC(2286)	63	54	70	62
Sequoia MH - Tri-Haven(2513)	15	12	15	12
Tom Brewer Recovery House(2816)	20	13	20	13
Tom Brewer SPC(5580)	2	1	2	1
xxWashCo - VASH (SP)(3035)	167	163	340	301

Community Connect - Occupied Beds Summary

Rapid Re-Housing

Provider	Max HH (worksheet)	HMIS Households	Max Persons (worksheet)	HMIS Persons
CAO - CoC RRH Families(4726)	30	26	90	90
CAO - County - OCD-ESG COVID19 RRH(7504)	45	42	125	105
CAO - County - OCD-ESG Rehousing(3949)	35	24	105	62
CAO - SSVF Rehousing(3928)	20	14	40	22
GNC - Housing Stabilization Program (WC)(2402)	12	3	30	11
New Narrative Reentry Housing Program(7554)	20	22	24	25

Transitional Housing

Provider	Max HH (worksheet)	HMIS Households	Max Persons (worksheet)	HMIS Persons
BGA - Transitional Living Program (WC)(2534)	7	7	10	10
Salvation Army Veterans & Family Center(4101)	60	45	86	76

Prompt Information	
Report:	WashCo - Community Connect - Occupied Beds Summary v04.1
Run By:	AngelaMu
Report effective:	Oct 15, 2021 7:14:24 AM
Provider Group:	WashCo Community Connect Reporting(1412)

VA Department of Veterans Affairs	**REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION**

Privacy Act and Paperwork Reduction Act Information: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA10P2 "Patient Medical Record - VA" and in accordance with the Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)

VA Portland Health Care System(VAPORHCS)
3710 US Veterans Hospital Rd, 97207

PATIENT NAME (Last, First, Middle Initial)

SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Washington County Continuum of Care: Salvation Army, Community Action, Luke-Dorf, LifeWorks, Sequoia Mental Health, Open Door, Washington County Housing, HomePlate

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

[ ] DRUG ABUSE   [ ] ALCOHOLISM OR ALCOHOL ABUSE   [ ] TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV)   [ ] SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

[ ] COPY OF HOSPITAL SUMMARY   [ ] COPY OF OUTPATIENT TREATMENT NOTE(S)   [X] OTHER (Specify)

Project Enrollment Form for data entry into Homeless Management Information System (HMIS) by Portland Housing Bureau as required by Housing and Urban Development (HUD)

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

For accurate data capture between city of Portland, HUD and the VA for services provided to Homeless Veterans in order in order for policy makers to plan appropriately for needed resources.

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____ (date supplied by patient); (3) under the following condition(s):

I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

DATE (mm/dd/yyyy)

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)

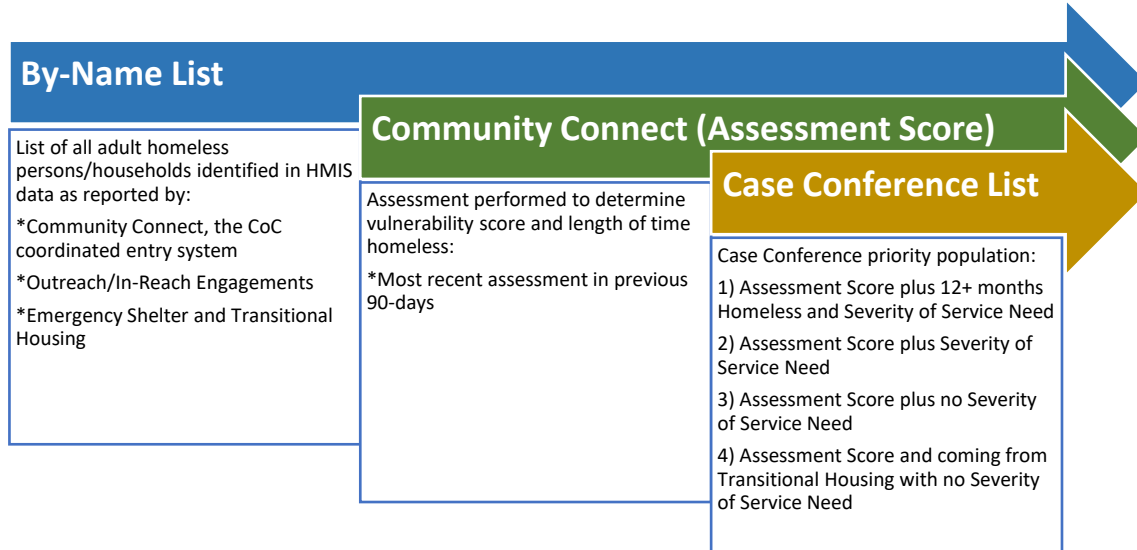### FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED

RELEASED BY

VA FORM
JUL 2013   **10-5345**

USE EXISTING STOCK OF VA FORM 10-5345, DATED MAY 2005.

1. PURPOSE

The purpose of this procedure is to outline the parameters of Case Conferencing for chronic[1] homeless persons on the By-Name Prioritization List (BNL) generated by the CoC coordinated entry system.

Visualizing the Case Conference process for chronically homeless persons.

By-Name List

List of all adult homeless persons/households identified in HMIS data as reported by:

*Community Connect, the CoC coordinated entry system

*Outreach/In-Reach Engagements

*Emergency Shelter and Transitional Housing

Community Connect (Assessment Score)

Assessment performed to determine vulnerability score and length of time homeless:

*Most recent assessment in previous 90-days

Case Conference List

Case Conference priority population:

1) Assessment Score plus 12+ months Homeless and Severity of Service Need

2) Assessment Score plus Severity of Service Need

3) Assessment Score plus no Severity of Service Need

4) Assessment Score and coming from Transitional Housing with no Severity of Service Need

2. AUTHORITY

The By-Name Case Conference Team is a subcommittee authorized by the CoC Board under the umbrella work of the Community Connect Oversight Committee, and all policies produced by the Case Conference Team must be approved by the CoC, commonly known as the Housing & Supportive Services Network (HSSN).
https://www.co.washington.or.us/Housing/EndHomelessness/hssn.cfm

3. REPRESENTATION

The following provides an overview of the appropriate organizations and program types that will be represented on the committee:
- Street Outreach/Housing Navigator
- Emergency Shelter
- Transitional Housing
- Permanent Housing Providers; e.g. All PSH and RRH Property Management, Housing Authority, and other Housing/Landlords
- Services Providers; e.g. nonprofit and public service providers
- Veteran Affairs By-Name List Liaison
- Families By-Name List Liaison
- CoC Coordinated Entry Coordinator
- CoC Lead; e.g. Case Conference BNL Prioritization Coordinator, HMIS Lead

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[1] Chronic Homeless: A person with a diagnosed disability that is staying in a place not meant for human habitation, in an emergency shelter, or a safe haven for the last 12 months continuously or having experienced four or more episodes in the last three years totaling at least 12 months homelessness.

- Built for Zero Cohort Leadership Team: Annette Evans and Mjere Simantel, Washington County; Katherine Galian, Community Action; John Trinh and Lindsay Downen, Luke-Dorf, Inc.; and Carol Herron, St. Anthony Severe Weather Shelter and Just Compassion EWC.

4. **RESPONSIBILITIES**

Agency leadership convened on December 4, 2019 and approved the following commitments:

1. Agency directors and supervisors will commit outreach, clinical, case management, and housing staff that will take responsibility to:
   a. Engage with chronic homeless individuals and families to collect their PII (personal identifying information) in HMIS during outreach and Community Connect assessments.
   b. Attend 2 case conferencing sessions (est. 1 ½ hours each) per month, with 75%+ attendance rate annually.
   c. Commit agency resources and staffing to assist chronically homeless persons to achieve housing move-in (placement) with appropriate services, as needed.

2. Washington County and the *Built for Zero* Cohort Leadership Team will commit to:
   a. Use HMIS to create a By-Name List prior to each case conference meeting session.
   b. Consider all comments and communications in developing and updating the policy and process that will be an Appendix to the Community Connect policy approved by the HSSN.
   c. Review monthly progress in reducing chronic homelessness and commit to adjusting the process to be more effective through continual system-level process improvement – we will not do something that is not working.
   d. Ending chronic homelessness followed by expansion to new target populations not currently prioritized through By-Name List Case Conferencing (e.g. youth) and drive toward ending all homelessness in Washington County.
   e. Report to Community Solutions on the Washington County CoC implementation of *Built for Zero* outcomes.

5. **ROLES OF THE BY-NAME CASE CONFERENCE TEAM MEMBERS**

Case Conference BNL Prioritization Coordinator
Responsibilities:

- Schedule and manage Case Conference Team meetings.
- Coordinate with CoC.
- Develop Training.

HMIS Lead
Responsibilities:

- Extrapolate data and prepare By-Name List 10-days prior to Case Conference Team meeting.
- Ensure HMIS data quality.
- Prepare monthly reports on "Inflow" and "Outflow" to be submitted by the 15th of each month to Community Solutions, the nonprofit agency leading the Built For Zero initiative Develop Training.

Outreach/Navigators
Responsibilities:

- Work with homeless individual to complete CoC coordinated entry assessment.
- Download the Case Conference BNL from HMIS and review client information prior to the Case Conference Team meeting, come prepared to support the needs of homeless persons on the list.
- Attend Case Conference meetings.

- Prepare 3rd party written documentation for all persons on the list that your agency may have had contact with.
- Provide a "warm hand-off" to the housing resource.

Case Conference Members
Responsibilities:

- Download the Case Conference BNL from HMIS and review client information prior to the Case Conference Team meeting, come prepared to support the needs of homeless persons on the list.
- Attend Case Conferencing meetings.
- Navigate clients that are in your shelter or that you have contact with.
- Be open to accepting referrals of non-clients into your program and assist the homeless individual to address housing barriers.
- Assist the homeless individual to complete housing subsidy applications and rental unit applications and prepare 3rd party written documentation for all persons on the list that your agency may have had contact with.

6. **CASE CONFERENCE TEAM MEETING PREPARATION**
   Prior to the Case Conference Team Meeting:
   1. Washington County HMIS Lead will post the most current By-Name Case Conferencing List in HMIS at least 10 calendar days prior to the Meeting.
   2. Outreach/Housing Navigators/Member Case Managers attempt contact with the household during the next seven (7) business days.
   3. All reasonable attempts[2] at contacts are recorded in HMIS.
   4. If the household is unable to be located the Outreach/Navigator moves to the next household on the list.
   5. The household must accept or decline navigation assistance immediately.
      a. The household's decision to decline assistance is documented in HMIS.
      b. The household must submit a written statement declining service.
      c. The household is removed from the active to denied services status. The signed statement and all communication regarding the declination of services is recorded in HMIS.
   6. Households that reach a 90-day anniversary from initial assessment date and are not currently housed will be reassessed.
      a. The assigned Navigator or Case Manager is responsible for assisting the client to complete the new assessment.
      b. If the household does not have an assigned Navigator or Case Manager a Community Connect Assessor will make contact or request the assistance of an outreach team to complete a new assessment.

No Contact/Inactive Policy
Households that cannot be located within 7 business days and have no record of services in the previous 90 days will be removed from the active status to inactive. This will be documented at the Case Conference Team meeting.
   1. Navigators and Case Managers will make every attempt possible to contact households to provide navigation services and connect to referrals for housing. This includes but is not limited to:
      a. Requesting search assistance of the outreach teams;

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[2] Reasonable Attempts: A reasonable attempt to assist a client is factual and may differ from person to person depending on their situation, but no less than six (6) documented conversations need to occur offering solutions/housing/actions which the homeless individual rejects.

       b. Contacting the current or most recent shelters the household has received services from (per documentation in HMIS);

       c. Phone contact; and

       d. Posting messages on community boards located at service providers frequented by the general population (i.e. Just Compassion of East Washington County, Open Door Counseling Center, Community Café in Tigard, Faith Café in Beaverton, Severe Weather Shelters while in operation November through March)

2. The date, time, and outcome of each attempt will be recorded in the Case Conference Team meeting notes.

3. After 7 standard business days of searching the Navigator or Case Manager will move to the next household on the list. Households that were not located and have not received any services within the previous 90 days will be moved from an active status to inactive. Households that contact the system once moved to the inactive list will be immediately reinstated to active. Assessors will make contact or request the assistance of an outreach team to complete an updated assessment.

7. **CASE CONFERENCE TEAM MEETING STRUCTURE**

   Case Conferencing Guiding Principles
   - Present basic client information including: Gender, Age, Race/Ethnicity, Location, Length of time of homelessness, Income, and Barriers to housing.
   - Solicit input from participating providers to address barriers and immediate needs.
   - Identify a concrete housing plan for each individual/household presented.
   - Provide updates on clients discussed at previous meetings to track success and gaps.
   - **Do not** share, release or publish names or other client identifiers without a Release of Information – the Case Conference data will reference the HMIS Client Identification Number that provides Personal Identifying Information in compliance with the Client Release of Information and Privacy and Security laws.
   - **Do not** present personal information that does not directly affect the housing and/or stabilization plan.
   - **Do not** coordinate a housing plan outside of the coordinated entry system.
   - **Do not** conclude a case without addressing solutions to housing barriers.

   Meeting Structure
   1. All members will sign-in to the Case Conference Team meeting and agree to privacy and security requirements of information shared about homeless individuals on the list.
   2. Case conference 10 to 15 most vulnerable persons/households based on the most recent CoC coordinated entry assessment score, with assessments older than 12 months requiring an update.
      a. All individuals will be prioritized using the CoC adopted prioritization outlined in CoC "Community Connect" Coordinated Entry Policy No. 578.7a-OR506CoC https://www.co.washington.or.us/Housing/EndHomelessness/upload/578-7a-OR506CoC_Community-Connect-Policy-and-Written-Standard.pdf
      b. Assistance is prioritized based on highest acuity and length of homelessness to ensure that people who are the most vulnerable receive housing.
   3. Ensure all individuals will be matched to a housing navigator/case manager.
      a. Questions to discuss:
         i. What action has been taken to house this individual? Where is the person currently staying? How do you know?
         ii. Define the largest obstacle the individual is facing this week. What is their case management need?

        iii.   Are they a registered sex offender in any state?
        iv.   What income do they have? Do they have any garnishments? If yes, describe.
        v.   What is our next step in housing the individual?

4. Ensure all individuals have a suggested housing resource.
   a. Prioritization using CoC adopted priorities established in CoC Policy No. 578.7a-OR506CoC to include on length of homelessness and service needs; e.g. severity of health and behavioral health challenges, frequent interactions with institutions of care, difficulty engaging.
   b. Prioritization using response to 7.3.a in this document.
   c. If an individual requires more intensive services than the housing program can offer, she/he is referred to appropriate services/housing options through regional care coordination or other opportunities.
5. Determine individuals who are document ready and able to be referred to housing resource.
6. Set target housing move-in date.
7. Team Member commitments will be recorded on behalf of each individual to include next steps and a date by which it will be completed.
8. Review each individual and family "length of time" on the by-name list; review monthly "inflow" and "outflow" data for submission to Community Solutions.

8. **AFTER CASE CONFERENCE TEAM MEETING**
   Action Oriented Follow-up
   1. All written communications regarding the homeless individual will use the HMIS Client ID instead of the first and last names for privacy and security.
   2. Members will complete steps provided by the housing plan established at the Case Conference Team Meeting.

9. **PRIORITIZATION FOR RAPID REHOUSING**
   Priority for Rapid Rehousing (RRH)
   1. Chronically homeless individuals or families with medium-level case management and no severity of service needs based on the CoC coordinated entry assessment – Community Connect – resulting in a 35 to 75 point score (see Appendix 10.9) may benefit from rapid rehousing, as compared to permanent supportive housing.
      a. Questions to ask:
         i. Is the individual interested in rapid rehousing?
         ii. Will the individual have the ability to meet with a housing specialist and search for housing?
         iii. If the individual does not have income, are they willing to look for employment? Is the individual willing to establish a plan to find employment?
         iv. If needed, does the individual have a payee or are they willing to get one?
   2. Does the individual have the needed documents for housing? Once the person is identified as document ready, they are matched to RRH housing resources.

10. **CASE CONFERENCE TOOL**
   1. The By-Name List tool in HMIS combines data from Outreach, Shelter and Coordinated Entry System into one list that reports all persons meeting the homeless status in the CoC.

   2. All persons are provided a Community Connect assessment that provides a vulnerability score as defined in CoC Community Connect, Policy No. 578.7a-OR506CoC Section 8: Referral and Housing Placement – Prioritizing Populations.

3. The Case Conferencing prioritization list be extrapolated from HMIS and include those persons active in the system during the last 90-days ranked in order by the highest vulnerability score to the lowest vulnerability score.

11. MEASURE EFFECTIVENESS

1. Measure the effectiveness of the meetings.

    a. Questions to Ask:

    i.   How many clients on the list have a clear next step documented?
    ii. How many clients have a housing plan that includes a target move-in date?
    iii. Percentage of the list with a target move-in date within the next month.
    iv. How many clients moved in by their target move-in date within the past month?

2. Utilize the By-Name List tool to report "Inflow" and "Outflow" data each month.