Connecticut Coordinated Access Network
Policies and Procedures Manual

Balance of State CoC and Opening Doors Fairfield County

Updated 1/11/21

Version History

- Draft for Public Input: May 2019
- Revised: July 16, 2019 for approval by ODFC and CT BOS
- Revised: January 11, 2021 for approval by ODFC and CT BOS

Table of Contents

I. Purpose of Manual

This manual is a system guide for Connecticut (CT) Coordinated Access Network (CAN) member agencies and their staff in the seven regions: Central CT CAN, Fairfield County CAN, Greater Hartford CAN, Greater New Haven CAN, Meriden, Middlesex, Wallingford CAN, Eastern CT CAN, Waterbury-Litchfield CAN, as well as other individuals and programs involved in implementing the CAN strategy of the CT Balance of State Continuum of Care (CT BOS CoC) and Opening Doors Fairfield County CoC (ODFC CoC). It provides a description of the system and each component, the relationships between components, and the general principles that guide Connecticut's Coordinated Access Networks. The manual also includes information about the suggested best practices for service delivery and how member agencies should remain accountable to the participants they serve.

II. CT Coordinated Access Networks

A. General Overview

In 2014, the state of Connecticut initiated a process to improve the delivery of housing and crisis response services and assistance to individual adults and families who are experiencing homelessness or at imminent risk of homelessness by redesigning the community's process for access, assessment, and referrals within its homeless assistance system.

Through the development of Coordinated Access Networks (CANs) that cover the entire state, Connecticut instituted a process to ensure consistent and uniform access, assessment, prioritization, and referral processes to determine the most appropriate response to each individual's and family's immediate housing needs. This new system of Coordinated Access is not only mandated by US Department of Housing and Urban Development (HUD) and many other funders, but is recognized nationally as a best practice which can improve efficiency within systems, provide clarity for individuals and families experiencing homelessness, and can help serve more people more quickly and efficiently with assistance targeted to address their housing needs.

The CT Coordinated Access Network Policies and Procedures Manual provides guidance and direction for the day-to-day operation, management, oversight, and evaluation of Connecticut's Homeless Response System. This manual will be updated and revised on an ongoing basis as the actual application and practical experience of coordinated access principles are refined and improved.

B. Purpose and Background

In 2009, Congress passed the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act. The HEARTH Act amended and reauthorized the McKinney-Vento Homelessness Assistance Act. Among other changes, the Act changed the focus of performance from individual program outcomes to how all programs work as a system, to achieve results for an entire community.

As part of the new HEARTH Act requirements, the U.S. Interagency Council on Homelessness (USICH) and its 19 member agencies developed the first comprehensive strategy to prevent and end homelessness, entitled *Opening Doors.* In alignment with the federal plan, the State of Connecticut developed Opening Doors – Connecticut, a framework to prevent and end homelessness in Connecticut.

In 2018 USICH updated the federal strategy with a new title of "Home, Together". This new plan covers fiscal years 2018 – 2022. This new plan has increased areas of focus including:

- Increasing Affordable Housing Opportunities
- Strengthening Prevention and Diversion Practices
- Creating Solutions for Unsheltered Homelessness
- Tailoring Strategies for Rural Communities
- Helping People Who Exit Homelessness to Find Employment Success
- Learning from the Expertise of People with Lived Experience

Under the requirements of the HEARTH Act, the state of Connecticut has implemented a Coordinated Access system. Coordinated Access is a powerful tool designed to ensure that persons experiencing homelessness and persons at risk of homelessness are matched, as quickly as possible, with the intervention that will most efficiently and effectively end their homelessness.

According to HUD guidance, key elements of Coordinated Access include:

- Access: ensures the entire geographic area of the state of Connecticut is covered and that service entry points are easily accessible and well-advertised.
- Assessment: standardizes information gathering on service needs, housing barriers, and vulnerabilities and strengths.
- Prioritization: reflects state-wide priorities based on severity of need, and establishes a priority rank for available housing and services, and;

- Referral: coordinates the connection of individuals to the appropriate and available housing and service intervention.

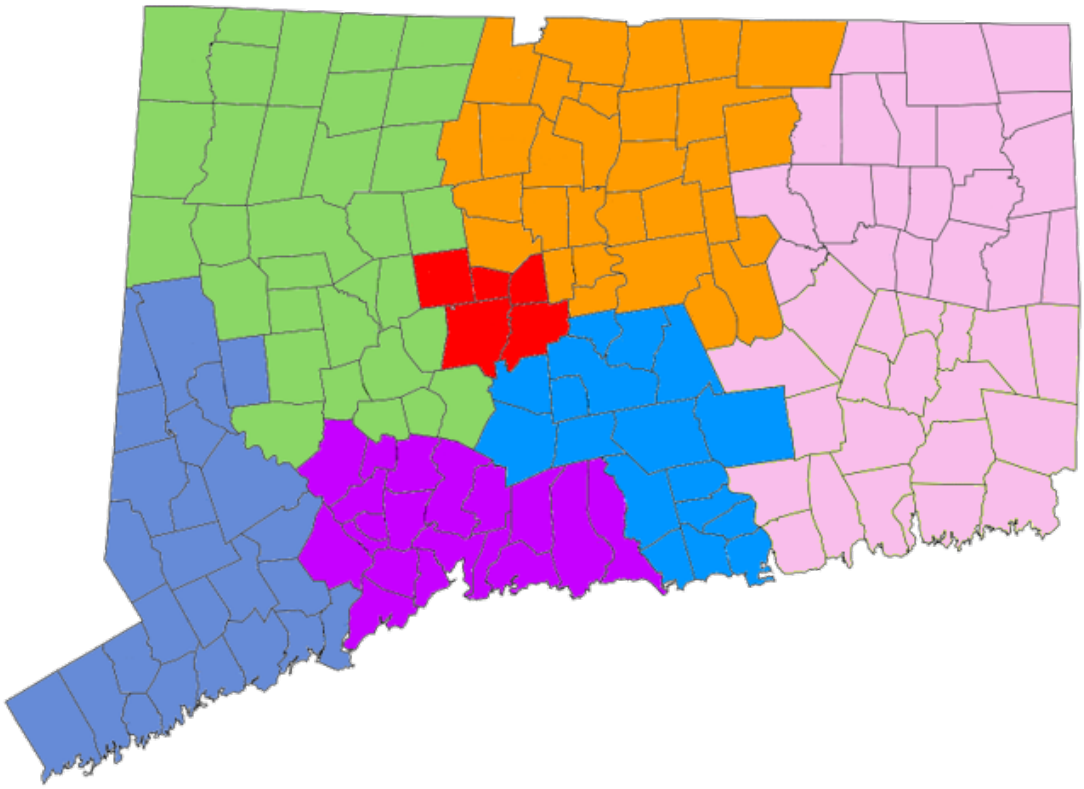
All projects serving people experiencing homelessness in Connecticut, including Emergency Shelter, Transitional Housing, Rapid Re-housing, Permanent Supportive Housing, must participate in coordinated access. This includes using the CANs common assessment/intake forms, following the CANs agreed upon referral process, and everything else as appropriate.

The CT BOS CoC and ODFC CoC work collaboratively with US Department of Housing and Urban Development, CT Field Office (HUD CT) and Emergency Solutions Grant (ESG) in each CAN region to ensure that the entry process for coordinated screening, assessment, and referrals for ESG projects are consistent with the written standards for administering ESG assistance.

The Opening Doors CT Statewide CAN Leadership Committee oversees the implementation of CANs and the homeless response system for the State of CT. This committee coordinates efforts with the CT BOS Steering Committee and the ODFC Executive Committee around policy and procedure development for Coordinated Access in CT.

The CT Coordinated Access Network policies contained herein apply to Permanent Supportive Housing (PSH), Emergency Shelter (ES), Transitional Housing (TH), and Rapid Rehousing (RRH) programs funded with HUD's CoC, State DOH and DMHAS funds, and ESG Funds in the CT BOS CoC and ODFC CoC jurisdictions. The aim is to set statewide standards but allow for CAN level or sub-CoC level customization and tailoring to local circumstances.

C. CT Coordinated Access Networks Map



Central CAN
Berlin, Bristol, New Britain, Plainville, Southington

Fairfield County CAN
Bethel, Bridgeport, Bridgewater, Brookfield, Cos Cob, Danbury, Darien, Easton, Fairfield, Greenwich, Monroe, New Canaan, New Fairfield, New Milford, Newtown, Norwalk, Redding, Ridgefield, Roxbury, Sherman, Stamford, Stratford, Trumbull, Weston, Westport, Wilton

Greater Hartford CAN
Andover, Avon, Bloomfield, Bolton, Canton, East Granby, East Hartford, East Windsor, Ellington, Enfield, Farmington, Glastonbury, Granby, Hartford, Hebron, Manchester, Marlborough, Newington, Rockville, Rocky Hill, Simsbury, Somers, South Windsor, Stafford, Suffield, Tolland, Vernon, West Hartford, Wethersfield, Windsor, Windsor Locks

Greater New Haven CAN
Ansonia, Beacon Falls, Bethany, Branford, Derby, East Haven, Guilford, Hamden, Madison, Milford, New Haven, North Branford, North Haven, Orange, Oxford, Seymour, Shelton, West Haven, Woodbridge

Waterbury/Litchfield County CAN
Barkhamsted, Bethlehem, Burlington, Canaan, Cheshire, Colebrook, Cornwall, Goshen, Hartland, Harwinton, Kent, Litchfield, Middlebury, Morris, Naugatuck, New Hartford, Norfolk, North Canaan, Plymouth, Prospect, Salisbury, Sharon, Southbury, Thomaston, Torrington, Warren, Washington, Waterbury, Watertown, Winchester, Winsted, Wolcott, Woodbury

Eastern CAN
Ashford, Bozrah, Brooklyn, Canterbury, Chaplin, Colchester, Columbia, Coventry, Danielson, Eastford, East Lyme, Franklin, Griswold, Groton, Hampton, Killingly, Lebanon, Ledyard, Lisbon, Lyme, Mansfield, Montville, Mystic, New London, North Stonington, Norwich, Old Lyme, Plainfield, Pomfret, Preston, Putnam, Salem, Scotland, Sprague, Sterling, Stonington, Thompson, Union, Voluntown, Waterford, Willimantic, Willington, Windham, Woodstock

Middlesex Meriden Wallingford CAN
Chester, Clinton, Cromwell, Deep River, Durham, East Haddam, East Hampton, Essex, Haddam, Killingworth, Meriden, Middlefield, Middletown, Old Saybrook, Portland, Wallingford, Westbrook

D. Guiding Principles of CT Coordinated Access Networks[1]

The CT BOS CoC has defined the following coordinated access guiding principles:

- Promotes collaboration among providers
- Honors client choice re: geography and services needed
- Incorporates provider choice in enrollment decisions
- Establishes standard, consistent eligibility criteria and priorities
- Eligibility requirements limited to those required by funding sources (and no additional requirements that are not required by funders) in order to accommodate providing services and resources to as many people as possible
- Ensures quality housing and services are provided
- Ensures clear and easy access for consumers
- Improves efficiency, communication, and knowledge of resources
- Is cost effective and focuses on cost effective solutions to end homelessness
- Uses systemic "Rapid Exit to Housing" approach
- Streamlines processing
- Accountability -The process must be transparent and consistent
- Leverage CT Homeless Management Information System (CT HMIS) resources and the use of "real time" data whenever possible
- Prioritizes Enrollment based on need
- Goal: a system that is clear and creates ease of access for clients
- All data collected is relevant to the process
- Staff are trained and competent in assessment

The ODFC CoC has defined the following coordinated access guiding principles[2]:

- Collective Impact
- Housing First
- Progressive Engagement

E. CAN Design and Purpose

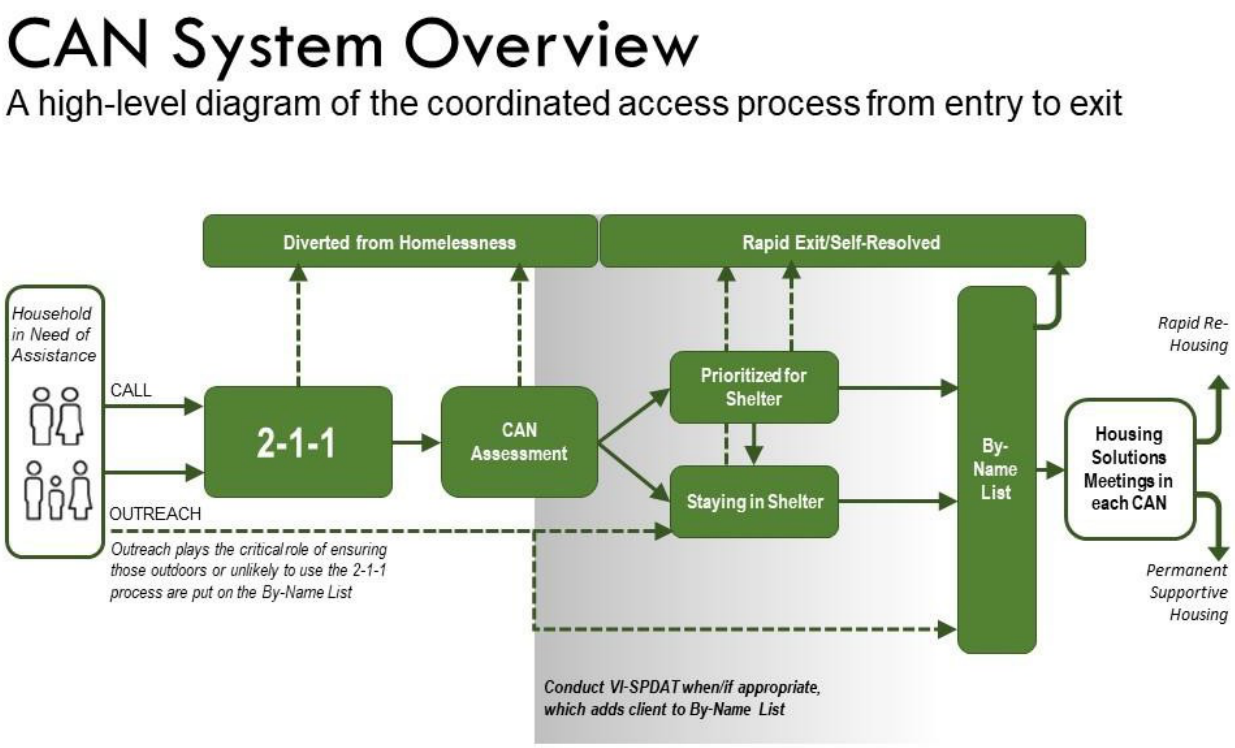
- Allow any household who needs assistance to know where to go to get that assistance, to be assessed in a standard and consistent way, and to connect with the housing/services that best meet their needs;

- Ensure clarity, transparency, consistency and accountability for clients experiencing homelessness, referral sources and homeless service providers throughout the assessment and referral process;

[1] CT BOS Policies
[2] FFC CAN Manual

- Facilitate exits from homelessness to stable housing in the most rapid manner possible given available resources;
- Ensure that clients gain access as efficiently and effectively as possible to the type of intervention most appropriate to their immediate and long-term housing needs;
- Ensure that people who have been homeless the longest and/or are the most vulnerable have priority access to permanent housing and support services resources;
- Institute consistent and uniform assessment and referral processes to determine and secure the most appropriate response to each individual or family's immediate and long-term housing needs;
- Prioritize quality assurance to ensure consistency in tools, standards, staff training, and opportunity for people experiencing (or at-risk of) homelessness throughout Connecticut and ensure staff who interact with the CAN process receive regular training and supervision. Each provider must ensure that employees have access to ongoing training and information related to the CT CAN system, including cultural competency and trauma informed care.

F. CT CAN System Overview Flow Chart



G. Housing First Principles[3]

Housing First is a programmatic and systems approach that centers on providing persons experiencing homelessness with housing quickly and *then* providing services as needed using a low barrier approach that emphasizes community integration, stable tenancy, recovery and individual choice.

1. **Low barrier approach to entry**

   Housing First offers individuals and families experiencing homelessness immediate access to permanent supportive housing without unnecessary prerequisites. For example:

   a. Admission/tenant screening and selection practices do not require abstinence from substances, completion of or compliance with treatment, or participation in services.

   b. Applicants are not rejected on the basis of poor or lack of credit or income, poor or

[3] CT BOS Policies, FFC Manual

lack of rental history, minor criminal convictions, or other factors that might indicate a lack of "housing readiness."

c. Blanket exclusionary criteria based on more serious criminal convictions are not applied, though programs may consider such convictions on a case by case basis as necessary to ensure the safety of other residents and staff.
d. Generally, only those admission criteria that are required by funders are applied, though programs may also consider additional criteria on a case by case basis as necessary to ensure the safety of tenants and staff. Application of such additional criteria should be rare, and may include, for example, denial of an applicant who is a high risk registered sex offender by a project serving children, or denial of an applicant who has a history of domestic violence involving a current participant.

2. Community integration and recovery

Housing is integrated into the community and tenants have ample opportunity and are supported to form connections outside of the project.

a. Housing is located in neighborhoods that are accessible to community resources and services such as schools, libraries, houses of worship, grocery stores, laundromats, doctors, dentists, parks, and other recreation facilities.
b. Efforts are made to make the housing look and feel similar to other types of housing in the community and to avoid distinguishing the housing as a program that serves people with special needs.

H. Fair Housing, Nondiscrimination and Equal Access

The CT Coordinated Access Networks requires recipients of Federal and State funds to comply with applicable civil rights and fair housing laws and requirements. Recipients and sub-recipients of HUD CoC Program and ESG Program-funded projects must comply with the nondiscrimination and equal opportunity provisions of Federal civil rights laws, including the following:

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

and operate places of public accommodation, which include shelters, social service establishments, and other public accommodations providing housing, from discriminating on the basis of disability.

6. CT CANs ensure that CoC resources are eligible to all individuals regardless of race, color, national origin, religion, sex, age, familial status, disability, actual or perceived sexual orientation, gender identity, or marital status.
7. CT CANs ensure that all people in different populations and subpopulations throughout the geographic area, including people experiencing chronic homelessness, veterans, families with children, youth, and survivors of domestic violence have fair and equal access to the coordinated access process, regardless of the location or method by which they access the crisis response system.
8. All providers in CT CANs document steps taken to ensure effective communication with individuals with disabilities. Access points must be accessible to individuals with disabilities, including physical locations for individuals who use wheelchairs, as well as people in Connecticut who are least likely to access homeless assistance.
9. Providing reasonable accommodations (i.e. changes, exceptions, or adjustments to a rule, policy, practice, or service that may be necessary for a person with a disability to have an equal opportunity to use and enjoy a dwelling), to include public and common use spaces. This may include allowing a service animal into shelter, arranging an inter-shelter move to accommodate an individual in a wheelchair, allowing nursing aid to come, providing private bathroom/room/space/eating, or access to a bottom bunk bed.

All shelter providers in the CT Coordinated Access System are expected to follow HUD's "Equal Access in Accordance with an Individual's Gender Identity in Community Planning and Development Programs" rule which requires equal access to individuals in accordance with their gender identity and access to any family unit with minor children as they present, no matter their gender, age, or family composition. It is prohibited for any homeless facility to segregate or isolate transgender individuals solely based on their gender identity. It is also prohibited under the Fair Housing Act for any landlord or housing provider to discriminate against LGBTQ persons because of their real or perceived gender identity or any other reason that constitutes sex-based discrimination.

III. Access

CT CANs provide individuals and families facing homelessness with one centralized point of entry into the homeless response system. The intake process meets all the state and federal guidelines related to determining eligibility, collecting data, explaining program options and responding to grievances[4].The CT CANs cover and are accessible to individuals, families, and youth experiencing homelessness throughout the entire geographic area of the state of Connecticut.

[4] CT CAN Principles, Goals, and Objectives

CT CANs work to ensure that they provide rapid access to initial intake appointments, and that the initial intake process is clearly documented and consistently executed. Access to services through the CT CAN process is sensitive to the special needs of domestic violence victims, adults with disabilities, children with special needs, and youth. For those who are reluctant to engage with services or to seek assistance, each CAN has outreach specialists who work to proactively outreach and engage those living outdoors or other places not fit for human habitation. Each CAN has also developed access sites for youth, including meeting the youth at a location of their choice in the community.

A. Single Point of Entry

CT CANs uses 2-1-1 as the universal "front door" to homelessness assistance. 2-1-1 operates every hour of every day, and as such clients can call at any time to schedule a coordinated entry assessment. Entry into the homeless service system should be exclusively through CAN and providers should not allow entry into programs through any other referral system or other "side doors."[5]

The two exceptions are minors may receive services from the U.S. Department of Health and Human Services' funded Runaway and Homeless Youth programs and Veterans may receive services from U.S. Department of Veterans Affairs funded homeless and at-risk of homelessness programs without first going through the 2-1-1 CAN process.

When a household (individual or family) calls 2-1-1 and is experiencing a housing crisis, 2-1-1 works with the individual to help identify any resources that might be able to resolve their crisis immediately. If the individual's crisis cannot be resolved with resources available through 2-1-1 (including utility assistance, emergency food assistance, and similar), 2-1-1 creates a CAN appointment for the individual with the appropriate CAN.

Because some homeless persons, in particular those with very high levels of need, may not be aware of 2-1-1 or may be reluctant to initially access services, all CANs have DMHAS state, and locally funded Street Outreach teams that work directly in the community to identify homeless individuals, families, and youth and assist them to engage in services.

All households currently experiencing homelessness or housing instability who are seeking housing resources should be directed by service providers to 2-1-1. If an individual or family arrives at any agency or provider looking for homeless services or resources, staff members should do the following:

1. Direct the household to contact 2-1-1 (option 3, then option 1) in order to access housing resources and other community resources.
2. Staff should determine if the household has access to a telephone and if the household does not, staff should provide them with an appropriate place to make the phone call. This location should provide a space that respects their privacy and preserves

[5] FFC Manual

confidentiality.

3. If the client does not appear capable of making the phone call independently, staff should facilitate the call to 2-1-1 and any subsequent communication with the client.
4. If household has presented at a shelter and temporary provisions can be made, shelter staff should assist the household in calling 2-1-1 and obtain an appointment for the following business day. The household should not be given a permanent shelter bed/unit until the appointment has been completed.

B. 2-1-1 Contact Specialists

When an individual who is homeless or experiencing housing instability contacts 2-1-1, Contact Specialists at 2-1-1 will:

1. Perform an initial screening to assess the household's current situation and needs. This should include an assessment for family safety/domestic violence and unaccompanied youth status.
2. Make referrals as needed to help individuals, families, and youth avoid homelessness and address any emergency safety issues. Provide all appropriate and available resources to connect individuals and families with services and financial assistance to help divert them from entering the homelessness response system.
3. Determine if the person has been previously screened or is a new caller. If new, get oral consent to perform an initial screening and to enter data into the CT Homeless Management Information System (HMIS).
4. Schedule next available CAN Appointment with one of the designated providers in the community where the person resides, or used to reside, using the protocol provided to 2-1-1 by each Coordinated Access Network. (Include 2-1-1 CAN protocol doc).
5. When closing out the call, the Housing Contact Specialist must explain the purpose and intent of the CAN Appointment is to continue the problem-solving process more in depth and in person. Emergency Shelter bed(s) may not be immediately available.
6. Enter a case note into CT Homeless Management Information System (CT HMIS) with details about options explored on the call and next steps.
7. Take reasonable steps to ensure that the needs of minority, ethnic, and groups with Limited English Proficiency (LEP) are served through the single point of entry process.

C. CAN Appointment Protocol

Each CAN has developed community-level appointment schedules in accordance with the needs of the members in the community and the availability of the providers that serve them.

The length of each time block and the number of CAN appointments that can be accommodated in each block are established by each individual centralized intake location and this information is furnished to 2-1-1.

Callers scheduled for CAN appointments are given information about the time, location, and purpose of the appointment and are recommended to bring with them any documentation that

they have including birth certificates, social security cards, photo IDs, income documentation, if applicable. They are also asked to call back if they need to reschedule or need referrals to other community resources.

As is the case with the entire CT Coordinated Access Network system, the appointment schedule should consistently be re-evaluated and evolve according to the needs of the community. Contact Specialists should make efforts to ensure that a balance is maintained across appointment locations. While the system first and foremost must be responsive to client choice and ease of access, Contact Specialists should seek to refer in a fair manner that does not unreasonably overload some assessment locations. Staff from 2-1-1 and the Department of Housing meet regularly to review patterns in scheduling to determine if changes need to be made.

D. CT HMIS and Release of Information

All households referred to CAN appointment must be entered into CT HMIS by the 2-1-1 Contact Specialist. The Contact Specialist should explain the types of data to be collected to the household and receive a verbal consent for Release of Information. The Contact Specialist will create a project entry in the "Coordinated Access 211" project.

E. Immediate Need Protocol

Where necessary, CANs will facilitate initial assignment to emergency shelter (or other short term sheltering option) to address the immediate crisis[6]. Typically, households are not referred to shelter or added to a Regional Shelter Waitlist until an in-person CAN appointment is conducted and diversion is attempted.

However, in the event there is a significant amount of time between a household's point of contact with 2-1-1 and the next available CAN appointment, the system also works to be responsive to the immediate needs of households in crisis. Because some emergency shelters at times can provide temporary shelter for literally homeless households in crisis who are awaiting their appointment, some providers have requested the ability to speak directly with the household at the time of crisis. The purpose of this phone call is to determine whether or not temporary provisions can be made to shelter a household in crisis as they await their scheduled community appointment. 2-1-1 maintains the list of emergency shelters that can make temporary provisions in each community.

In order to make an immediate referral to emergency shelter, Contact Specialists should do the following:

1. Complete the initial screening and schedule a CAN Appointment as described above.

[6] CT CAN Principles, Objectives, Goals

2. Contact the appropriate Emergency Shelter or after hours emergency CAN contact directly to see if any temporary provisions can be made until the appointment. The appropriate shelter is determined based on population type and the geographic location of the client.
3. It is imperative that the provision of temporary shelter during crisis periods does not result in households bypassing the CAN (and/or other households on the Regional Shelter Waitlist) and receiving services by walking in or contacting providers directly.

F. Severe Cold Weather Alerts and Cold Weather Protocols

During the winter months CT CANs implement a severe weather protocol to ensure all those in need are sheltered during severe cold weather. 2-1-1 maintains records of each region's Cold Weather Protocols and makes referrals as appropriate from December to March.

G. Access for Vulnerable Populations

Special efforts are made in each CAN to engage people who are at risk of and experiencing homelessness who might encounter the greatest difficulty reaching an access point due to geography, physical or mental disability, or concerns about personal safety.

Individuals with disabilities are able to easily access the CAN system and have access to auxiliary aids and services necessary to ensure effective communication (e.g. Braille, audio, large type, assistive learning devices, and sign language interpreters). CAN policies document steps taken to ensure access points (if physical locations) are accessible to individuals with disabilities, including accessible physical locations for individuals who use wheel chairs.

1. Street Outreach

Connecticut is working towards having a comprehensive outreach system that allows for rapid response and implementation to identify, assess, and meet the needs of the unsheltered population. Outreach staff play a key role in engaging persons who are unsheltered or staying in places not meant for human habitation and those who are not capable of contacting 2-1-1 themselves to seek assistance. Outreach staff are trained to engage with people who often have been homeless for longer periods, may be reluctant to engage with services or to seek assistance. The main function of outreach is to provide supportive services that aim to assist individuals and families in being rehoused. This can be done by connecting the client to the CAN via 2-1-1, by conducting a CAN appointment in the field, or directly referring to shelter until a CAN appointment is able to be completed.

Outreach staff regularly visit areas where homeless people are likely to congregate[7]. They share information and work with others likely to interact with homeless individuals such as law enforcement, merchants and community members. Outreach Specialists often engage with individuals over a period of time in order to develop trusting relationships prior to an assessment or a service engagement. This may be accomplished in part by assisting homeless individuals residing on the streets to address immediate needs by offering items such as food, hygiene kits, blankets and clothing and linking them to emergency resources. Where possible, clients should be provided with mobile case management support and be linked to the larger homeless service system through the CANs.

In 2019 the CT CAN Leadership Committee plans to continue to work on expanding outreach coverage by exploring new technology to map unsheltered hot spots. Additionally, there are plans to convene soup kitchens and first responders to expand the coverage of connecting all households experiencing unsheltered homelessness to services and resources.

2. Accepting People from Other Public Systems of Care[8]

The McKinney-Vento Act, as amended by the HEARTH Act, stipulates that state and local governments have policies and protocols in place to ensure that publicly-funded institutions do not routinely discharge individuals into homelessness. The Reaching Home Campaign is working with mental health, foster care, correctional, public health system, and publicly funded institutions to ensure that all other discharge options have been exhausted before discharge into homelessness. Work is currently underway to ensure that other systems of care are regularly provided with information about how to best connect clients in need of resources through the proper channels, and are provided with training and technical assistance on best practice diversion strategies.

Several CANs have developed medical and psychiatric respite programs to ensure clients who are discharging from institutions have an appropriate level of support and are not discharged to the street or shelter.

3. Ensuring Families with Children are Not Denied Admission or Separated

To maintain family unity, shelters and housing providers funded by the HUD CoC or ESG to serve families are prohibited from denying admission to any family based on age or gender (e.g. admissions policies disallowing entry for adult males or boys over 15 are not permissible).

[7] FFC Manual
[8] BOS Policies

CT CANs recognize that household composition may change during the course of a homeless episode. (For example, a family may enter emergency shelter as a parent with two teenage children but the plan is to reunite in permanent housing with a younger child who is currently staying with a relative.) To the greatest extent possible, CT CANs are encouraged to make efforts to accommodate changes in family composition.

Participants in or applicants to any emergency shelter, transitional housing, rapid re-housing, or permanent supportive housing project have the right to decide for themselves who is a member of their family and to be served together as a family. A family may include adults and children or just adults of any age, disability, marital status, actual or perceived sexual orientation or gender identity. This requirement applies whether the family initially presented together upon admission or the family composition changed post admission. It is the intent to allow families to form and change composition during their participation in projects, unless prohibited by funding requirements or households' safety.

Projects may restrict changes to family composition in the following situations:

The Unit is not large enough to accommodate additional family members in accordance with applicable federal, state, and local standards (that CoC-funded programs are required to have at least one bedroom or living/sleeping room for each two persons and may not require children of the opposite sex, other than very young children, to occupy the same bedroom or living/sleeping room); and/or the services required to meet the needs of a new family member are not available; and/or housing the family together would present an imminent health and/or safety risk. Shelters are strongly encouraged to make reasonable accommodation for family composition.

When circumstances prevent a project from accommodating changes to family composition, projects should assist the family in accessing a different unit or work with their CAN and assist the family in accessing a different project that meets their needs and can accommodate them together as a family.

4. Domestic Violence Protocol[9]

The Coordinated Access System in CT:

Includes domestic violence service providers in the coordinated access systems in every community will:

- Domestic violence providers are engaged in all phases of the Coordinated Access process from planning through implementation and evaluation.
- Domestic violence providers are included in the day to day operations of the

[9] CT BOS Policies

Coordinated Access system, including daily identification and coordination of services for domestic violence survivors.

- Has safety assessment options for survivors of domestic violence and offers immediate referral to domestic violence services if needed;
- Provides an option for survivors to access the statewide network of domestic violence providers;
- Takes a trauma-informed approach;
    - Recognizes the prevalence of trauma and how it impacts people and responds by fully integrating knowledge about trauma into policies, procedures, practices, and settings.
    - Takes a thoughtful perspective on how assessment is completed and how many times survivors may be asked to tell their stories, the impact of these questions and the potential for re-traumatizing survivors in this process
- Screens for domestic violence in the initial steps of the coordinated access process; CT Coalition Against Domestic Violence
    - Screening questions for DV will be included in the CT HMIS Intake, that will indicate when referral to DV services may be needed
- Allows self-certification of homelessness for survivors of domestic violence (in accordance with federal law around eligibility for services that indicate that domestic violence survivors are considered homeless if they are actively fleeing)
- Provides for training of all coordinated access staff in the confidentiality and privacy rights of domestic violence survivors, included in the federal Violence Against Women Act (VAWA) and CT state law;
- Permits survivors and others to decline having their personal information entered into HMIS, and maintains confidentiality, without limiting their access to programs and services, in accordance with the Violence Against Women Act;
    - Ensures anonymous entry of domestic violence survivors into HMIS in order to meet funder data entry requirements with a protocol to be determined.
- Encourages referrals for domestic violence survivors that are made based on knowledge of the programs and program types that are most appropriate for survivors of domestic violence;
- Provides for training of coordinated access staff on issues related to domestic violence survivors, including risk assessment and delivery of trauma-informed services;
    - Training will be provided CCADV.
- And recognizes that survivors connect to housing services most successfully when domestic violence service providers work in conjunction with homeless services providers.
    - Rapid rehousing, transitional housing and permanent supportive housing resources are critical for all homeless households entering the services system including survivors of domestic violence.

2-1-1 call specialists, trained in working with survivors of domestic violence, will continue to serve as a front door for screening of domestic violence survivors and will make immediate

referral to domestic violence services when needed.

The CT Coalition to End Homelessness (CCEH) and the CT Coalition Against Domestic Violence (CCADV) shall work together to cross-train homeless services providers and providers of DV services in each CAN. The objective of this cross training shall be to ensure that all providers understand the services and resources available in each system, and are able to quickly cross-refer clients so that their needs can be addressed.

If a household being served in the homeless response system and identified as experiencing DV does not wish to seek DV specific services, the household will nonetheless have full access to the Coordinated Access Network programs and services for which the household is eligible.

Clients in the DV system who have no housing options and who determine that they would benefit from housing resources in the homeless system will be referred to the appropriate CAN Housing Registry through a special procedure that protects client identity consistent with provisions of the federal Violence Against Women Act (VAWA).[10]

IV. Assessment

Coordinated Access Networks (CANs) assess the housing needs of all households experiencing homelessness, with a focus on identifying those who may meet the criteria to be included in a special population (Chronic, Veterans, Families, Youth, and others). Once referred by 2-1-1, literally homeless or at risk of becoming homeless households whose housing situation cannot be resolved through referrals to services outside of the crisis response system are scheduled for a CAN appointment. The CAN appointment is an opportunity to meet with specially trained staff to determine the appropriate level of service needed to resolve the immediate crisis: diversion, prioritization and referral to an emergency shelter, or connection to outreach.

At each stage of the Assessment process, staff should endeavor to divert households to utilize mainstream services to resolve their housing crisis. *Diversion* techniques should be used to help households to recognize and access resources immediately available to them, such as family and community supports.

If a client is unable to be diverted, the client will be offered the next available shelter bed or placed on a prioritized waitlist for shelters. If a client does not want shelter and chooses to remain unsheltered, every attempt will be made to connect them to street outreach teams at the time of the CAN assessment. When CAN or outreach staff encounter someone unsheltered staff will immediately assess the individual for housing resources and add them to the CAN By

[10] For further information please see: http://www.cceh.org/housing-domestic-violence-survivors/

Name List (BNL). This is generally done by outreach workers in collaboration with CAN staff to make appropriate referrals for safety.

It is important to note, that Connecticut does not have legislation that guarantees access to shelter, often known as "right to shelter". Often, especially for single adults, the demand for shelter far exceeds the available beds. Most CANs have decided to prioritize shelter beds for those who have been observed to be unsheltered.

A. Components of Assessment Process

1. Assessment of needs related to housing and other basic needs (food, clothing, etc.) and referrals as appropriate
2. Diversion/problem-solving conversation and referrals to both formal and informal supports where possible.
3. Completion of Releases of Information (ROI) to allow data entry into CT HMIS
4. For street outreach providers ONLY: Completion of the Vulnerability Index Service Prioritization Decision Assistance Tool (VI-SPDAT) or Next Steps Tool for all literally homeless households engaged by street outreach. All other literally homeless households (sheltered) are given a 14 day window to self-resolve prior to conducting a VI-SPDAT assessment.[11]
5. Refer to shelter, if unable to divert and the household is/will be unsheltered that evening
6. Record the information from the assessment and result of the appointment in CT HMIS.

All CAN Appointment Staff are trained to use standardized messaging to ensure that the assessment process and its results are communicated clearly and consistently.

Additional detail regarding each step is as follows.

B. Needs assessment

CAN Appointment staff should determine if the household has any urgent health and safety needs, such as food, clothing, healthcare, etc. This should also include an assessment for safety including any domestic violence that may be present. Referrals to both mainstream resources and crisis services should be provided as indicated to ensure the health and safety of the household.

C. Diversion

The purpose and intent of CAN Appointments are to use a strengths based approach to problem solve with the client around their current housing crisis. Shelter should be considered an absolute last resort. Staff should allow the client to determine what plan works best for them. CANs should

[11] DOH VI-SPDAT Guidance

work to ensure that flexible resources are available to assist in carrying out the Housing Plan. The most effective tool to carry out Diversion is Active Listening. There are no income requirements to be eligible for diversion assistance.

A critical component of Diversion is the clients have a uniform experience in this appointment. Agencies who run Diversion programs should hire seasoned professional staff and ensure they are trained in the Diversion model through CCEH.

Another way to ensure uniformity is to use a standardized "Housing Plan" form. (See attached). The information on this form should be entered into HMIS to assist with communication.

All Diversion sessions should conclude with giving the client a copy of the "Housing Plan" form and contact information of the staff they should follow up with. Staff should inform clients to follow up with the Diversion staff directly rather than calling 211 for a new appointment.

People who return to the CAN system after being diverted, Diversion Specialists should always explore another viable Housing Plan before resorting to a shelter placement. There is no set limit on how many times someone can be offered Diversion assistance, but if staff observe the same household repeatedly access Diversion assistance without stabilizing their housing, consult with local leadership and/or DOH CAN Managers for guidance.

Best practices:

- Read all prior notes in HMIS prior to meeting with the client
- Enter a detailed case note in HMIS including the financial resources provided to the client
- Staff must be trained in Diversion through CCEH, have adequate supervision and be able to implement in a strengths based approach
- Agencies employing Diversion Staff should have a process for evaluating staff performance to ensure the best fit for the position
- System wide data analysis should look for trends in Diversion rates, by area, agency and staff person

D. Release of Information and CT HMIS[12]

CAN Appointment Staff must enter the additional information collected at the CAN Assessment appointment into CT HMIS utilizing the client record initially created by 2-1-1. During the CAN Appointment, the Assessor will request that the head of household sign a Release of Information for the Coordinated Access Network and a Release of Information for CT HMIS and will make clear to the household how information may be shared. This will allow communication between all participating agencies region-wide, and allow member agencies to

[12] FFC CAN Manual

share information pertaining to the coordinated waitlists and by name lists, case conferences, etc.

In instances where a household is unwilling to complete a Release of Information, CAN Appointment staff should follow protocols for continuing to assess and provide services, based on the statewide process for keeping track of de-identified households within the Coordinated Access Network.

It is critical to enter a case note into HMIS detailing the diversion conversation and any next steps. Staff should also include their name and contact information, in the event the client calls back 211 or presents at another point in the system, anyone can see this note and continue assisting the client. All case notes entered in HMIS by CAN Assessment staff are defaulted to "shared" so the entire system can see them if needed.

E. Late and Missed Appointments

If a person or household arrives late for their assigned CAN appointment or block, the CAN Assessment provider may use their discretion in determining the best course of action within the parameters described below. Appointments should be consistent and no quality of service sacrificed by rushing. If the household can still be appropriately accommodated, then the appointment should proceed as normal. If the household arrives too late for the provider to accommodate, the provider should call 2-1-1 (using the direct extension provided for provider use). 2-1-1 will then schedule the client for the next available appointment that can be accommodated by the household.

Assessment staff should document all missed appointments (whether they are no-shows or late arrivals resulting in cancellation) in HMIS for future reference. 2-1-1 will use this information to inform future engagement with the household, as will the community provider, however, households will never be refused access to an appointment due to previous no –shows; also there is no limit on number of missed appointments allowed.

F. Outreach Assessors and Ad-hoc CAN Assessment

Some Outreach Specialists are also able to complete CAN Assessment, including the VI-SPDAT. This allows those most in need of immediate shelter to be prioritized directly into an Emergency Shelter bed (if one is available) or added to the Regional Shelter Waitlist, if applicable.

Outreach Assessors should use their best judgment to determine if the household may be eligible for a CAN Appointment. In those cases, the Outreach Assessor should call 2-1-1 directly and 2-1-1 will schedule an Ad-hoc CAN Assessment appointment immediately, and the

Outreach Assessor will complete the CAN Assessment with the household. The appointment scheduling is intended to track the assessment and to be consistent with the process for other callers, but allows the assessment to happen right away. In these instances, Outreach Assessors will request that the head of household sign a ROI for the Coordinated Access Network and a ROI for CT HMIS and will make clear to the household how information may be shared.

Diversion from unsheltered situations is possible and it is critical for Outreach staff to be aware they can access Diversion or Rapid Rehousing funding to immediately house someone who is unsheltered. It should not be that an unsheltered person must go into shelter to gain access to housing resources.

G. Coordinated Assessments Forms (VI-SPDAT, SPDAT, Next Steps Tool)

All CT CAN Permanent Supportive Housing (PSH), Emergency Shelter (ES), Transitional Housing (TH), and Rapid Rehousing (RR) programs funded by CoC and ESG are required to use the following common assessment forms: VI SPDAT 2.0, Family VI-SPDAT 2.0, and the Next Step Tool for transition aged youth.[13]

1. VI-SPDAT Assessment

The Vulnerability Index Service Prioritization Decision Assistance Tool (VI-SPDAT) is a pre-screening, or triage tool, that is designed to be used by providers to quickly assess the health and social needs of those experiencing homelessness and to match them with the most appropriate level of case management support and housing interventions that are available. The VI-SPDAT assessment is available in CT HMIS, and VI-SPDATs should always be entered into CT HMIS as soon as possible to ensure that households are quickly added to the By Name List[14].

The VI-SPDAT should only be completed with households who are currently literally homeless, and should only be completed once per household. All emergency shelters should wait to administer the VI-SPDAT assessment until a household has been literally homeless for at least two weeks[15]. The one exception is for young adults, aged 18-24, who are also assessed if they qualify for services under HUD's broader definition of experiencing Category 4 homelessness, for example trading sex for housing, and shelters may administer the assessment to youth immediately but can wait up to 14 days. Those who are observed to be unsheltered should have a VI-SPDAT completed immediately, and/or a placeholder on the BNL in the event the client declines to complete the survey. Only trained outreach and/or case management staff should

[13] CT BOS Policies
[14] Greater Hartford CAN Manual
[15] DOH VI-SPDAT Guidance

administer the VI-SPDAT. To check and see if a household has already completed a VI-SPDAT, please refer to the By-Name List (BNL) in CT HMIS.

There are three versions of the VI-SPDAT: the VI-SPDAT for Individuals (25 years old and over), the Next Steps Tool (for individuals aged 18-24), and the VI-SPDAT for Families. The VI-SPDAT for families is to be used for households with dependent children under the age of 18 who will be housed with the head of household. For any all-adult family, all adults in the family household should complete a VI-SPDAT for individuals. Parenting youth should still complete a VI-SPDAT for families.

Staff should use the result of the assessment to start a conversation about which housing intervention may be a good fit for their service needs. If staff does not believe that a VI-SPDAT has appropriately indicated a household's level of service needs, trained staff should complete a full SPDAT assessment with that household as soon as feasible.

Upon completion of a VI-SPDAT in HMIS, households will automatically be entered onto the statewide By-Name List. The By-Name List is a centralized list of all literally homeless households in each CAN who have not self-resolved, and is referred to when making referrals to housing openings.

In general, the VI-SPDAT should only be administered once, but there are instances where it is appropriate to re-administer the VI-SPDAT rather than completing a full SPDAT.

2. When to Re-Administer the VI-SPDAT:

If there is an existing VI-SPDAT score and there has been a major life change within the last year, refer to major life change chart, re-administer the VI-SPDAT after approval from the local CAN Housing Solutions Meetings.

If a new VI-SPDAT is being completed, staff should download the previous VI-SPDAT as a PDF from HMIS and upload it to the client "Files and Documents" section so the information from the original assessment is maintained in the client record.

Significant Life Changes include: a new episode of homelessness, changes in the family unit, or significant changes in health.

3. Domestic Violence Victims and Survivors

Because Domestic Violence providers are unable to directly enter any data about shelter residents into the CT HMIS system, Connecticut has created a separate and secure process to consider households currently residing in domestic violence shelters for any housing openings in

the Coordinated Access System. Domestic violence providers are able to complete hard-copy VI-SPDATs with any households residing in their shelters for two weeks or more.

Once a hard-copy VI-SPDAT has been completed, the domestic violence service provider will send the score information to the Connecticut Coalition Against Domestic Violence (CCADV). CCADV will then share this score information, along with bedroom size, with the Connecticut Coalition to End Homelessness, and this household will be placed, with an anonymous identifier, onto the By-Name List. No personal information will appear on the By-Name List, and domestic violence providers will join Housing Solutions Meetings with records of what identifier corresponds to the clients in their shelter. This will allow for discussion of housing needs at the local Housing Solutions Meetings without compromising the security of the households' information.

4. Full SPDAT Assessment

The VI-SPDAT is the triage tool used throughout the state of Connecticut. In some instances, a VI-SPDAT may not provide enough information to appropriately prioritize the household within Housing Solutions Meeting. In some instances, a full SPDAT assessment may be recommended.

5. When to Administer the Full SPDAT Assessment

When there are two or more vastly contradicting VI-SPDAT Scores within the past year, a provider representative must take the case to the housing committee and get approval to determine whether a full SPDAT should be administered. The new SPDAT should be done by a different provider.

Once a client reaches nine continuous months of homelessness or three episodes totaling to nine months or more of homelessness and has a score of three or lower, staff should administer the full SPDAT in consultation with the Housing Solutions Meeting. The new SPDAT should be administered by a different provider.

Any paper copy of the SPDAT needs to be uploaded into CT HMIS or the SPDAT needs to be administered electronically in CT HMIS.

If the provider thinks the VI-SPDAT has a wide discrepancy from the client's vulnerability, based upon review of the VI-SPDAT and the provider's knowledge of the client, consult with the housing committee about administering the full SPDAT.

For the purposes of quality control, only staff who have been trained in the full SPDAT assessment can complete this assessment. All staff who have been trained in the SPDAT must complete an annual recertification through the CT Coalition to End Homelessness.

Please note that while our common assessment tools (VI-SPDAT, SPDAT, Next Step Tool) are a primary mechanism to prioritize our most vulnerable, they are considered to be one tool in the determination of vulnerability. During the CAN Housing Solutions Meetings (see below) providers also rely on case-conferencing and other factors, such as tri-morbidity, length of time homeless, length of time unsheltered, past enrollments in rapid re-housing, and interface with crisis services such as hospitals and the judicial system.

H. Assessment Staff Training

The CT Coalition to End Homelessness (CCEH) provides training opportunities to organizations and staff persons that serve as access points to administer assessments. CCEH works collaboratively with CT and the CT CANs to provide continuous updates and training protocol to Connecticut providers. All staff administering assessments in CANS have access to materials that clearly describe the methods by which assessments are to be conducted with fidelity to the CT System CAN written policies and procedures.

I. Statewide By-Name-List

The statewide By-Name-List (BNL) is a centralized and prioritized list of individuals, families, and youth experiencing homelessness. An individual and family is added to the BNL when a VI-SPDAT is completed and entered into CT HMIS. VI-SPDATs are only completed on clients who are literally homeless, based on HUD guidelines, as residing in a shelter or place not meant for human habitation (i.e. car, abandoned building, train station, etc.)[16]. The statewide BNL provides CANs with a uniform process to be used for matching individuals and families to appropriate interventions and prioritizing placement into housing.

All state and federally funded rapid re-housing, transitional housing, and permanent supportive housing projects are required to accept referrals ONLY from the By-Name List that is maintained by each CAN and monitored by CT DOH, and should be filtered for each CAN's homeless population for prioritization decisions.

Community providers in each CAN collect and review all required documentation for designated housing resources and interventions. Clients housing status is marked based on eligibility and verified documentation on the BNL. Staff within each CAN work to ensure client's housing status is accurate based on continuous communication with shelter case managers, outreach workers, and any other provider connected with the client. Clients who are no longer literally homeless are marked as Not Active on the BNL.

[16] CT BOS Policies

V. Prioritization and Matching

CT CANs use Coordinated Access to prioritize homeless persons for referral to housing and services. Coordinated Access establishes a standardized statewide framework for prioritization applied consistently across all homeless assistance projects within each CAN throughout Connecticut. This common framework ensures that all CAN, CoC, and ESG resources are used as strategically and effectively as possible. Resources will be targeted to serve persons with the highest needs and greatest barriers to obtaining and maintaining housing on their own. Coordinated Access establishes a prioritization standard for each housing assistance type: permanent supportive housing, rapid re-housing, and transitional housing.

A. CAN Housing Solutions Committees

Housing Solutions Meetings (formerly known as Housing Matching Meetings) are an integral part of the CAN matching and prioritization process. These meetings are an opportunity for providers in each CAN to discuss housing vacancies (current or upcoming), resolve barriers, and make decisions about priority, eligibility, enrollment, termination, and appeals. Housing Solutions Committee meetings occur weekly or bi-weekly in each CAN and are facilitated by designated CAN staff. Shelter workers, outreach staff, navigators, and housing providers are all encouraged to attend these meetings on a regular basis and participate fully in the CAN prioritization process.

These Committees have agreed to not only focus on “matching” to housing resources but brainstorming housing solutions for all clients, regardless if a resource is available. More emphasis is being placed on reconnecting with family or friends, utilizing other community resources or finding affordable housing options the client can access with their own income. Given the scarce amount of housing resources through State and Federal programs, it is critical to assist in resolving homelessness with the least amount of assistance needed.

B. CT CAN Resources and Eligibility for Service

CT CAN resources have minimal screening criteria, providing housing and services regardless of perceived or actual barriers (i.e. substance use, no or low income, domestic violence history, sexual orientation, gender identity or expression, resistance to receiving services, mental health, and criminal record) and are limited to only that screening criteria required by funding contracts. Programs may not establish additional eligibility requirements beyond those specified below and those required by other funders, including documentation, income, or employment.

Veterans who are ineligible for U.S. Department of Veterans Affairs housing and services shall be prioritized in CT CoC funded projects.

C. Emergency Shelter Eligibility and Prioritization

1. Eligibility

Applicants must be screened for diversion and admitted to shelter only if no other options (such as staying safely with friends or family) are available. Applicants must be literally homeless. For family homeless shelters, registered sex offenders are not eligible.

2. CT BOS Prioritization for Emergency Shelter:

There are no priorities for emergency shelter defined by CT BOS CoC. CANs and local sub-CoCs in CT BOS may establish local priorities provided they follow ESG, DOH and other funding guidelines. Most CANs prioritize shelter beds for those who have been observed to be unsheltered.

3. ODFC and Fairfield County CAN Prioritization for Shelter:

Households are prioritized for shelter that are literally homeless as defined by HUD and who are currently without appropriate shelter. In order to qualify as literally homeless, a household must lack a fixed, regular, and adequate nighttime residence.

4. YHDP Short-Term Crisis Housing:

YHDP Short-Term Crisis Housing is a modified transitional program under the HUD Youth Homelessness Demonstration Program, which operates like crisis housing, providing temporary safe housing to young adults aged 18-24 who are experiencing HUD Category 1, 2, or 4 homelessness and are without a safe place to stay that night. Each of the four CANs awarded YHDP Short-Term Crisis Housing funding are following local prioritization within funding guidelines.

D. Transitional Housing Eligibility and Prioritization

Applicants for transitional housing must be screened for diversion and admitted only if no other options are available. Projects may serve only participants coming from emergency shelter and unsheltered locations, including those who have been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days AND who were residing in an emergency shelter or unsheltered location immediately before entering that facility. Projects may serve only participants with income below 30% of area median income (AMI). Applicants must be able to be safely maintained in the program, including not posing any danger to other participants.

1. Priority for Service in Transitional Housing[17]

- **A.** Not able to be diverted OR currently slated for PSH AND
- **B.** At least one prior episode of homelessness (except for young adults) AND
- **C.** In one of the following life stage transitions
  - young adults 18-24,
  - family with children under age 5,
  - fleeing DV and DV cause of recent homeless episode.

E. Permanent Supportive Housing (PSH) Eligibility Review and Documentation

It is the responsibility of each CAN to manage the PSH eligibility determination process, in accordance with the criteria and procedures described below.

PSH Eligibility Criteria

Only applicants who meet the following criteria are eligible for PSH – terms in quotes are defined below:

1. The applicant must have a "disabling condition" in accordance with HUD requirements; AND
2. The applicant must meet HUD criteria for "DedicatedPLUS" which includes but is not limited to people who meet HUD's definition of "chronically homeless."
3. At the point in which a PSH vacancy occurs, if there are no eligible households identified in the CAN who meet DedicatedPLUS criteria and who are ready to accept assistance, a "literally homeless" applicant may be admitted (see *PSH Prioritization Criteria when there Are No Eligible DedicatedPLUS Households* below*).*

Disabling Condition is (1) A condition that: (i) Is expected to be long-continuing or of indefinite duration; (ii) Substantially impedes the individual's ability to live independently; (iii) Could be improved by the provision of more suitable housing conditions; and (iv) Is a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury; (2) A developmental disability, as defined in this section; or (3) The disease of acquired immunodeficiency syndrome (AIDS) or any conditions arising from the etiologic agent for acquired immunodeficiency syndrome, including infection with the human immunodeficiency virus (HIV).

DedicatedPLUS: Recent CoC Competition NOFAs have defined DedicatedPLUS as follows:
individuals, households with children, and unaccompanied youth that at intake are:

(1) experiencing chronic homelessness (CH); or

(2) residing in a Transition Housing (TH) project that will be eliminated and was chronically homeless when entered TH project; or

(3) residing in Emergency Shelter or unsheltered location and had been admitted and enrolled in a PSH or RRH project (having met CH criteria upon entering) within last year, but was unable to maintain housing placement; or

(4) residing in TH funded by a Joint TH and PH-RRH component project and who were experiencing

chronic homelessness prior to entering the project; or

(5) residing in Emergency Shelter or unsheltered location for at least 12 months in the last 3 years, but has not done so on 4 separate occasions and the individual or head of household meet the definition of 'homeless individual with a disability'; or

(6) receiving assistance through a Department of Veterans Affairs (VA)-funded homeless assistance program and met 1 of the above criteria at initial intake to the VA's homeless assistance system.

Chronically Homeless: HUD's Final Rule on Homeless Emergency Assistance and Rapid Transition to Housing: Defining "Chronically Homeless" defines chronic homelessness as follows:

A ''homeless individual with a disability'' who:

(1) Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; AND

(3) Has been homeless and living as described in paragraph (1) above continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) above. Stays in institutional care facilities for fewer than 90 days will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; OR

(2)An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; OR

(3) A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Literally Homeless: The definition of "literally homeless" as defined in the HEARTH Act: Defining ''Homeless'' Final Rule:[1]

The individual or head of household is living in a place not meant for human habitation, in an emergency shelter, transitional housing, or a safe haven; OR

Is fleeing or attempting to flee domestic violence, dating violence, sexual assault or stalking; and has no other residence; and lacks the resources or support networks to obtain other permanent housing.

Participants currently receiving rapid re-housing assistance (RRH), who met these criteria prior to entry into RRH, retain their literal homeless status during the time period that they are receiving

[1] 24 CFR Parts 91, 582, and 583; Homeless Emergency Assistance and Rapid Transition to Housing: Defining ''Homeless'' Final Rule; Federal Register / Vol. 76, No. 233 / Monday, December 5, 2011 / Rules and Regulations. Available at https://www.hudexchange.info/resource/1928/hearth-defining-homeless-final-rule/

the RRH assistance.

Participants currently in transitional housing (TH), who originally came from the streets or an emergency shelter, retain their literal homeless status during the time period that they are residing in TH. Participants currently in TH may, however, be restricted from occupying some permanent supportive housing if that housing was funded under a 'Bonus' in certain CoC NOFA Competitions, as they cannot be considered Chronically Homeless.

Applicants residing in an institution for less than 90 days who were homeless and living in a place not meant for human habitation, a safe haven, or in an emergency shelter immediately prior to entry into the institutional care facility retain their literal homeless status. People who lived in Transitional Housing prior to entering an institution are not literally homeless.

What are the differences between the DedicatedPLUS and chronically homeless definitions?
It is important to note that the criteria for Dedicated Plus and chronic homelessness are very similar, for example:

- DedicatedPLUS projects generally must serve only households with a disabled adult or head of household who has been homeless for at least 12 months

A Dedicated Plus project can, however, also serve some people who don't meet the strict HUD definition of chronic, for example:

- People who have been homeless for 12 months over 3 years during fewer than 4 separate occasions; and
- Some people who had been admitted and enrolled in a PSH or RRH project within the last year, who were unable to maintain the housing placement.

Other eligibility requirements as stipulated by funders
PSH projects may not impose additional eligibility requirements except as required by a funder. Connecticut works with partners to serve special populations who have specific vulnerabilities. And in some cases, projects are restricted by their funding source to serving particular target populations. For example, only applicants who have a serious mental illness, chronic problems with alcohol, drugs or both, or acquired immunodeficiency syndrome (AIDS) and/or related diseases are eligible for DMHAS PSH projects.

CANs will make every effort to refer only eligible applicants for PSH program vacancies. CANs will follow the order of priority outlined in the prioritization criteria below while also considering the identified target populations served by the project. For example, when filling a vacancy at a program required by a funder to serve homeless persons with a serious mental illness, the CAN will follow the order of priority to the extent to which persons with serious mental illness meet the criteria. In this

example, if there were no persons within the CAN with a serious mental illness that also met the criteria for DedicatedPLUS, the CAN would refer a person with a serious mental illness who is literally homeless in accordance with the order of priority outlined in Section F below.

Initial Eligibility Screening

CANs are responsible for:

- identifying the applicable eligibility criteria and the documents necessary to establish eligibility for all PSH projects in the CAN;
- ensuring a case manager, navigator or other staff person is assigned to assist the applicant, as needed, to gather the necessary eligibility documents;
- coordinating to ensure that the assigned staff person is well informed regarding what information and documents are required and is actively working to promptly secure the necessary information and documents;
- conducting initial applicant screening to preliminarily determine eligibility for PSH;
- providing the applicant written notification regarding eligibility decisions, details regarding any missing documents, and information about who can help them to obtain missing documents; and
- ensuring that only applicants preliminarily determined eligible are referred for PSH and that preliminary eligibility is adequately documented in accordance with HUD and other funder requirements.

Final Eligibility Determination

The admitting PSH project is responsible for:

- reviewing eligibility documents provided by the CAN to verify that all required documentation of eligibility, in accordance with HUD and/or the applicable funders' standards, is present in the application records prior to admitting any participant;
- updating eligibility documents provided by the CAN as necessary; this includes ensuring that, for CoC projects, eligibility is documented at the time of project entry. HUD requires documentation of homeless status up until the project entry date, i.e., the date on which the project offers, and the participant accepts entry into the project. This is often the date the CoC RA certificate is issued. The project entry date typically precedes the date in which the participant is housed and follows the last date on which the CAN documented eligibility. For example: A CAN might determine and document an applicant's eligibility on 5/1/20. A vacant unit may not be immediately available, and the CAN may not refer the participant to a CoC RA project until 6/15/20. The CoC RA project may not issue a CoC RA certificate until 6/24/20. The participant may not sign a lease and obtain housing until 8/15/20. In this example, the admitting PSH project must ensure that the participant meets the relevant homeless criteria and that homelessness is documented as of the 6/24/20 certificate date.

- ensuring that the required documentation of eligibility is maintained in each participant's chart; and
- maintaining documentation of each program participant's eligibility in accordance with funder record retention requirements (e.g., 5 years after the expenditure of all funds from the last grant under which the program participant was served for CoC projects).

In addition, If the applicant either does not meet all eligibility requirements or the required documentation of eligibility has not been obtained, the PSH project is responsible for:

- notifying the CAN and referring the household back to the CAN; and
- providing the applicant and CAN written notification regarding the eligibility decision, including specific information about the reason for the decision, and detailed instructions regarding what additional documents are required, who the applicant can contact to obtain assistance, and how to appeal the decision.

Eligibility Documentation

CANs are required to document PSH eligibility prior to making a referral for PSH using the verification forms linked below. Admitting PSH projects are required to verify documentation is adequate and update these forms as necessary and described above. These forms are consistent with HUD's recordkeeping requirements:

- Disabling condition (Disabling Condition Verification Form)
- Qualified homelessness (Homelessness Verification Form)
- Due diligence in attempting to obtain third-party documentation of homelessness, if applicable; documenting such due diligence is required; however the format used for such documentation is discretionary; a sample format is available here).

CANs and admitting PSH projects are strongly encouraged to use the other optional homelessness verification resources available here.

Note that it is also allowable to admit the applicant and continue to seek the necessary documents – this option may only be used when the CAN and admitting PSH project agree with certainty that the applicant meets eligibility criteria and the documents will be obtained (HUD has determined that this is allowable and that the project must work to obtain the required documentation within 180 days from project entry – more details are available in HUD FAQ ID 2872).

Order of Priority for Obtaining Evidence of Homelessness

As per HUD requirements, CANs and admitting PSH projects are required to use the following order of priority for obtaining evidence of homelessness:

1. **Third-party documentation**, such as
   i. Letter from a shelter

ii. Letter from an outreach team
iii. Letter from another service provider (e.g., doctor, therapist, counselor, clergy member, etc.)
iv. HMIS record

Letters must:

- Be on agency letterhead
- Be signed and dated
- Include name and title of the person signing

CANs shall not rely on letters from an applicant as third-party documentation.

2. **Intake worker observation** of the conditions where the individual was living

3. **Self-certification**, including:
   - A dated letter signed by the applicant attesting to the qualified locations where the applicant lived and the approximate dates living in each location – sample available here; AND
   - Intake worker must also document in the client file:
     - The living situation and circumstances that necessitate reliance on self-certified evidence (such as, client was camping in a remote area and did not have contact with any service providers or emergency shelter where client resided was unresponsive to multiple attempts to obtain third party documentation); AND
     - Steps taken to obtain third-party documentation, including documenting attempts to locate HMIS records and attempts to obtain letters from an emergency shelter or other service provider knowledgeable of the applicant's homelessness. A sample tool for documenting due diligence in attempting to obtain third-party documentation of homelessness is available here.

Limitations on Self-Certification

Disability cannot be self-certified[2]. In all instances, project staff must perform due diligence as specified above in attempting to obtain third party documentation prior to relying on self-certification. As necessary, for all clients, up to 3 months of homelessness can be documented through self-certification. In limited circumstances, up to the full 12 months of homelessness can be documented through self-certification. Self-certification of the full 12 months should be limited to rare and extreme cases and may not be used for more than 25 percent of households served by a project during an operating year. This limitation does not apply to documentation of breaks in homelessness between separate

[2] For more information about a time-limited waiver of this requirement for CoC PSH projects see Memorandum: HUC CoC & ESG Waivers

occasions, which may be documented entirely based on self-report.

F. Permanent Supportive Housing (PSH) Prioritization

This section addresses general principles used for prioritization of households to be served in PSH and the intent of PSH prioritization criteria. It also describes the household types to which and the circumstances under which PSH prioritization criteria are applied. Finally, this section details the actual prioritization criteria to be used by CT CANs.

PSH Prioritization – General Principles

The prioritization process outlined below is intended to address four principles. These four principles are:

1. **HUD Prioritization criteria** as outlined in HUD Notice CPD 16-11 - the CT BOS and ODFC CoCs have adopted HUD Notice CPD 16-11. The PSH prioritization process described in this manual is consistently with that notice, and specific criteria are outlined below. These criteria prioritize people for PSH placement based on the length of time homeless and severity of service needs.
2. **System Flow** – The prioritization process described in this manual is intended to support an efficient and coordinated process that moves people through the crisis response system from homelessness to housing as quickly as possible. The Coordinated Access Network (CAN) system strives to ensure that the rate of exit from the system is proportional to the rate of entry into the system.
3. **Addressing Service Need –** Prioritization protocols address the services needs of households to identify the best possible match for the household's need given available housing interventions.
4. **Right-sizing**. Connecticut continuously strives to ensure that the homelessness response system has the best possible composition of housing resources (Rapid Rehousing (RRH), Permanent Supportive Housing (PSH), shared housing, moving-on, on affordable housing, etc.) to meet the services needs and preferences of households served. The system's goal is to ensure that no housing resources are left vacant. However, as we strive to ensure that limited community resources are used in the most strategic way possible, there may be times when leaving a resource vacant for a short-period of time has longer-term benefit to the system flow. As an example, a long-term shelter stayer with severe service need is 1 week away from obtaining clinical verification of a disabling condition. Allowing the housing resource to remain vacant for one week longer would allow the CAN to serve a high need person compared to someone who may have completed documentation for housing, but has a less severe service need.

The intent of the prioritization criteria outlined below is to balance the following:

1. **Reducing overall length of time homelessness -** The system assumes that a long length of cumulative homelessness that cannot be resolved with a less intensive intervention (shared housing, rapid exit, etc) is an indicator of high service need. Additionally, reducing length of

time homeless on a system-wide level is a metric used by HUD to evaluate community performance.

2. **Enabling access to PSH for those with the highest service needs** – Some people whose assessment indicates a severity of service needs may be able to resolve their homelessness without assistance. People who with the highest service needs who are unable to self-resolve are prioritized for PSH placement.

3. **Consideration of housing resource availability.** Within the prioritization framework, the intent is to start with a light touch of services, which may include assistance with self-resolution, housing with minimal financial assistance, connection to mainstream services and/or moving on to independent housing. When RRH is available, the majority of households on the BNL will be offered this resource. If service needs increase, staff may offer more intensive case management or, ultimately, refer the participants to a more service enriched and/or long duration case management or rental assistance. The CAN's case conferencing process may identify a small cohort of individuals whose service needs are significant enough to necessitate a direct admission to supportive housing.

In the future Connecticut may refine its system for determining severity of service need to ensure that the most vulnerable individuals/families are receiving priority access to appropriate housing and service resources. Until an alternative approach is determined, the VI-SPDAT/ SPDAT tools will be a proxy for quantifying severe service need.

PSH Prioritization Categories

This manual includes a single set of prioritization criteria to be applied for both of the following target populations:

- *Households that include an Adult 25 Years of Age or Older*
- *Households that include only People Under Age 25*

This manual includes prioritization criteria for the following circumstance:

- PSH Prioritization Criteria for Eligible DedicatedPLUS Households
- PSH Prioritization Criteria for when there are No Eligible DedicatedPLUS Households

Detailed prioritization criteria appear below. Except as noted under *Section G: Prioritization for PSH Under Special Circumstances,* CANS will use these criteria when making decisions about how to prioritize eligible applicants for PSH assistance.

PSH Prioritization Criteria - Households that include an Adult 25 Years of Age or Older and Households that include only People Under 25 Years of Age

CANS will follow the order of priority outlined below when determining which households should be

prioritized for PSH assistance. These criteria are applied to all households regardless of age or composition.

Please note that, to establish eligibility for PSH in all cases, a verified disabling condition as required by funder criteria is mandatory. See Section E for details.

PSH Prioritization Criteria for Eligible DedicatedPLUS Households

Priority #1: Currently enrolled in RRH and DedicatedPLUS at RRH entry, who have been identified by the CAN as needing a higher level of housing care.

a. Full SPDAT score indicates PSH level of care.
b. Cohort is prioritized by the earliest enrollment date in RRH.
c. If a household is currently unsheltered and also enrolled in RRH, that factor is used as a tie breaker.
d. Exceptions may be made, based on CAN case conferencing discussion. See Section G for details.

Priority #2: Verified Chronic Homelessness

a. Cohort is prioritized by cumulative length of time homeless verified by a third party
b. Generally, VI-SPDAT/SPDAT score (or equivalent tool for population) should indicate the household for PSH. If the VI-SPDAT score or equivalent indicates a lower level of care, the CAN will generally offer RRH if available; however, CANs may exercise discretion when case conferencing reveals that the score does not accurately reflect a client's need/vulnerability. If RRH is unavailable, the CAN will need to determine if the individual/family will be offered PSH based on several factors, including, but not limited to:
    i. Anticipated availability of RRH.
    ii. Timeliness of identifying a PSH referral.
    iii. Identified service needs.
    iv. Household primarily experiencing unsheltered homelessness.
c. If a household is currently unsheltered, that factor is used as a tie breaker, with priority status provided for the unsheltered household.
d. Exceptions may be made based on CAN case conferencing discussion. See Section G for details.

Priority #3: Verified DedicatedPLUS and not Chronic Homelessness

a. Cohort is prioritized by cumulative length of time homeless verified by a third party
b. Generally, VI-SPDAT/SPDAT score (or equivalent tool for population) should indicate the household for PSH. If the VI-SPDAT score or equivalent indicates a lower level of care, the CAN will generally offer RRH if available; however, CANs may exercise discretion when case conferencing reveals that the score does not accurately reflect a client's need/vulnerability. If RRH is unavailable, the CAN will need to determine if the individual/family will be offered PSH based on several factors, including, but not limited to:
    i. Anticipated availability of RRH.
    ii. Timeliness of identifying a PSH referral.
    iii. Identified service needs.
    iv. Household primarily experiencing unsheltered homelessness.

c. If a household is currently unsheltered, that factor is used as a tie breaker, with priority status provided for the unsheltered household.
d. Exceptions may be made based on CAN case conferencing discussion. See Section G for details.

PSH Prioritization Criteria for when there are No Eligible DedicatedPLUS Households

It is the responsibility of CANS to coordinate with housing and service providers in their covered geographic area to ensure due diligence in conducting outreach and assessment to locate and engage eligible households who meet DedicatedPLUS criteria. However, PSH units should not be kept vacant indefinitely while waiting for an identified eligible individual or family to accept an offer of PSH.

PSH Projects may serve applicants who meet the criteria below only when there is no eligible DedicatedPLUS applicant who wishes to live in the local CAN region where the vacancy exists. 100% of PSH beds will continue to be designated as DedicatedPLUS, regardless of whether any particular bed is, at any given point in time, occupied by someone who does not meet DedicatedPLUS criteria. This means that, anytime there is a vacancy, the CAN must always first seek to fill that vacancy with an eligible DedicatedPLUS qualified household.

CANs must provide and PSH projects admitting a participant that does not meet DedicatedPLUS criteria must obtain from the CAN and maintain in the participant's chart, records certifying that:

- the By Name List is updated regularly and included no qualified DedicatedPLUS households who were willing to accept PSH at the time the PSH vacancy became available; and
- street outreach and shelter in-reach is occurring regularly, and the CAN, in partnership with local providers is making all reasonable and feasible efforts to locate and identify all persons experiencing homelessness within their community.

CANS will follow the order of priority outlined below when determining which households should be prioritized for PSH assistance.

Priority #4: Currently Literally Homeless AND Formerly but not Currently Chronic and/or DedicatedPLUS

Households prioritized under this category must:

a. be currently literally homeless; AND
b. be formerly but not currently chronic or DedicatedPLUS; AND
c. have lost chronic or DedicatedPLUS status due to an institutional stay; or
d. have lost PSH or RRH within the last year.

It is important to remember that in all cases households must qualify under HUD's definition of disability to be eligible for PSH (See Section E for details):

Examples of households that could be served under this category are described below.

- EXAMPLE FOR CATEGORY C: have lost chronic or DedicatedPLUS status due to an institutional stay

  - Client was formerly chronically homeless - client was homeless continuously for 12 months from September 2016 to October 2017; and
  - Client lost chronic status due to an institutional stay - client was incarcerated from October 2017 to December 2020 and a portion of their homelessness is now outside of the 3 year window; and
  - Client is currently disabled and literally homeless - client is living in shelter as of January 2021.
  - Client meets all criteria for this prioritization category and could be prioritized in January 2021.
- EXAMPLE FOR CATEGORY D: have lost PSH or RRH within the last year
  - Client was formerly DedicatedPLUS – client was living in shelter from January to June 2019, with a friend for 2 week, then in a shelter from July to December 2019; and
  - Client lost PSH or RRH within the last year - Client entered RRH in December 2019 then abandoned the unit and was discharged from RRH in April 2020 because he could not be located; and
  - Client is currently disabled and literally homeless - Client was evicted by his landlord, was engaged by an outreach team and was living on the streets in June 2020; and client has been hospitalized since December 2020 hospitalized (i.e., less than 90 days).
  - Client meets all criteria for this prioritization category and could be prioritized in January 2021 without having to return to the streets, a safe haven or a shelter.

Priority #5: Currently enrolled in RRH *and* **literally homeless (HUD Category 1 & 4)** at RRH entry, and have been identified by the CAN as needing a higher level of housing care.

a. Generally, VI-SPDAT/SPDAT score (or equivalent tool for population) should indicate the household for PSH; however, CANs may exercise discretion when case conferencing reveals that the score does not accurately reflect a client's need/vulnerability.

b. Cohort is prioritized by the earliest enrollment date in RRH.

Priority #6: All Other Currently Literally Homeless (HUD Category 1 & 4), Excluding those in Transitional Housing

a. Cohort is first prioritized by cumulative length of time homeless verified by a third party.
b. Cohort may also be prioritized by VI-SPDAT/SPDAT as a proxy of severe service need.

Priority #7: Homeless Individuals and Families Coming from Transitional Housing.

a. Time in transitional housing cannot be applied toward the 12 months of homelessness necessary for chronic and/or DedicatedPLUS eligibility;
b. Households currently living in transitional housing are literally homeless but not qualified as chronic or DedicatedPLUS;
c. Such households may only be served in PSH under priority #7.

G. Prioritization for PSH Under Special Circumstances

CANs do not have discretion regarding eligibility criteria and documentation and must follow the

protocols outlined in Section E. For CoC projects, CANs also may not admit an applicant who does not meet DedicatedPLUS criteria unless there is no eligible DedicatedPLUS applicant who wishes to live in the local CAN region where the vacancy exists as described in Section F.

The prioritization criteria outlined in Section F will be followed by CANs; however, in cases involving an emergency transfer, CANs are required to diverge from this prioritization process. This mandatory exception is described below, and CANs do not have discretion in applying this exception. For more detail, see the applicable CoC's Emergency Transfer Plan.

- **Prioritizing access for Emergency Transfers -** The Violence Against Women Act (VAWA) allows survivors of domestic violence, dating violence, sexual assault, stalking, and/or human trafficking to move to another subsidized unit to protect their safety and maintain affordable housing. Survivors living in projects that receive federal or state funds who qualify for emergency transfers but cannot make an immediate internal emergency transfer (i.e., within the inventory of the agency currently assisting them) must be provided with priority over all other applicants for a new unit elsewhere. All projects are required to comply with the relevant CoC's emergency transfer plan (CT BOS Emergency Transfer Plan). Providers must retain records for all emergency transfer requests and outcomes.

In addition to the mandatory exception outlined above there may be allowable circumstances in which a CAN opts to diverge from the prioritization process described in this manual due to the housing resource available and/or the needs of individuals/families who are prioritized on the By Name List. Circumstances in which cans do not have discretion to diverge are described above. CANs opting to diverge are required to document the rationale for the exception. One such example is described below:

- **Supportive Housing Transfers -** Existing PSH participants being transferred from one PSH project to another PSH project are exempt from the order of priority established in this manual. Such transfers should be considered both within and across CANs to best serve the needs of PSH participants and/or ensure efficient use of PSH resources. All PSH transfers must be coordinated through and approved by the appropriate local CAN(s) to ensure consistency with local priorities and that any resulting PSH vacancy is filled using the order of priority established in this manual. The only exception would be in cases where existing PSH participant households exchange units. In all cases, PSH units must be prioritized for eligible applicants residing in the applicable CoC's covered geography over eligible applicants residing in another CoC. CANs and the admitting PSH project need to maintain documentation indicating that the transfer was approved by the relevant CAN(s) prior to enrolling the participant into the PSH program.

There may be other allowable circumstances in which a CAN opts to diverge from the prioritization process described in this manual due to the housing resource available and/or the needs of individuals/families who are prioritized on the By Name List. Additional exceptions should be rare.

H. CASE CONFERENCING

Housing Solutions Meetings are an integral component of the CAN matching and prioritization process and are where case conferencing occurs in the CAN system. Case Conferencing should be focused on linking clients to community supports, housing focused solutions, and problem solving.

These meetings are an opportunity for providers in each CAN to discuss housing vacancies (current or upcoming), resolve barriers, and make decisions about priority, eligibility, enrollment, termination, and appeals. Housing Solutions Meetings occur weekly or bi-weekly in each CAN and are facilitated by designated CAN staff. Shelter workers, outreach staff, navigators, and housing providers are all encouraged to attend these meetings on a regular basis and participate fully in the CAN prioritization process.

Housing placement meetings should only utilize a very short period of time. The majority

Reinforce problem solving in case conferencing, and housing focused solutions, as part of case conferencing.

The BNL is the uniform tool CT uses to ensure households are prioritized and offered housing in the correct order based on the factors above. The BNL is exported from CT HMIS on a weekly or bi-weekly basis, then sorted and saved in the uniform manner using the DOH Excel tool. Concurrently, the CAN staff in charge of facilitating Housing Solutions Meeting will be responsible for gathering housing vacancy information from providers. The exported BNL and information on current housing vacancies will be a central component of Housing Solutions Meeting Committee meetings.

During Housing Solutions Meetings, community providers will use case conferencing to determine whether or not housing programs are a good fit for the households (based on the clients' input and desires) and ensure that client choice plays an integral role in choosing their housing. CANs have developed case conferencing forms (See Addendum A) to request discussion during housing meetings.

In the event the resource that the household is being prioritized for is not available, the case conferencing team will determine an alternative arrangement until the vacancy becomes available. For example, a former PSH participant is being prioritized for another PSH program, but there are no

vacancies at this time. The team may decide to use RRH to move this person into housing until a vacancy becomes available.

Furthermore, the case conferencing team must review participants at risk of losing current housing or supports and prioritize those participants that need referral to a more intensive intervention. On a case by case basis, CAN Housing Solutions Meeting by consensus, may recommend extending, modifying, or intensifying supports (financial assistance and/or services) within the current program enrollment to elevate chances of success or may recommend referral to a higher level of care.

Criteria required to be presented for discussion for PSH referral or referral to higher level of care:

- Must meet criteria for PSH prior to entry in RRH
    - (Disability may be verified after enrollment to RRH)
- Significant and/or consistent impairment in functioning related to housing stability
- Full SPDAT completed and have scored as indicated in need of PSH
- Applied for all permanent housing opportunities available to them while enrolled in the RRH program (as available)

Additional issues that may indicate a need for intensifying services:

- Co-morbidities
- Length of time in Rapid Re-Housing
- Active substance use
- Safety issues (i.e.: forgetting to turn the stove off)
- Suicidality
- Human trafficking
- Active and continuous severe mental health symptoms
- Unable to connect to community resources

It is conceivable that some participants may need to start at a higher level of intervention, such as PSH. The case for moving directly into PSH must be presented and approved by consensus or majority vote at Housing Solutions Committee meeting. Participants will be presented for consideration, if they are shown to have a service need for PSH as indicated by the full SPDAT and meet the requirements listed above for PSH referral.

I. Rapid Re-Housing Prioritization and Eligibility

Rapid Re-housing (RRH) is designed to assist literally homeless households (individuals and families) as they quickly move out of homelessness (Category 1 and 4, as defined by HUD) and into permanent housing through the provision of time-limited housing support and strategies with the ultimate goal of stable housing. RRH uses a combination of housing location and

stabilization services combined with financial assistance, if necessary, to assist homeless households (individuals and families) to move as quickly as possible into permanent housing and achieve housing stability.[18]

The range of RRH programs varies across Connecticut. Rapid Re-Housing is a statewide intervention that provides financial assistance and services needed to return people experiencing homelessness to housing. The Connecticut Department of Housing administers the majority of rapid rehousing funds through HUD Continuum of Care and Emergency Solution Grants, and State General funds. A small number of programs individually contract with HUD with independent rapid rehousing programs, yet all are required to participate in the agreed upon prioritization and service delivery models.

Rapid Rehousing programming targeting Veterans is also funded through the U.S. Department of Veteran Affairs through the Supportive Services for Veteran Families Program (SSVF)[19].

1. Participant Eligibility for Rapid Rehousing and Homeless Status

RRH eligible participants are homeless families with children and adult-only households. This definition complies with HUD's Category 1 and 4 definition of homelessness. The term "homeless," "homeless individual," "homeless person" or "homeless household shall be defined as:

A. A household who lacks a fixed, regular, and adequate nighttime residence; and
B. A household who has a primary nighttime residence that is
    i. A supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill);
    ii. An institution that provides a temporary residence for individuals intended to be institutionalized; or
    iii. A public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.
C. Any individual or family who: (i) Is fleeing, or is attempting to flee, domestic violence; (ii) Has no other residence; and (iii) Lacks the resources or support networks to obtain other permanent housing .

2. Household Income

[18] Rapid Re-Housing in Connecticut ESG and COC - Policy manual SFY 2018
[19] FFC CAN Manual

Applicants must be homeless. Households with no income at initial evaluation and/or re-evaluation are eligible.

Recipients and sub recipients must conduct regular re-evaluations, at least every 90 days, of program participants receiving RRH assistance. To continue to receive rental assistance, the program participant household's annual income must be less than or equal to 30% of Area Median Income (AMI) for ESG programs and less than or equal to 50% AMI for CoC/YHDP programs at the 12 month evaluation.

3. VI/SPDAT Assessment

Households must have completed a VI-SPDAT or Next Step Tool for transition aged youth. Score on the VI-SPDAT is not used in determining eligiblity. Programs will be monitored on this to ensure that only literally homeless households who have been through the CAN process are enrolled in RRH programs.

4. Other Eligibility Considerations

As indicated by HUD, households who are participants in rapid-re-housing programs still retain their homeless or chronically homeless eligibility while enrolled in the program thus ensuring that rapid re-housing so that someone can move into a more intensive permanent housing program should they not be successful within rapid re-housing.

Maintenance of homeless and chronic eligibility while in rapid re-housing programs allows providers the capability of attempting to serve those households with slightly higher barriers than they normally would for fear that the household would ultimately need a more intensive intervention. Allowing providers to take more risks will benefit households by providing them with the opportunity to be served through the least restrictive and most independent program that works for them.

Rapid Re-Housing programs may vary and specific program requirements should be followed, and made known to the regional CAN.

5. Participant Prioritization Policy

RRH contractors must work within their CAN to receive appropriate referrals that coincide with the above described prioritization. The CAN decides how to prioritize their allocation of RRH funds for financial assistance. CANs may also establish specific policies regarding short- and longer-term rapid rehousing, or other specific population RRH programs, with regard to targeting these sub-programs to specific populations eligible for RRH.

The Fair Housing Act prohibits discrimination in housing on the basis of race, color, religion, sex, family status, national origin or disability. Other than prohibiting the seven bases of discrimination listed above, the Act does not limit the considerations that may be taken into account in making a housing decision, or prevent the adoption of preferences as long as those preferences do not violate the rights of one of those seven classes. The Act permits preferences for persons who are disabled.

J. Rapid Rehousing Prioritization - Youth (Under Age 25)

1. When we encounter youth in crisis we will take a trauma-informed, individualized approach to assisting the youth with achieving a safe resolution. If we cannot assist a youth with quickly resolving their housing crisis through light touch services, including but not limited to: reunification with family, shelter diversion or rapid exit funding, assistance with self-resolution, crisis housing, etc., then youth on the By-Name-List may be considered for youth-specific housing resources at the local CAN housing placement meetings. Other resources such as Department of Children and Families (DCF) Re-entry, CT Department of Mental Health and Addiction Services (DMHAS) Young Adult Services (YAS) assistance, the START rapid rehousing program, and as necessary, Permanent Supportive Housing should be considered as well when applicable. Exceptions to priori may be considered at the CAN exit solutions meetings and approved by the meeting facilitator or other locally authorized individual and DOH via the rapid rehousing exception form. YHDP Rapid Rehousing is limited to young adults aged 24 or under at time of program entry.

1. ***Youth experiencing chronic homelessness.*** Next Step Tool (or equivalent common assessment tool) score. In the event that there is more than one youth who is verified as experiencing chronic homelessness with the same score, then other factors such as safety concerns, length of homeless history, or unsheltered history should be considered.

2. ***Youth experiencing homelessness*****:** If all youth who are verified as experiencing chronic homelessness are matched to resources, then all other youth (except for youth currently residing in transitional housing) on the Youth BNL will be prioritized for YHDP RRH using the Next Step Tool (or equivalent common assessment tool), serving the most vulnerable first. If more than one youth has the same score, then other factors such as safety concerns, length of homeless history, or unsheltered history should be considered.

3. ***Youth in transitional housing*****:** If all youth from the first and second priority categories are matched to resources, then youth who are currently residing in a transitional housing project, where they were experiencing HUD Category 1 and/or 4 prior to entering transitional housing, can be considered for YHDP RRH and prioritized based on their Next Step Tool (or equivalent common assessment tool) score. If more than one youth has the same score, then other factors such as safety concerns, length of homeless history, and/or unsheltered history should be considered.

CANs need to ensure that youth have access to both youth-specific resources and resources intended for the adult population (Age 18+).

K. YHDP Diversion/Rapid Exit Fund

The YHDP Diversion/Rapid Exit Fund is a modified rapid rehousing program under HUD's Youth Homelessness Demonstration Program that provides short-term financial assistance to young adults aged 25 or under experiencing HUD Category 1, 2, or 4 homelessness to assist them with avoiding entering emergency shelter or to quickly exit from emergency or transitional housing. Youth must have an annual gross household income of less than or equal to 50% AMI at program entry and will be served on a rolling basis based on the date their application for assistance is submitted to the Connecticut Coalition to End Homelessness until the Fund is depleted or expires. Youth do not need a VI-SPDAT or Next Step Tool assessment score to be eligible for this program.

VI. Referrals to CT CAN Participating Project Openings

The CT Coordinated Access System includes a uniform and coordinated referral process for all beds, units, and services available in participating projects for housing and services. All CoC program recipients and sub recipients use the coordinated entry process established by the CT CANs as the only referral source from which to consider filling vacancies in housing and/or services funded by CoC and ESG programs.

All CT CAN participating projects work to ensure that potential project participants are not screened out for assistance based on perceived barriers related to their service needs. Housing providers are encouraged to keep secondary screening to a minimum and to "screen-in" rather than screen out as many referrals as possible. Reasons for denials are tracked on the BNL and discussed at CAN case conferencing[20].

All agencies participating in the CT CANs comply with equal access and nondiscrimination provisions of Federal civil rights laws.

The CT CAN referral process is informed by the federal, state and local fair housing laws and regulations and ensures that participants are not "steered" toward any particular housing facility or neighborhood because of race, color, national origin, religion, sex, disability, or presence of children.

A. Referrals from CAN Centralized Priority Lists and By-Name Lists[21]

1. Referrals to Emergency Shelter

When issuing a referral for Emergency Shelter that cannot be immediately accommodated because no vacancy exists, the CAN may assign the individuals and families seeking services to a

[20] FFC CAN Manual
[21] CT BOS Policies

shelter priority list. Most CANs are prioritizing shelter for those who have been observed to be unsheltered.

2. Referrals to Permanent Supportive Housing

The By-Name-List (BNL) is a centralized priority list for housing resources, including PSH. Each CAN has BNL for their geographic area. When a provider has a vacancy, the next eligible person on the list will be referred to the program with the vacancy at the next CAN Housing Solutions Meeting. To ensure that vacancies are promptly filled, the Coordinated Access Network may issue up to three referrals per vacancy.

3. Referrals to Transitional Housing or Rapid Rehousing

When issuing a referral to Transitional Housing or Rapid Re-housing when there are no vacancies, the Coordinated Access Network will assign the person/household seeking services to the priority list for TH or RRH using the prioritization criteria described above.

When a vacancy becomes available, the Coordinated Access Network will, at the next Housing Solutions Meeting Committee Meeting, based on the prioritization criteria, determine the next individual or family on the applicable priority list and refer them to the program. To ensure that vacancies are promptly filled, the CAN may, at its discretion, issue up to three referrals per vacancy.

B. Notification of Vacancies[22]

All Programs: All Emergency Shelter, Transitional Housing, Rapid Re-housing, and Permanent Supportive Housing Programs are required to report vacancies to the CAN as soon as possible, with the goal of reporting within 24 hours of unit/bed becoming available. If providers know of an impending vacancy, they are required to report the anticipated availability date within 72 hours of being made aware of such availability. Programs must notify the appropriate CAN contact with vacancy information, with the goal of updating within one business day of a unit/bed being filled.

C. Time frames and Expectations for Responses to Referrals by Providers[23]

Emergency shelters will take into immediate shelter any client referred by that shelter's CAN at intake, provided there is available space. Clients experiencing literal homelessness who cannot be accommodated immediately in shelter will be promptly referred to local outreach for services.

[22] CT BOS Policies
[23] CT BOS Policies

Housing programs will accept eligible clients referred by their CAN as quickly as possible, given program capacity and availability of program slots. The process for assignment to a housing resource will comply with eligibility and prioritization guidelines, above, and will be further specified through the local CAN Housing Solutions Meeting process.

D. Client/Consumer Choice – Preference and Decline Policy[24]

Consumers may decline a referral because of program requirements that are inconsistent with their needs or preferences. There is no limitation on this option to decline. The Receiving Program must document the reason for client rejections in the Due Diligence section of CT HMIS in the client record associated with the By-Name List.

The CAN after two rejected referrals by the consumer shall hold a case conference to review and resolve rejection decisions by consumers. The purpose of the case conference will be to resolve barriers to the client receiving the indicated and desired level of service.

E. Provider Declination Policy

1. Emergency Shelter

Emergency Shelters may only decline individuals and families found eligible for and referred by the Coordinated Access Network under limited circumstances, such as there is no actual vacancy available, the household presents with more people than referred by the Coordinated Access Network, or based on their individual program policies and procedures the Emergency Shelter has determined that the individual or family cannot be safely accommodated. The Emergency Shelter must report the reason for any decisions to reject a client to CAN staff. If the rejected client has not otherwise been accommodated for the night, the Emergency Shelter must refer the client back to the CAN, and document that outcome in CT HMIS (or other method of communication such as SmartSheets).

2. Transitional Housing, Rapid Rehousing and PSH Receiving Programs

TH, RRH, and PSH receiving programs may only decline individuals and families found eligible for and referred by the Coordinated Access Network under limited circumstances: such as there is no actual vacancy available; the individual or family missed two intake appointments; the household presents with more people than referred by the Coordinated Access Network; or based on the individual program policies and procedures the Receiving Program has determined that the individual or family cannot be safely accommodated or cannot meet tenancy obligations with the supports provided by the program. Programs may not decline persons with psychiatric disabilities for refusal to participate in mental health services except as required by a funder. Providers must accept at least two thirds of all referrals. Failure to accept

[24] CT BOS Policies

two thirds of all referrals will result in a review of program eligibility by the local CAN Leadership Committee or decision making body.

An intake decision notification will include at a minimum:

- First available move-in date, if applicable
- Reason the client cannot enter the program, including reason for rejection by client or program, if applicable.
- Alternative recommendation regarding indicated housing model/exit option for the client with justification, if applicable.
- Instructions for appealing the decision, including the contact information for the person to whom and time frame under which the appeal should be submitted.

If the homeless individual or family is accepted, the Receiving Program must document that acceptance and notify applicant of acceptance within one business day. In all cases, best faith effort for prompt unit turnover should be made. On average, project-based units should be turned over within 5 business days. Every effort should be made to secure housing within 30 days for clients awarded scattered-site housing certificates.

If the homeless household referred by the Coordinated Access Network has not presented at the Receiving Program within 3 business days from the intake appointment, the Receiving Program should make at least 3 contact attempts to reach the household. All attempts to contact the household should be documented in CT HMIS, in the due diligence section associated with the client record on the By-Name List. In the instance where, after a week of no contact and at least three different contact attempts, if the receiving program is still unable to reach the household, they should immediately notify the Housing Solutions Meeting Committee and request a new referral for the vacancy and return this referral to the Coordinated Access Network.

F. Clients Declined by Multiple Programs

The CAN may convene a case conference in the event that a client is declined by 3 programs. The purpose of the case conference will be to resolve barriers to the client receiving the indicated level of service. The CAN will determine which parties will attend the case conference including but not limited to the Assessment Entity, the Receiving Programs, the Funding Agency, the Client, and other as determined necessary.

G. Returns to Homelessness and Discharges without a Stable Placement

If an individual or family residing at a permanent housing project is at risk of returning to homelessness or an individual or family is being discharged from a transitional housing project or shelter without a stable placement, the service provider is required to notify the local CAN at the earliest possible point in the process. The CAN will convene a case conference to evaluate

the situation, determine intervention(s) that might help to preserve housing or secure an alternative placement, plan for the best possible outcome and try to prevent a return to homelessness. This requirement does not apply in situations of imminent risk to self or others, however, if a participant is immediately discharged as a result of risk to self or others the housing program must notify the Housing Solutions Meeting as soon as possible.

H. Holding Beds/Units - Emergency Shelter[25]

Once a referral is made to emergency shelter, the provider is required to hold a bed until the shelter curfew (or the latest time possible given staffing limitations).

In the event an admitted client does not return for their bed, shelters may adopt their own policies to hold that bed for up to 2 additional nights.

I. Holding Beds-Transitional Housing, Rapid Rehousing and Permanent Supportive Housing

Once referrals have been made by the CAN, the Receiving Program is required to hold the program opening vacant for a minimum of 7 days in order to locate and inform the individual/household of the availability of housing and arrange the intake. Programs should make a minimum of 3 different contact attempts over the course of the week.

J. Grievance and Appeal Policies

All households shall have the right to appeal eligibility determinations and, individual program acceptance decisions, and discharge decisions. Appeals of program acceptance and discharge decisions should be first made to the receiving or discharging agency, using their grievance process. The entity receiving the appeal must respond in writing to all appeals within 14 days.

For DMHAS Funded Programs: All appeals of eligibility decisions and discharges that could not be resolved to the satisfaction of the applicant through the receiving agency's grievance process shall be managed in accordance with the CT Department of Mental Health and Addiction Services Appeals Process. That process entails these steps: 1) Informal conference with the Appeals Committee (a segment of local CAN Leadership) 2) Hearing with the DMHAS Appeal Panel 3) Final review with the staff within the DMHAS Housing Unit - Office of the Commissioner. Each step is available to the applicant if the previous step did not result in satisfactory resolution.

DMHAS funded programs must comply with their appeals process.

K. Process for Referrals to Domestic Violence Programs

[25] BOS Policies

The CT Coalition to End Homelessness (CCEH) and the CT Coalition Against Domestic Violence (CCADV) shall work together to cross-train homeless services providers and providers of DV services in each CAN. The objective of this cross-training shall be to ensure that all providers understand the services and resources available in each system, and are able to quickly cross-refer clients so that their needs can be addressed.

Regardless if the household does or does not wish to seek DV specific services, the household will have full access to the CAN programs and services for which the household is eligible.

L. Process for Referral to VA Programs

2-1-1 seeks to identify veterans experiencing a housing crisis when they call seeking services. 2-1-1 refers these veterans directly to the VA and/or SSVF providers depending on their immediate level of service need. If a veteran enters the homelessness response system and is subsequently identified as a veteran, the presence of that veteran in the system will be notified to VA/SSVF providers via a daily alert sent to the veteran providers to alert them to any new enrollments. Each identified veteran experiencing a housing crisis is tracked from their first point of entry in the system. There is an SSVF project responsible for the outreach and engagement of veterans identified as experiencing homelessness in every CAN/region of the state.

M. Moving On

Over the course of time in a PSH project, many participants stabilize, connect to community supports and experience marked recovery from the disability they presented with. These participants may not need the level of supportive services associated with the PSH project. Discussions about exiting PSH services should be individualized for each participant, informed by the DMHAS Assessment and Acuity Score, tenant preference for discharge from services, and comprehensive service plan for transition from services. All participants in Moving On must be assisted through the transition fully and informed that they may at any time contact the PSH program for assistance to ensure they remain stably housed.

On the DMHAS Assessment and Acuity tool, if all applicable levels fall consistently within the “ideal range” the tenant may be a good candidate for a referral to a Moving On Preference (as available) and/or other affordable/subsidized housing programs.

For participants residing in a Project Based PSH who wish to relocate to a scattered site unit and do not require on site services, they may choose to make steps to greater independence to a scattered site PSH subsidy in the community. This can be facilitated through Housing Solutions Meeting, based on availability.

DOH has established a Homeless Preference for the State of Connecticut Section 8 HCV Program for PSH participants ready to discharge from services but still require a subsidy to maintain housing. Other Housing Authorities throughout the State have also implemented similar “Moving On” preferences. These resources should be incorporated into the local Housing Solutions Meeting and case conferencing process.

Should any household transitioned from PSH to a Moving On Voucher become unstable in their housing, the previous PSH provider should attempt to re-engage with the household, develop a plan to mitigate the crisis and connect to community supports as needed.

Some communities may have subsidies available through a Homeless Preference that are not targeted for "Moving on" from PSH. These subsidies can be targeted towards large families who cannot be matched to other affordable options, families where the children are disabled, and/or affordability for people receiving SSI. Each CAN and subsidy administrator should work together to identify critical gaps in the system.

VII. Best Practices

A. Outreach

Effective street outreach assists people in moving directly from living outdoors into housing of their own without requiring that person to go into shelter. Often those experiencing unsheltered homelessness have many strengths and assets that have allowed them to navigate living outdoors safely. Encampments are difficult to maintain if you are a person experiencing homelessness. A well-organized encampment, when assessed and understood properly, can be a clear sign that the person has a number of organizational and life skills to make the leap directly to housing[26].

A critical component of Outreach is to begin the housing conversation immediately upon encountering an unsheltered person. The housing conversation can happen concurrently while also engaging the client, assisting with basic needs and offering low barrier shelter. Outreach staff may access Diversion or Rapid Exit funding to quickly move an unsheltered person into housing.

Persons living outdoors have the opportunity to access CAN either via calling 2-1-1 or through an outreach worker. Outreach workers and/or drop-in centers act as a parallel path to Coordinated Entry and can access the same resources as a person entering through 2-1-1.

If the unsheltered person cannot be quickly rehoused using their personal income, Rapid Exit or Diversion funds, all Outreach staff must be equipped to complete the mobile VI-SPDAT or paper VI-SPDAT entered into HMIS same day. Furthermore, documentation in HMIS of all encounters is necessary to have a valid history of homelessness and to document eligibility for resources.

It is important that Outreach staff participate in Case Conferencing and Housing Solutions Meeting meetings to ensure no one is left off of the housing resource radar.

B. Shelter

[26] http://www.orgcode.com/5_thoughts_on_outreach_to_housing

The way in which shelters are operated can dramatically impact how long a person remains homeless. Housing Focused Shelters employ a strengths based approach to act as a spring board to quickly get persons experiencing homelessness back into housing.

- Explore diversion options prior to offering a shelter bed/unit, even if the person already was offered diversion.
- Train all staff to focus on housing, even those who serve meals, clean etc.
- Use "Housing Plan" form to continue the conversation started at Diversion. Upload into CT HMIS and all future versions into CT HMIS as well. Set expectations with clients to actively work on housing plan from first day in shelter.
- Differentiate between case management and housing assistance:
    - All residents should be offered assistance locating housing, brainstorming housing options from the moment they enter shelter.
    - Housing groups can be held daily to help more people at one time.
    - Case management will be reserved for those who cannot exit shelter quickly and have additional service needs.
- Ensure shelter is "low barrier" and is able to operate twenty-four hours/ seven days a week for crisis situations.
- Shelter staff support client choice and empowerment at all points in the housing process.

Shelters should work with CT Coalition to End Homelessness (CCEH), National Alliance to End Homelessness (NAEH) and Org Code to ensure they are trained on best practices and work towards statewide uniformity[27][28][29]. It can be a major culture shift to move towards being a low barrier and housing focused shelter. Working through this culture shift with appropriate training and supervision is critical to Progressive Engagement. Shelters who do not shift in this direction will likely have longer lengths of stay and less exits to permanent housing than shelters who have shifted to best practices.

C. RAPID REHOUSING & CRITICAL TIME INTERVENTION

In the event households are unable to self-resolve or exit shelter with a Rapid Exit intervention, the remainder MAY be offered Rapid Rehousing according to the above stated Prioritization Procedures (as funding is available). It is important to keep in mind, the resource gap is such that only a fraction of those who are literally homeless will be able to access RRH resources. It is important to set realistic

[27] https://endhomelessness.org/resource/emergency-shelter/
[28] http://www.orgcode.com/housing_focused_shelter
[29] http://www.cceh.org/resources-library/

expectations with clients and continue to seek multiple housing options and not "wait" for RRH to become available.

According to the National Alliance to End Homelessness:

Rapid re-housing is an intervention designed to help individuals and families to quickly exit homelessness and return to permanent housing. Rapid re-housing assistance is offered without preconditions (such as employment, income, absence of criminal record, or sobriety) and the resources and services provided are tailored to the unique needs of the household. The three core components of rapid re-housing include:

- find housing fast for an individual or family experiencing homelessness
- help pay for the housing through a subsidy
- connect to jobs and other services that help retain housing

In order for clients to have a uniform and equitable experience in RRH, it is recommended that all RRH programs operate in a Critical Time Intervention (CTI) informed approach to services.

Components of CTI[30]:

Rather than providing ongoing assistance, CTI's emphasis is on mobilizing and strengthening client supports during the critical period of transition with the goal of ensuring that these supports remain in place afterwards.

Pre-CTI:

- Develop a trusting relationship with client.

Phase 1: Transition:

Provide support & begin to connect client to people and agencies that will assume the primary role of support.

- Make home visits
- Engage in collaborative assessment
- Meet with existing supports
- Introduce client to new supports
- Give support and advice to client and caregivers

Phase 2: Try-Out:

Monitor and strengthen support network and client's skills

- Observe operation of support network
- Mediate conflicts between client and caregivers
- Help modify network as necessary

[30] https://www.criticaltime.org/cti-model/manuals/

- Encourage client to take more responsibility

Phase 3: Transfer of Care:

Terminate CTI services with support network safely in place.

- Step back to ensure that supports can function independently
- Develop and begin to set in motion plan for long-term goals
- Hold meeting with client and supports to mark final transfer of care
- Meet with client for last time to review progress made

The expectation is that participants in RRH are contributing towards paying their rent, in increasing amounts, and are discharged from the program when they are able to maintain paying their rent. **Finding an affordable unit, even if that means cohabitating or renting a room, is imperative for RRH to be effective.** Participants must be recertified every three months for continued assistance from the RRH program.

VII. Data Management

Since 2004, communities across Connecticut have been entering data into the CT Homeless Management Information System (CT HMIS). The system is managed by the CT HMIS Lead Agency which is tasked with coordination and provision of data management services to Homeless programs, including emergency shelter, transitional and supportive housing programs, and other HUD funded programs that are required to participate in a CT HMIS.

Use of CT HMIS is required of all providers in the CT Coordinated Access System. This statewide database has collects client demographic, service usage and length of stay information on unduplicated clients. CT HMIS has privacy and security protocols for: (1) obtaining program participants' consent for collection, use, storage, and sharing of their information, such as a release of information ROI), and (2) protecting information that is stored or shared outside of CT HMIS. Training on confidentiality, privacy, and security is required, as is ensuring agencies are taking necessary precautions to protect client information

Detailed information regarding the requirement of participating agencies can be found at http://www.cthmis.com. The website includes a detailed policy and procedure manual as well as updates and training materials for users.

A website for Connecticut homelessness data was created in 2018 at www.CTCANData.org to serve as the home for innovative new interactive data dashboards, reports, and other tools that make summary performance data accessible to all. The site features interactive project

performance dashboards for outreach, emergency shelter, transitional housing, rapid re-housing, and permanent supportive housing that are updated with enrollment data from CT HMIS on a weekly basis.

VIII. Evaluation

CT CANs strive to create the best possible design for coordinated access, as well as a mechanism for performance improvement. Ongoing oversight of the system and review of system performance will allow for adjustments to be made as needed. CT CAN Leadership will work closely with CT BOS CoC and ODFC CoC to make timely decisions that incorporate regular feedback from stakeholders, including consumers.

Data from the CT CANs will be reviewed monthly by CAN Leadership using various reports such as CAN Data Dashboard, CAN Data Dashboard CAN Comparisons, Family Homelessness Data Dashboard, Rapid Re-Housing Data Dashboard, and monthly housing reports.

A full system review and evaluation will be conducted on an annual basis reviewing the above data as well as a survey administered to formerly homeless individuals and families, as well as currently homeless individuals and families to provide an ongoing system improvement process.

Beginning in 2019, we have implemented an annual CAN Partner survey for stakeholders, staff, and volunteers associated with the Coordinated Access Network system for homelessness response in Connecticut. This CAN Partner survey is part of our ongoing effort to hear from CAN participants about the quality and effectiveness of the entire coordinated entry system. Additional surveys are in development to gather feedback from all clients who engage with the coordinated entry process as well as clients who are served by projects in our system.

IX. Policy Review

CT CAN Coordinated Entry Policies and Procedures Manual will be reviewed and updated at least annually, or as required by HUD regulatory guidance change.