Greater Richmond Continuum of Care
Coordinated Entry
Policies and Procedures

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Introduction to Coordinated Entry in the GRCoC

The Greater Richmond Continuum of Care (GRCoC) serves the City of Richmond, town of Ashland, and the counties of Charles City, Chesterfield, Goochland, Hanover, Henrico, New Kent, and Powhatan.

Coordinated entry is the unified approach (policies and processes) that governs how people experiencing homelessness access the services available to them. Coordinated entry switches from a project-centered approach to a person-centered approach. The development and use of a Coordinated Entry System is a requirement for communities and programs to receive federal and state funding targeted to address homelessness.

The GRCoC came together in 1997 to understand and meet the needs of our neighbors experiencing homelessness. One of the needs identified early on was to make it easier for people in crisis to access shelter and other services. The community worked together to review models in other communities and recommended a single point of entry to coordinate access to homeless shelters, which was formed in 2004. With the passage of the HEARTH Act in 2009, the introduction of rapid re-housing programs, and the early success of housing first programs, the GRCoC began to review our coordinated entry system and processes. The Richmond region began a concentrated effort in 2013 to design and implement a comprehensive, housing- focused coordinated access system. In 2014, the GRCoC formally established the Coordinated Entry (formerly Coordinated Access) committee, which determined a series of key focus areas for design of the coordinated entry system and its implementation.

Following the publication of HUD's Notice Establishing Additional Requirements for a Continuum of Care Centralized or Coordinated Assessment System in January 2017 (HUD CPD-17-01) and the Coordinated Entry Core Elements guide in June 2017, the GRCoC established a Coordinated Entry Policy Task Force to draft policies and procedures to meet new HUD requirements, as well as community-suggested changes to the Coordinated Entry System. This task force produced the first GRCoC Coordinated Entry Policies and Procedures (this document), which included public comment and was approved by the GRCoC Board in November 2017.

Thereafter, the GRCoC System Policy and Process Committee was charged with regular updates and modifications of this document, in consultation with the GRCoC Board. These updates include

incorporating new locally adopted policies designed to better meet the needs of people experiencing homelessness in our community.

To ensure that the GRCoC's coordinated entry process is flexible and responsive to new information about more effective approaches, this manual will be regularly updated by the System Policy and Process Committee. This manual should be reviewed yearly to ensure the assessment for and entry into homeless services is conducted according to the following procedures.

This manual serves as guidelines for all aspects of the Coordinated Entry System, regardless of funding sources, to ensure that all participants including households in need of assistance are clear about process and expectations.

Version history: First developed and approved in 2017, this manual has been updated in 2019, 2022, 2024, and, most recently in 2026.

Guiding Principles of the GRCoC Coordinated Entry System

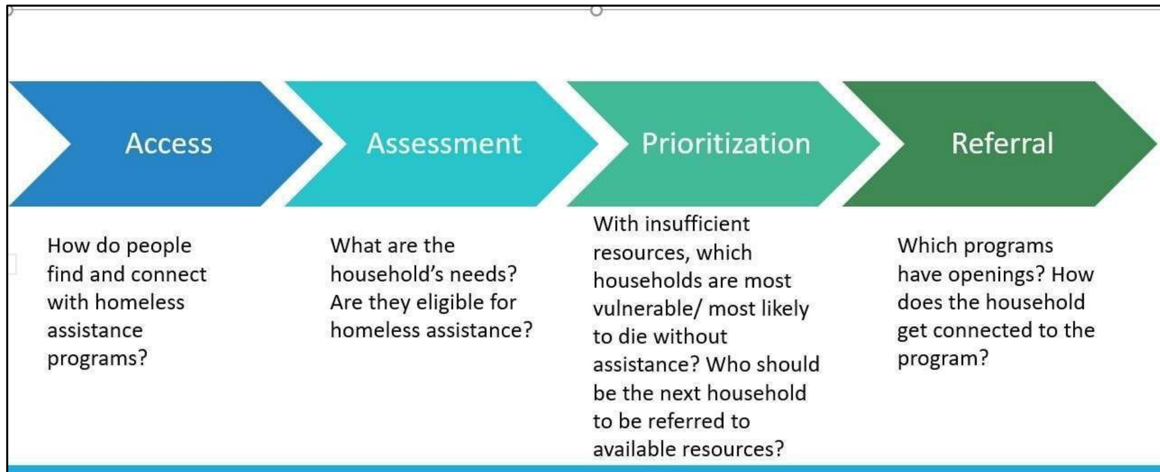
Through significant and sustained community engagement including the voices and input of people experiencing homelessness in our region, the GRCoC has made a commitment to uphold the following principles in our Coordinated Entry System design:

- Transparent: All processes and resource distributions to agencies and clients will be community-driven, visible, and standardized.
- Evidence-based and Data-driven: Data and other evidence will form the basis of all CE decision-making, accountability, and resource allocation.
- Strengths-based and Client-focused: The CES design and implementation will focus on clients' needs/strengths to ensure a dignified, empathetic response that encourages self-determination.
- Easily Accessible: Ensuring that the broader community can easily access the CES will be a priority.
- Housing Focused: All parts of the CES will maintain a focus on housing.
- Continually Improving: Input and data will be gathered for continuous quality improvement, including through feedback from people experiencing homelessness.
- Equity-centered: community members from different backgrounds, particularly those with lived experiences of homelessness, help build and inform the design of the Coordinated Entry System.

Overview of Coordinated Entry

Four Components of Coordinated Entry

The four core components of Coordinated Entry are: Access, Assessment, Prioritization, and Referral. All four components are how a community allocates homeless assistance resources and connects households experiencing homelessness to programs and interventions designed to solve their homelessness and to make connections to mainstream or community-based resources to maintain their housing stability.



No component of coordinated entry—alone or in combination with others—enables a community to serve MORE people or to provide resources which are not available. Coordinated entry allows a community or coalition of providers to make the best use of limited resources to serve the most vulnerable households and to reduce suffering caused by homelessness. Homeless service providers maximize their limited resources so they can say yes to helping as many people as possible, but the reality remains that we can't give someone a resource that we don't have.

Providers in the Greater Richmond Continuum of Care (GRCoC) come together through Coordinated Entry to work through highly complex and interconnected challenges so they can have the biggest impact possible.

Housing-focused Homeless Service Interventions

Outreach: Street outreach and engagement will be low barrier, meaning it will not require high involvement from clients. The target population for outreach will be all individuals living outdoors ("on the streets") and in other places not meant for human habitation. Essential elements for outreach include a staff that visits persons experiencing homelessness in their physical locations; developing trust to engage hard to reach households experiencing homelessness; completing the continuum-wide assessment packet; and providing housing-focused, comprehensive, and coordinated services. While some encounters may take place in an office or other facility, the primary role of outreach is to engage people least likely to seek services.

Community-based Case Management: Problem-solving and resource/service navigation often provided by human service or faith-based organizations.

Diversion: A strategy that prevents homelessness for people seeking shelter by helping preserve their current housing situation or making immediate alternative and safe arrangements. Essential elements for diversion include a dedicated staff that treat the screening process as an opportunity to explore a household's current housing crisis and to be creative about housing options. Screening involves asking the person about every available resource they might have to stay housed or move directly to other safe alternative housing.

Emergency Shelter: Emergency Shelter is defined by the U.S. Department of Housing and Urban Development (HUD) in 24 C.F.R. § 576.2 (2012) as any facility, the primary purpose of which is to provide a temporary shelter for people experiencing homelessness in general or for specific populations of people experiencing homelessness, and which does not require occupants to sign leases or occupancy agreements. Emergency Shelters provide emergency housing to address an individual's or family's immediate housing crisis. Assistance is offered without preconditions (such as employment, income, absence of criminal record, or sobriety) and with few to no barriers. The resources and services provided are typically tailored to the unique needs of the individual or family. Essential elements include no or low barriers to entry, a safe and accessible physical environment, the development of a housing stability plan, and linkages to supportive and mainstream resources.

Housing Choice and Project-based Vouchers: Housing Choice Vouchers: A federal tenant-based rental assistance program administered by Public Housing Authorities. These vouchers are issued to individual households. Voucher holders can use this resource to pay a portion of their rent in private market rental housing. In recent years, HUD has mandated that certain Housing Choice Voucher types (Emergency Housing Vouchers, Mainstream Vouchers) receive referrals from local Coordinated Entry Systems.

Project-based Vouchers: The GRCoC may develop homeless preferences and other referral partnerships in order to target certain vouchers to people experiencing homelessness or a specific subpopulation.

Joint Transitional Housing/Rapid Re-housing: short-term housing and supportive, wrap-around services (up to 12 months) to prepare individuals and families that are experiencing homelessness to secure and maintain permanent housing at exit. This intervention targets individuals and families in life stage transition with moderate to high barriers to housing. Essential elements include affordable housing, case management, provision of or formalized partnership to housing referrals and placement services, and linkage to community supports and/or wraparound system of services in relation to housing placement.

Rapid Re-Housing (RRH): A short to medium term housing option that quickly moves individuals and families experiencing homelessness into permanent housing with needed services to maintain stability. Essential elements include housing-focused services, supportive services coordination, temporary financial assistance, and long-term housing stability planning. Assistance is offered without preconditions (such as employment, income, absence of criminal record, or sobriety); however, RRH recipients must have a lease.

Permanent Supportive Housing (PSH): Permanent, lease-based rental assistance with supportive services that are appropriate to the needs and preferences of tenants. PSH is targeted to chronically-homeless individuals or chronically homeless head of household for families.

Definitions

Access Point: A program through which households experiencing homelessness complete the Coordinated Entry System assessment from which point they can be prioritized and matched to the most appropriate resource(s). The Coordinated Entry System Access is not synonymous with a referral to a homeless assistance intervention. While Access Points assist households experiencing homelessness (intake, safety screening, diversion, etc.) they do not make direct referrals to

additional programs (e.g., emergency shelter). Access points are designated on an annual basis by the GRCoC SPP Committee.

Acuity: Complexity and severity of a client's health conditions. For example, this may include the number of disabilities or chronic health conditions, age, and overall medical vulnerability.

Agency: Any organization providing services to eligible persons experiencing homelessness or at risk of experiencing homelessness.

Client: A person who is eligible to receive services. Also known as program participant.

Continuum of Care: The primary decision making body for coordinated homeless services. The Greater Richmond Continuum of Care is the regional Continuum of Care and is led by the Board of Directors and is designated by HUD to serve this region.

Coordinated Entry System (CES): A system that identifies households that are experiencing homelessness or at risk of experiencing homelessness, assesses their housing and service needs, and quickly connects them to available appropriate housing and services necessary to end their housing crisis as quickly as possible. Common elements of a CES include screening, assessment, and referral, and an electronic information system that helps agencies and people in need of assistance share information. CES serve the interests of people seeking homeless assistance by helping them locate the housing and services they need; of providers, by minimizing time spent assessing people that are not eligible for their projects and services; and of GRCoC stakeholders and public sector funders, by ensuring that the right housing and services are connected to the right people at a community-wide level.

Chronically Homeless Individual: An unaccompanied individual experiencing homelessness, or head of household, with a disabling condition who has either been continuously homeless for a year or more or has had at least four episodes of homelessness in the past three years that total at least one year in length. To be defined as chronically homeless, a person must be sleeping in a place not meant for human habitation (e.g., living on the streets) or in emergency shelter at the time of the count or eligibility determination. The definition does not include those currently in transitional housing, however, chronic status may be retained if chronic homelessness status was established and documented immediately prior to entry into transitional housing.

Greater Richmond Continuum of Care (GRCoC): Serves the City of Richmond, Town of Ashland, and the counties of Chesterfield, Hanover, Henrico, Goochland, Powhatan, New Kent, and Charles City. GRCoC is formally identified by HUD as VA-500 Richmond/Henrico, Chesterfield, Hanover Counties CoC.

Homeless: In order to obtain assistance from the Coordinated Entry System and GRCoC programs, households must meet specific definitions of homelessness as defined by HUD under 24 CFR 576.2. Eligible households include any individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:

1. An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;

2. An individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and

hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low-income individuals[1]); or

3. Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence.

Given the high volume of people experiencing housing instability in the region, the GRCoC targets its resources to households within 3 days of losing their housing.

Homeless Connection Line (HCL): The Homeless Connection Line (HCL) is a phone-based system accessible—at a minimum—during normal business hours. After hours and when the Line is closed for training or other operational necessities, information about available emergency services is provided via a recorded message. Voice messages can be left during operating hours; messages are returned within 24 hours. The HCL number is 804-972-0813.

Homeless Management Information System (HMIS): A database specifically designed to capture client-level, system-wide information over time on the characteristics and service needs of people experiencing homelessness.

Homeward Community Information System (HCIS): An implementation of HMIS used by the GRCoC.

Household: Includes, but is not limited to, regardless of marital status, actual or perceived sexual orientation, or gender identity, the following:

- A single person, who may be an elderly person, displaced person, disabled person, near-elderly person, or any other single person.
- A group of persons residing together, and such group includes, but is not limited to:
    - A family with or without minor children (a child who is temporarily away from the home because of placement in foster care is considered a member of the family).
    - An elderly family.
    - A near-elderly family.
    - A disabled family.
    - A displaced family.
    - The remaining member of a tenant family.

U.S. Department of Housing and Urban Development (HUD): Primary driver of homeless strategy and policies in the U.S. State-level strategy and funding follows HUD's lead. Single largest funder of targeted homeless programs in the region.

Mainstream resources: A term used to describe a variety of federal, state, and county government assistance programs not specifically targeted to persons experiencing homelessness.

Vulnerability: A state of being or a possibility that someone's health and physical safety is being harmed by their situation or others.

[1] See https://www.homewardva.org/point-in-time-count for a detailed briefing on which programs are considered emergency shelters.

Coordinated Entry Governance

System Policy and Process Committee

The Greater Richmond Continuum of Care System Policy and Process Committee uses provider input and expertise to review and update Coordinated Entry policies and processes and program standards as required by federal and state funding and based on need within Greater Richmond Continuum of Care. Relevant policies include access, assessment, prioritization, and referral to emergency shelter, rapid rehousing, joint TH-RRH, and permanent supportive housing, as well as other relevant interventions. Committee members will review drafted documents, provide feedback on documents, and make recommendations for action. The committee is staffed by the Coordinated Entry System Coordinator. Many policies endorsed by the System Policy and Process Committee must be approved by the GRCoC board.

The System Policy and Process Committee is comprised of one voting member representative from each provider type (e.g., emergency shelter, outreach, permanent supportive housing, etc.) and one non- voting Coordinated Entry staff member.

Coordinated Entry System Coordinator

Homeward is the Greater Richmond Continuum of Care designated Coordinated Entry System Coordinator. In this role Homeward manages day-to-day operation of coordinated entry including facilitating referrals, recordkeeping documentation, technology, and other infrastructure that supports the implementation of coordinated entry at the CoC or homeless response system level.

The designation of the Coordinated Entry System Coordinator is governed by a Memorandum of Understanding established/renewed between Homeward and the Greater Richmond Continuum of Care Board.

Evaluation of Coordinated Entry

The GRCoC regularly reviews its access, assessment, prioritization, and referral Coordinated Entry components. These reviews use HCIS data to analyze program and system performance. In addition to HCIS data, qualitative data from service providers, program participants, and people with lived experience of homelessness whose perception and experience may not be captured in numbers, are also included in Coordinated Entry analyses. The Coordinated Entry System Coordinator provides these analyses with considerations for improvements or enhancements to the Coordinated Entry System to the System Policy and Process Committee.

The System Policy and Process Committee annually reviews the role of the Coordinated Entry System Coordinator which includes a review of Coordinated Entry regulatory compliance.

Coordinated Entry as a Requirement for Funding

Coordinated Entry not only streamlines access to and ensures the fairness of the local homeless response system, but it is also a requirement in order to receive funding from certain public sources coordinated through the GRCoC. The Greater Richmond Continuum of Care receives nearly $9 million dollars annually in renewable federal and state funding for homeless services. Locally, each provider applying for funding through these annual coordinated grants must demonstrate that they participate in the Greater Richmond Continuum of Care Coordinated Entry System.

Participation in Coordinated Entry

Homeless service providers demonstrate participation in the GRCoC Coordinated Entry System by executing a Coordinated Entry System Memorandum of Understanding. The Coordinated Entry System Memorandum of Understanding is an annual GRCoC document designed to outline roles and responsibilities of homeless service providers in the Greater Richmond Continuum of Care.

Updated and approved by the System Policy and Process Committee, the Memorandum of Understanding defines service coordination, Homeless Management Information System use, and the System Policy and Process Committee voting and membership eligibility. When considering approval, the System Policy and Process Committee reviews if the provider meets relevant program standards, as well as demonstrating a commitment to complying with policies and coordinating services. Two staff members from each participating agency are required to attend a yearly Coordinated Entry System training before submitting the Memorandum of Understanding.

Coordinated Entry Policies and Processes

Policies on the Implementation of Coordinated Entry Core Components

Access

Access Points are avenues through which households in a housing crisis complete the Coordinated Entry standardized assessment and are connected to the most appropriate available resource(s). Coordinated Entry System Access is not synonymous with a referral to a homeless assistance intervention. While Access Points assist households experiencing homelessness (intake, safety screening, diversion, etc.) they do not make direct referrals to additional programs (e.g., emergency shelter).

Based on our community's geography and transportation options, the GRCoC has multiple access points:

1. The Homeless Connection Line (HCL) is a phone-based system, accessible—at a minimum—during normal business hours. After hours and when the Line is closed for training or other operational necessities, information about available emergency services is provided via a recorded message. Voice messages can be left during operating hours; messages are returned within 24 hours.

2. Coordinated outreach providers will cover the entire geographic area of the GRCoC. When outreach is requested, staff should engage with the household within 2 business days. Evening and early morning outreach may be used to find individuals and families who may not be seeking out services.

3. The Empowernet Domestic Violence hotline is available during all hours on all days for individuals and families experiencing and at risk of sexual and/or domestic violence, dating violence, trafficking, or stalking.

At the access points, workers:

- Initiate the continuum-wide assessment packet, including (at minimum) a safety screening, diversion, and basic assessment (HUD required data elements—highlighted in red in HCIS).
- Enter information from the assessment into HCIS or comparable database for Empowernet.
- Facilitate problem-solving and housing-focused conversations with household.
- Ensure effective communication with individuals with disabilities by providing appropriate auxiliary aids and services such as Braille, large print, and sign language interpreters.

Assessment

Standardized Assessment: All Permanent Supportive Housing, Emergency Shelter, Joint Transitional/Rapid Re-housing, and Rapid Re-housing programs funded with Continuum of Care (including Youth Homelessness Demonstration Program) and Emergency Solutions Grant funds are required to use a standardized assessment tool. In the GRCoC Coordinated Entry System, all referrals to Permanent Supportive Housing, Emergency Shelter, Joint Transitional/Rapid Re-housing, and Rapid Re-housing are based on the standardized assessment.

Intake workers at all Access Points will use the standardized assessment to review clients' situations and determine eligibility for services. The structure of the assessment and the specific questions it contains enable the GRCoC to collect information in a standardized way, to determine a household's eligibility for specific housing interventions, and to prioritize households for housing interventions.

The standardized assessment contains several basic components and is initiated by Access Points. Access Points conduct assessments to gather or determine:

1. Immediate safety of the household
2. If household is able to be diverted
3. Verification and documentation of homelessness as defined by HUD
4. Basic demographic/contact information including the information required by HUD and information necessary to continue contact with the household.
5. Acuity of service needs (health, mental health, physical disability, risk of victimization, pregnancy)

Assessment Process: All households will receive a phone or in-person assessment, based on the household's need, to determine its eligibility for homeless services. Clients may decline to answer certain assessment questions without fear of retribution or loss of services; however, some programs may require specific information to determine eligibility. Staff completes assessment in safe and confidential ways so that individuals can share information privately. Households must be reassessed for HUD eligibility criteria if more than 21 days have passed since the previous assessment.

Sample Script to explain assessment: "*We are conducting an assessment to refer you to the most appropriate resource. These questions will assist in determining the best referral for individuals experiencing a housing crisis. Some of the questions may seem repetitive. These questions are needed to match you with the best available housing intervention. There is no guarantee of service because we do not have immediate access to services at this time. It is important to stay in contact with us or another case manager to update your situation and continue to explore housing options while we work to match you with community resources."*

Households must complete the following sections of the assessment:

1. Immediate Safety Screening - If a household is identified by any component of the Coordinated Entry System to be fleeing domestic violence that household is transferred to the DV Access Point, the EmpowerNet Hotline at 804-612-6126, immediately. If the household does not wish to use DV specific services, the household will have full access to the CES, in accordance with all protocols described in this manual. If the DV hotline determines that the household is not at imminent risk, the household is transferred via warm handoff to the other Access Points of the CES.
2. Homelessness Screening - If household is self-reported to be neither at imminent risk of

homelessness nor experiencing homelessness as defined by HUD, the household is provided information on other community resources.

3. Diversion Questions/Assistance - Essential elements for diversion include trained staff that treat the screening process as an opportunity to explore a household's current housing crisis and be creative about housing options. Diversion supports exploring housing options; helps mediate conflicts with landlords, family, or friends connected to housing; and assists in identifying resources and natural supports to retain or access housing. Assistance is offered without preconditions (such as employment, income, absence of criminal record, or sobriety).
4. Basic Assessment - Basic demographic/contact information including the information required by HUD and necessary to continue contact with the household (HUD required data elements—highlighted in red in HCIS).
5. Acuity of Service Needs Assessment[2]:
    i. In the past week, have you used an emergency hotline or crisis service? Such as: emergency rooms, in-patient psychiatric center/hospital, sexual assault crisis, mental health crisis/hotline, family/intimate violence, and suicide prevention hotlines?
    ii. Do you feel that your physical safety is at risk?
    iii. Do you require medical attention for wound care, dialysis, chemo, and/or disease?
    iv. Are you currently 3 months or more pregnant?

<u>Prioritization Policies and Referral Process</u>

1. Access to the Coordinated Entry System/Initial Request for Services – Households in need may initiate requests for service through any of the designated Access Points. These Access Points are designated by the SPP Committee.
2. Assessment – Initiated at Access Points and supplemented by emergency shelters and other providers, assessments are conducted with households in need.
    a. The standardized assessment is completed using HCIS, with the exception of those clients accessing providers prohibited from using HCIS. This includes HUD-required data elements, and questions about medical/behavioral health vulnerabilities, physical safety, and pregnancy.
    b. Persons seeking assistance who are experiencing homelessness or will experience homelessness in less than three days have a diversion conversation to determine if safe housing can be retained or accessed. Persons who will become homeless in more than 3 days are connected to relevant mainstream resources to assist in resolving their housing instability.
3. Eligibility and prioritization for shelter - Households are eligible for emergency shelter when they cannot be immediately connected with housing and have nowhere else to go or while the housing location process occurs. Referrals to emergency shelter are based on shelter space availability, is sorted by community prioritization criteria, and is facilitated by community referral processes.
    a. Shelter bed referral process (for non-DV and non-Veteran beds)- Once a match has been made, Coordinated Entry referral staff will attempt to contact the household by phone (phone numbers are listed in HCIS) or through coordination with an outreach worker. Once contact is made, the Coordinated Entry referral staff provides information to the client about shelter location and intake times and processes. The Coordinated Entry referral staff then communicates the referral to the shelter provider and records the referral in HCIS.

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[2] The acuity questions of the standardized assessment were developed from questions in the Vulnerability Index -Service Prioritization Decision Assistance Tool (VI-SPDAT). The VI-SPDAT was previously used by the GRCoC as for an assessment tool and prioritization method. The acuity questions used in the current standardized assessment were endorsed by the System Policy and Process Committee, and were selected based on community stakeholder input, including people with lived experience of homelessness. The acuity questions are aligned with the GRCoC's Plan to Serve Individuals and Families Experiencing Homelessness with Severe Service Needs.

4. Housing intervention prioritization (Rapid Re-housing, Permanent Supportive Housing, Joint Transitional/Rapid Re-housing, Housing Vouchers) – Information gathered from assessments is used to determine which available housing intervention is best suited to end the household's homelessness. Community prioritization criteria, through HCIS or comparable database (if DV-specific) reporting will create reports to match clients with Rapid Re-housing and Permanent Supportive Housing program spots through community processes. Housing program providers will report current and upcoming vacancies to their respective referral process. The referral process staff then match clients to reported openings based on the opening type, client eligibility, and community priorities. This match will include preliminary verification of client eligibility (e.g. the client is still experiencing homelessness) and client interest in the housing intervention.
    a. Housing intervention referral process (for non-DV- non-Veteran-specific programs)– Once a match has been made by Coordinated Entry referral staff, households will be connected to a case manager at the housing provider, who begins or continues the work necessary to house the client(s). This work should be coordinated with shelter case managers, outreach workers, and/or other case managers for the benefit of the client(s). Rapid Re-housing providers should schedule an intake with a referred client within three business days of referral and begin the housing search and navigation process.

Case Conferencing

Case conferencing is the regular meeting of GRCoC service providers, led by the Coordinated Entry System Coordinator, that collaboratively problem-solves identified barriers to housing for households that are eligible for a housing intervention. This meeting also allows for case managers to present qualitative information about a household's situation that may not be captured in HCIS data. The goal of case conferencing is to address the identified barriers in order to more quickly house people.

Client Choice and Denial of Service

The GRCoC prioritizes client choice which may include a denial of offered services. A client's choice to decline services or housing does not impact the client's future prioritization, assessments, or referral opportunities. Clients may decline a referral because of program or agency requirements that are inconsistent with their needs or preferences. There is no limitation on the number of times a client can decline. When this occurs, case management staff will communicate that limited community resources are available and multiple declines might leave few community resources available for a housing match. Case conferencing can be used to help find housing options in these situations. Programs may require participants to provide certain pieces of information to determine program eligibility only when the applicable program regulation requires the information to establish or document eligibility. In accordance with HUD Coordinated Entry requirements (24 CFR 578.7(a)(8)), assessments must not require disclosure of specific disabilities or diagnoses unless such information is necessary to determine program eligibility.

Data Sharing and Reporting Requirements

Homeward Community Information System

The Homeward Community Information System (HCIS) is used to track all data related to the GRCoC's Coordinated Entry System. HCIS is a local implementation of a Homeless Management Information System. The HCIS is a HIPAA-compliant online database used to record and retrieve client-level and systems-level data. HCIS meets or exceeds all federal regulations regarding Homeless Management Information Systems. Prioritization reports may be managed outside of HCIS but the reports are generated using client information in HCIS to update the list/pool.

HCIS Policy and Client Confidentiality

Agencies that participate in the HCIS have access to a common set of tools and agree to uphold standards of privacy and confidentiality as a condition of continued use. Those standards are codified in the HCIS Policies and Procedures, which can be found on Homeward's website (www.homewardva.org).

The GRCoC 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, and (2) protecting information that is stored or shared outside of HMIS. Training in confidentiality, privacy, and security is required, as is ensuring agencies are taking necessary precautions to protect client information.

All programs receiving funds through the GRCoC (e.g., Continuum of Care/Youth Homelessness Demonstration Program, Virginia Homeless Solutions Program) and Emergency Solutions Grant are required to maintain client data in HCIS, unless otherwise prohibited from doing so, as is the case with Domestic Violence service providers receiving Continuum of Care or Emergency Solutions Grant funding (Domestic Violence service providers use a comparable database).

HMIS will be used for the following activities, to the extent the database can support them:

- Entering assessment: The assessment for connecting clients to the appropriate housing intervention.
- Eligibility matching: Each project's funder-mandated eligibility criteria.
- Tracking real-time program availability: HMIS reporting will be used to provide information on availability of beds/openings in real-time.
- Client referrals: All referrals, including for emergency shelter, will be made and tracked in HCIS to streamline the process for providers and clients and for system performance improvement purposes. Relevant HCIS case notes related to referrals and CES should be continuously updated in the client record to reflect the latest activities and engagements.
- Program documentation: Capture and save important client documents in the system, such as releases of information, copies of client IDs, or eligibility documentation.
- Recordkeeping: Homelessness status must be verified through recordkeeping and documentation procedures outlined by HUD in 24 CFR 576.

All agencies that wish to or are required to participate in the Coordinated Entry System must comply with the HCIS application and implementation processes and adhere to the requirements in the HCIS policy manual including completing required trainings and ensuring client confidentiality. Agencies that do not currently have HCIS access must first meet with the HCIS Lead staff at Homeward and then complete an application for HCIS Committee consideration.

Non-Discrimination Policy

The GRCoC expects providers to comply with Fair Housing Laws, including the Fair Housing Act (protected classes include race, color, national origin, religion, sex, disability, and familial status),the Americans with Disabilities Act and the Virginia Fair Housing Law, which further protects “elderliness,” individuals age 55 or older, from housing discrimination. Complying with these statutes includes:

- Making known that rental assistance and services are available to all on a nondiscriminatory basis and ensuring that all households have equal access to information about and equal access to the financial assistance and service providers.
- Providing meaningful access to persons with limited English proficiency.
- Informing households how to file a housing discrimination complaint – Housing Discrimination Hotline: 1-800-669-9777 or the Virginia Fair Housing Office at 1-888- 551-3247.

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 using a wheelchair, allowing nursing aid to come into shelter, providing private bathroom/room/space, and/or providing access to a bottom bunk bed. The nondiscrimination policy applies to all GRCoC providers who participate in Coordinated Entry.

Equal Access Policy

Shelter providers 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 LGBTQIA persons because of their real or perceived gender identity or any other reason that constitutes sex-based discrimination.

Grievance and Appeals Policy

All households served by agencies within the Greater Richmond Continuum of Care (GRCoC) have the right to file a complaint or grievance with any agency within the GRCoC homeless response system if they feel they have been:

- Unjustly denied service through not receiving a referral or being discharged/banned from the program.
- Received threats of harm or actual harm to their person or property within the GRCoC homeless response system.

All households must initially file a complaint or grievance through the agency’s formal process. The GRCoC grievance appeal process is only enacted when an agency has not followed or properly documented their own grievance policy.

Clients are given a copy of the Grievance Policy and a Client Grievance Form when the grievance is identified. Staff at GRCoC agencies, including Coordinated Entry System (CES) staff, should explain clients’ rights to them and how the grievance procedure works. If asked, staff members will help clients complete the form and file the grievance.

Operational Guidelines

Referral Process

Notification of Vacancies

All Emergency Shelter, Rapid Re-housing, Joint Transitional/Rapid Re-housing, and Permanent Supportive Housing providers are required to report vacancies to the Coordinated Entry referral staff within 12 hours of the unit/bed availability. If Rapid Re-housing, Joint Transitional/Rapid Re-housing, and Permanent Supportive Housing providers know of an upcoming opening, they are required to report the anticipated availability within 72 hours of being made aware of such availability, ideally reporting the next 2 weeks of projected availability. Emergency Shelter providers must report vacancies using HCIS no later than 8:30am each weekday morning.

Referral to Emergency Shelter

GRCoC Coordinated Entry referral staff refer clients to general population (non-Veteran or non-DV) Emergency Shelter using HCIS, to include a HCIS notification, as well as an email to the Emergency Shelter provider. Relevant information about household size, necessary shelter intake information, and special accommodations is included in the notes of the referral. General population shelter providers may only take referrals the Coordinated Entry System process.

Receiving Providers

All Emergency Shelter, Rapid Re-housing, Joint Transitional/Rapid Re-housing, and Permanent Supportive programs are “receiving providers” and are responsible for reporting vacancies in compliance with the methods detailed in this document. Any such provider that receives a referral through Coordinated Entry is responsible for responding to that referral in accordance with this document.

Timeframes and expectations for response to referrals by providers

Emergency Shelter: Provider must make a determination of eligibility of a referred client presenting at shelter prior to providing a shelter bed to that individual/household.

Emergency Shelters may only decline households found eligible for and referred through Coordinated Entry under limited circumstances, such as a household presenting with more people than referred. The shelter must report the reason for rejecting a household to the Coordinated Entry referral staff.

Rapid Re-housing: Provider must determine eligibility and acceptance or rejection into the program within two business days of intake.

Rapid Re-housing providers may only decline households found eligible for and referred by the CES under limited circumstances, such as a household misses two intake appointments. The provider must report the reason for rejecting a household to Coordinated Entry referral staff.

Permanent Supportive Housing: Provider must schedule a client intake within 3 business days of referral, as well as determine eligibility and acceptance or rejection into the program within two business days of intake.

Permanent Supportive Housing: may only decline households found eligible for and referred by the CES under limited circumstances, such as if household misses two intake appointments. The

provider must report the reason for rejecting a household to Coordinated Entry referral staff.

Joint Transitional Housing/Rapid Re-housing: These youth-specific programs are funded through the Youth Homelessness Demonstration Program and were implemented in October 2023. In order to support these new programs, a timeline for determining eligibility had not been finalized at the time of this document's latest revisions.

Eligibility and Prioritization Criteria by Service Type

GRCoC 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, previous declines of services, mental health, and criminal record) and 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, and/or employment.

To ensure flexibility informed by new research, data analyses, and input from people experiencing homelessness and homeless service providers, the System Policy and Process Committee may make recommendations for additional targeting and prioritization criteria.

Diversion: Households that are three days or less from losing housing, including those that are already experiencing homelessness, are eligible for diversion assistance.

Domestic Violence Emergency Shelter: Households that are in imminent danger are eligible for domestic violence emergency shelter. Imminent Danger is defined as: Recent Occurrence (Case by case); On-Going and Consistent; Threats by means of Sexual, Physical, Verbal, and Emotional violence; Threat and/or access to Weapons/Firearms; and/or Children experiencing Violence, Threat of Violence, and/or Witness of violence. Eligibility and priority are further described in the following four tiers:

1. Client and/or her/his children are in imminent danger of domestic and/or sexual violence.
2. Client and/or her/his children have recently experienced domestic and/or sexual violence but are not currently in imminent danger.
3. Client and/or her/his children are homeless and are past victims of domestic and/or sexual violence but are not currently in imminent danger.
4. Client and/or children are homeless, have not experienced domestic and/or sexual violence and there are beds available.

Emergency Shelters: Emergency shelter is prioritized for households that are not able to be diverted and are within three days or less of experiencing homelessness as defined by HUD. Households are further prioritized based on length of homelessness of the current episode of homelessness, determination of vulnerability due to health, victimization, age, or other factors as established by the GRCoC.

Rapid Re-housing (RRH): To obtain rapid re-housing, households must meet the HUD definition of homelessness and be without other housing resources. RRH is prioritized among all sheltered and unsheltered homeless households based first on acuity of service needs and length of homelessness in the current episode of homelessness.

Joint Transitional Housing/Rapid Re-housing (Joint TH/RRH): To access the Joint TH/RRH project, households must meet the eligible HUD definitions of homelessness, be without other

housing resources. At the point of enrollment, all adults in the household must be between the ages of 18-24, though members of the household outside of that age range may be added after enrollment. Joint TH/RRH resources are prioritized among all sheltered and unsheltered homeless households between the ages of 18-24 first by unsheltered status and then by length of homelessness in the current episode of homelessness.

Permanent Supportive Housing (PSH): Households that meet the definition of chronic homelessness are eligible for PSH. This includes sheltered and unsheltered households, as well as households that are currently receiving RRH financial assistance and were chronically homeless prior to moving into housing. PSH is prioritized among all chronically homeless households (sheltered or unsheltered) based first on acuity of service needs and length of homelessness in the current episode of homelessness.

Supportive Services for Veteran Families (SSVF): All SSVF beds/units are Veteran-specific and assigned through the VetLink housing team. Priority for these beds/units is based on vulnerability. The VetLink Team uses length of time on the VetLink case conferencing list, acuity of service needs, and age to determine vulnerability. (Other transitional beds/units exist in the community but are not part of/assigned through coordinated entry).

Public Housing: The GRCoC has an agreement, in cooperation with Homeward and the Richmond Behavioral Health Authority (RBHA), with the Richmond Redevelopment and Housing Authority (RRHA) to provide a preference for public housing for families experiencing homelessness. These families must currently be in a GRCoC emergency shelter and meet additional criteria (such as certain criminal background restrictions) set forth by RRHA. A RBHA staff member conducts assessments, facilitates the application process, and provides supportive services for families connected to public housing through this preference. The preference is codified in a regular Memorandum of Understanding.

Housing Choice Vouchers Made Available to the CES: The GRCoC has an agreement with local Public Housing Authorities, such as Richmond Redevelopment and Housing, Henrico, and Central Virginia Resource Center to coordinate referrals for Housing Choice Vouchers mandated by HUD to come through Coordinated Entry (e.g., Mainstream Vouchers). Guidelines for how these vouchers are administered are set by HUD and the local public housing authority. The GRCoC has a local prioritization process to connect eligible applicants to a voucher who are currently residing in PSH and are ready to move on, clients engaging in street outreach, emergency shelter, and clients who are matched and or housed in RRH and are currently receiving services but would be best served with a voucher to receive ongoing rental assistance.

Summary of Prioritization Criteria

Intervention	Eligible Population	Prioritization
Diversion	Households that are 3 days or less (including literally homeless) from losing housing	None
Domestic Violence Emergency Shelter	Households that are in imminent danger (Recent Occurrence [Case by case]; On-Going and Consistent; Threats by means of Sexual, Physical, Verbal, and Emotional violence; Threat and/or access to Weapons/Firearms; and/or Children experiencing Violence, Threat of Violence, and/or Witness of violence).	Household is connected to safe, temporary accommodations. Determination of service connection is made by the Empowernet DV collaborative.
Emergency Shelter	Households within 3 days of becoming homeless and cannot be diverted.	• Longest current episode of homelessness • Unsheltered homelessness status • Other vulnerability factors as determined by as determined by the SPP Committee.
Rapid Re-Housing	Households that are literally homeless and are without other housing resources.	Acuity of service needs as determined by the SPP Committee. Longest current episode of homelessness
Permanent Supportive Housing	Households that meet the definition of chronic homelessness.	Longest current episode of homelessness Acuity of service needs as determined by the SPP Committee.

SSVF	Households that are homeless and Veterans.	Length of time on the Velink case conferencing list, severity of service needs, and age.
Joint Transitional Housing/Rapid Re-housing	Households aged 18-24 within 3 days of becoming homeless, or otherwise meet HUD definitions of homelessness in categories 1, 2, and 4.	Households that are currently unsheltered or living in a place not meant for human habitation (sorted by length of homelessness All other eligible households (sorted by length of homelessness)
Public Housing	Households with minor children who reside in GRCoC family emergency shelters and meet other RRHA-established criteria.	None

Housing Choice Vouchers	All household types (singles and families) who are currently residing and/or engaging with an eligible provider type.	1. Household is prepared to move from HUD-funded PSH AND does not need ongoing supportive services or has access to the supportive services needed from another program. 2. Household is currently unsheltered and in an open outreach program with a history of 45 days unsheltered within the past 90 days AND does not need ongoing supportive services or has access to the supportive services needed from another program. 3. Household is prepared to move from HUD- or VHSP-funded RRH program AND does not need ongoing supportive services or has access to the supportive services needed from another program. 4. Household is a current resident in an emergency shelter program with a literally homeless living situation reported in HMIS and has a history of multiple (2 or more) or lengthy (longer than 45 days) emergency shelter

		stays within the last 3 years AND does not need ongoing supportive services or has access to the supportive services needed from another program.