Greater New Haven
OPENING DOORS
A Regional Alliance to Prevent and End Homelessness

Coordinated Access Network

Policy and Procedures Manual

This manual would not be possible without the hard work and dedication by dozens of individuals from various agencies and organizations who participated in multiple meetings and discussions.

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Staff members at Duty Service Coordinator Meetings and Housing Case Conferences also participated in helping to draft various parts of this manual.

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Adopted
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Purpose of this Manual

The policies and procedures contained in this manual will guide the implementation, governance, and evaluation of the Greater New Haven Coordinated Access Network (CAN) and serve as a universal communication and training tool for agencies participating in the CAN. The policies and procedures were developed through an inclusive process that included all the agencies providing homeless services (shelter, supportive housing, rapid re-housing, and diversion) to individuals, families, and youth in the Greater New Haven region.

Values and Guiding Principles

- **Consumer Focused**: Clients will be given clear and easy access to services that offer choices, and will be engaged as valued partners in the implementation and evaluation of the CAN.
- **Collaboration**: Collaboration will be fostered through open communication, transparent and collective decision making and consistent reporting on the performance of the system.
- **Data Driven:** Data collection on people experiencing homelessness and evidence based practice are key components of the CAN. Data on client needs, effective interventions, and system and program performance will be used to assist with the realignment of services and resources to support the efforts needed to end homelessness for residents of Greater New Haven.
- **Prioritizing the Most Vulnerable**: The CAN will prioritize services for vulnerable individuals and families, and will efficiently and effectively match appropriate resources based on shared tools and processes to end or prevent homelessness.

Result

To end homelessness for people who are veterans or chronically homelessness by 2016, and to end family homelessness and all other forms of homelessness by 2020. Ending homelessness does not mean no one will become homeless. Rather it means that when someone becomes homeless in our community, the community goal is to ensure that they move into permanent housing within 30 days.

Target Population

The CAN is intended to serve people experiencing or at imminent risk of homelessness.

Indicators

- Reduce new entries into homelessness
- Reduce lengths of episodes of homelessness
- Reduce repeat entries into homelessness

SECTION I: ENTRY INTO SHELTER

Connecticut's coordinated access guidelines now require that everyone seeking emergency shelter go through the state's 2-1-1 system.

A. PRESCREENING

A trained 2-1-1 Housing Specialist will perform an initial assessment, make referrals as needed to help avoid homelessness and, when appropriate, schedule a community-level assessment appointment. The initial assessment will determine if the single male, female or family has an ***immediate need defined as nowhere to stay tonight*** or is at imminent risk. For families, imminent risk is defined as they will be homeless within 7 days and for individuals it is defined as being homeless with 48 hours.

2-1-1 will work with the family or individual to encourage shelter diversion to greatest extent feasible, and will refer clients to other resources (e.g. eviction prevention programs) as appropriate. If no immediate diversion is possible and eligibility for intake verified, 2-1-1 will schedule an assessment appointment with Duty Services Coordinator for the next available business day.

In the event that the client is literally homeless and has nowhere to go for the night, provisional arrangements can be made as follows:

- **Singles:** Single men are directed to available walk-in or warming facility (seasonal). Single women are directed to Columbus House or warming facility (seasonal), but due to limitations on shelter beds the situation may arise that a provisional arrangement may not be available. (Appendix 1)
- **Families:** 2-1-1 calls the designated provisional shelter for the day to determine bed availability. If there is an opening and the client needs transportation to the shelter, the 2-1-1 housing specialist will complete a taxi voucher (Appendix 2; Taxi Voucher protocol). If all the beds and emergency cots in the GNH CAN family shelters are full, a hotel/motel room can be set up for the family if funding is available (Appendix 3; Hotel/Motel protocol).

In the event that the client has a status change (single to family or vice versa) the client is required to call 2-1-1 again and begin the process over.

Special populations – Veterans and youth[1] will also be prescreened by 2-1-1. The GNH CAN currently has a distinct assessment and placement procedures for Veterans. If a veteran calls 2-1-1 with a housing need and self identifies as a veteran, they are offered a vet-specific assessment appointment with SSVF and assigned an appointment within 2 business days. If the veteran shows up for their appointment, they will sign the HMIS release and the VA serves the veteran by usual protocols. If the veteran does ***not*** self-identify as a Vet, 2-1-1 will follow the normal CAN protocols. If subsequently, the individual identifies themselves as a Vet the DSC will send the Vet to the Errera Center where the regional Supportive Services for Veteran Families Program provider (SVFF) staff have co-located to conduct the veteran assessment (Appendix 4: Veterans Protocol). The Veterans Administration will ensure that clients' data are entered into HMIS.

[1] *There is currently no existing distinct assessment and placement procedure for unattached Youth. This is currently under development by CT Opening Doors Committees.*

Inter-CAN Transfer -- A statewide Inter-CAN Transfer Policy has been developed to ensure the system is client-centered and is intended to return individuals and families back to their community of origin, or reconnect households with informal or formal resources.

INTER-CAN TRANSFER POLICY

For any individual or family who wants to be housed in another CAN they must call 2-1-1 and request to be added to another CAN's Housing Registry/Priority List, schedule a CAN appointment in their chosen location, and complete a CAN intake in accordance with the receiving CAN's policies and procedures.

B. ASSESSMENT APPOINTMENT

The purpose of the assessment appointment is to assess the client's immediate situation and to determine whether the client can be diverted from shelter. The assessment appointment ***may not*** require or result in shelter admission. Clients who miss assessment appointments will be referred back to 2-1-1 to re-schedule.

Depending on funding, cash resources may be available to divert a family or individual from entering shelter by maintaining or establishing stable housing, which may include relocation (Appendix 5: singles diversion procedure and Appendix 6: family diversion procedure).

On a daily basis, the Duty Service Coordinator (DSC) Team will conduct a conference call to review assessment appointments for the day (using HMIS) and provide assessment services scheduled by 2-1-1. The Duty Service Coordinator of the day will facilitate the conference call.

At the assessment appointment the Duty Service Coordinator will:

- Have the client complete the CAN HMIS Authorization for Release of Information and the Greater New Haven CAN Authorization for Release of Information and **may** upload the releases into HMIS if necessary technology is available. If not, releases must be placed in client's file.
- Complete the workflow in HMIS, including the CT Statewide CAN Intake.
- Complete the VI-SPDAT for Individual.
- Match clients that require emergency shelter and have no other viable alternatives with best-fit shelter opening (providers report open units on daily basis at morning conference call).
- Call ahead to shelter with open unit, and then send client to the shelter (arrange transportation, if required).
- Update HMIS with outcome of client appointment (no show, diverted, accepted for enrollment, waitlist, refused). If a client refuses shelter, the reason for the refusal should be recorded in the notes section.

If the Duty Service Coordinator has a planned absence it is the responsibility of the DSC to 1) Attempt to find coverage for that day if possible either within their agency or by switching with another DSC. 2) Notify the CAN Entry Coordinator and 3) Inform 2-1-1. This should be done with as much notice as possible. If the DSC is unable to find coverage they should notify the CAN Entry Coordinator and 2-1-1 at

least 2 business days prior to absence. The CAN Entry Coordinator will request that 2-1-1 reschedule all appointments over the next two weeks not exceeding the maximum daily scheduled appointments.

If the Duty Service Coordinator has an un-planned absence OR the Assessment Office is closed for whatever reason , it is the responsibility of the DSC to 1) Notify the CAN Entry Coordinator and 2) Inform 2-1-1 **immediately**. The CAN Entry Coordinator will request that 2-1-1 reschedule all appointments throughout the next two weeks not exceeding the maximum daily scheduled appointments.

Assessment Appointment Wait Time – The Greater New Haven CAN strives for a ZERO wait time. However, at any point there may be more clients scheduled for assessments than there are available appointments. Duty Service Coordinators will make every effort to divert using diversion strategies and funding, as available, if the client has come through 2-1-1 and they have an assessment appointment scheduled (Appendix 5: singles diversion procedure and Appendix 6: family diversion procedure).

ASSESSMENT WAIT TIME POLICY

Alternative strategies to complete assessments will be triggered by the DSC Team as follows:

- **Singles:** 8 days wait from 2-1-1 call to assessment appointment
- **Families:** 2 weeks wait from 2-1-1 call to assessment appointment

In the event the assessment appointment wait list cannot be reduced through diversion efforts, the Duty Service Coordinator Team and CAN staff can initiate other strategies to reduce the assessment appointment wait list (e.g., wait list clinic).

SECTION II: SHELTER PLACEMENT

The GNH CAN is the local gateway for shelter placement in the region. Working collaboratively, shelter providers will collectively ensure that vulnerable individuals and families are prioritized for shelter placement.

A. MATCHING CLIENTS

On a daily basis, the Duty Service Coordinator Team will conduct a conference call to review current availability of shelter space and match clients that require emergency shelter using the shelter placement priority policy with the best-fit shelter opening (Appendix 7: DSC daily call protocol).

When making shelter placement decisions, the DSC Team will take into account family circumstances (e.g., family size and composition), the level of care needed by the client and the services provided by the programs in order to ensure the most appropriate fit for the client.

SHELTER PLACEMENT PRIORITY POLICY

It is the policy of the GNH CAN that shelter beds will not be held for any client.

All Clients (singles and families) will be prioritized for shelter placement if they are literally homeless with no place to go tonight.

Shelter placement for families will also be prioritized if the family:

1. Is homeless under other federal statutes;
2. Is doubled up, or in a motel paid for by a CAN partner agency
3. Is at imminent risk of being homeless within one week

Once a client has been matched to an open shelter bed, the DSC will call ahead to the shelter with open unit, and send the client to the shelter. DSC may arrange transportation, pending available resources (If taxi service is required see Appendix 2: Taxi Voucher protocol and forms). ***Shelter providers are responsible for initiating the housing document verification process once the client is placed in the shelter.***

In an emergency situation and/or in the absence of an immediately available shelter option, the DSC can authorize motel/hotel night(s) for families, pending available funding, and then follow up with the household to make a shelter placement as quickly as possible (Appendix 3; Hotel/Motel protocol).

B. SHELTER PREFERENCE

Because of limited bed availability, it is the overall policy of the GNH CAN to not allow any client shelter preference. If the client refuses the open bed that is available then they must go back to 2-1-1. In order to remain client centered, the shelter preference policy allows for three exceptions ***only*** after external resources have been explored first (e.g., transportation vouchers) as outlined below.

SHELTER PREFERENCE POLICY

1. A severe medical situation exists (e.g., a parent or child requires daily dialysis treatment) and the client needs to be closer to a medical facility.
2. The client needs to be closer to their place of employment.
3. The Duty Service Coordinator Team accepts a compelling reason as presented by the DSC who conducted the assessment.

In the event that the Duty Service Coordinator Team accepts the compelling reason by a documented majority vote and there is no available open bed that can accommodate the clients' needs, the client will be ***provisionally placed*** in the open bed with the knowledge that this is an emergency placement and they will be moved to a more appropriate shelter when there is an opening.

C. SHELTER WAIT LIST

If there are no shelter beds available, **individual** clients will be placed on a waitlist in chronological order based on date.

Family clients will be prioritized and placed on a waitlist. Family clients on the waitlist will be prioritized as follows:

- 1 – literally homeless, no place to go tonight
- 2- homeless under other federal statutes; doubled up, motel paid for by agency
- 3 - homeless within a week
- 4- homeless in 7 or more days

The Duty Service Coordinators will maintain the waitlist through the Google waitlist. They will enter the client code (first two letters of first name, first two letters of last name and ECM ID) and the best way to contact client, by phone, text or email and best time of day to be reached (if they are working). The DSC will also make sure all contact information is correct in HMIS, including a secondary contact number and/or email address.

The DSC will inform the client that they will be called by a shelter when an opening arises and they need to either answer or return the phone call within 24 hours to secure the opening. Just because a client receives a phone call about an opening, does not mean a bed is being held for them. The client must return the phone call and speak with shelter staff to secure a bed. The DSC Team will use the shelter placement priority policy when placing clients from the wait list.

If the client is called for an available bed and does not accept it, that will be considered "refused shelter" and they will have to go back through 2-1-1 for another CAN Assessment. If a client refuses shelter, the reason for the refusal should be recorded in HMIS.

SECTION III: EXIT INTO HOUSING

With a standardized and common process of access, assessment, referral and housing placement, individuals experiencing homelessness can be connected to appropriate assistance, no matter which organization in the community offers this assistance.

A. HOUSING TRIAGE & ASSESSMENT

U.S Department of Housing and Urban Development guidelines instruct communities to use a shared method to prioritize housing placements. As part of the CT Balance of State, Greater New Haven Coordinated Access Network has incorporated the use of the Vulnerability Index (VI) and Service Prioritization Decision Assistance Tool (SPDAT) to triage client needs, assess vulnerability, and prioritize the CAN's housing registry. The common tools help remove some of the subjectivity involved in the process of prioritization, especially in a resource constrained environment.

The Vulnerability Index –Service Prioritization Decision Assistance Tool (VI-SDPAT) is a ***triage*** tool that allows providers to quickly assess the relative health and social needs of individuals experiencing homelessness. The tool also indicates the most appropriate level of case management support and housing interventions for the individual based on their needs and vulnerability. The VI-SDPATs can be administered by trained providers.

The VI-SPDAT provides triage options for specific populations (individuals, families, and transitional age youth 18-24). As HUD and CT Balance of State guidelines evolve, Greater New Haven Coordinated Access Network may incorporate the use of population-specific VI-SPDATs.

TRIAGE ASSESSMENT POLICY

It is the intention of the Greater New Haven Coordinated Access Network to conduct a VI-SPDAT for every client (single, family, and youth) that is homeless or in immediate need in our region, regardless if they opt to enter into shelter, in order to provide a pathway to appropriate housing and services. The timing of the assessment to be determined by the protocols for the population and the services to which they have been matched.

Clients are required to sign a common release form that allows all providers to input all VI-SPDAT assessments and other key information into HMIS[2] (Appendix 8: common release form). Individuals who do not sign the release of information are considered as having refused to complete the assessment and must be informed that their failure to complete this assessment may affect their ability to access housing.

The results of the triage assessment (VI-SPDAT) and the scores are entered directly into HMIS. All case managers and housing providers will be able to access the information immediately.

[2] *Youth under age 18 are not allowed to sign release of information. This is currently under development by CT Opening Doors Committees.*

Comprehensive Assessment -- In order to accurately match an individual or family to housing services, there may be times when a comprehensive assessment is warranted. The Service Prioritization Decision Assistance Tool (SPDAT) will serve as the comprehensive assessment tool for GNH CAN.

COMPREHENSIVE ASSESSMENT POLICY

A comprehensive assessment (SPDAT) can be requested under the following circumstances:

1. A service provider disputes the VI-SPDAT score because it does not reflect the level of care needed.
2. A client has duplicate VI-SPDAT scores.
3. The client or a household member experiences a life changing event that has the potential to affect their VI-SPDAT score.

The procedure for obtaining a SPDAT assessment is as follows:

a. Service provider contacts CAN staff to request a SPDAT Assessment.
b. CAN staff will make arrangements with a trained provider to complete the SPDAT Assessment.
c. Results of the assessment are presented at the Housing Case Conference meeting.
d. Registry prioritization will be adjusted based upon the results of the Housing Case Conference meeting discussion.
e. Referring service provider and participant will be notified of the outcome.

B. DOCUMENT VERIFICATION

All clients will need to be completely verified in order to be matched with a permanent supportive housing placement. The process of becoming document ready will begin once a client enters the CAN.

In order to be completely verified, the client must have the following documentation:

- ***Disability Verification*** – a process verifying that an adult household member is disabled or needs to request reasonable accommodations related to a disability.
- ***Chronic Homelessness Verification***- a form verifying that an individual meets the chronic homelessness definition (Appendix 9).

Clients will also need ***income documentation*** prior to placement. Shelter providers will work with clients to obtain this documentation once they are placed in an emergency shelter.

HUD Definition of Chronic Homelessness

To be chronically homeless an **individual** must meet the following four criteria:

1. Live in a place not meant for human habitation, a safe haven, or in an emergency shelter;
2. Have been homeless and residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least 4 separate occasions in the last 3 years. BOS has defined "occasion". The BOS guidance is to follow HUD priority, which is longest time homeless. As of July 2015the GNH CAN has defined "occasions" as 14 days or longer. Any alternate definition adopted by the CT Balance of State after July 2015 will superseded the GNH CAN definition of occasion;
3. Be diagnosed (or able to be diagnosed) with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability.
4. 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 who was chronically homeless before entering that facility also qualifies.

A chronically homeless **family** is defined as 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 defined above, including a family whose composition has fluctuated while the head of household has been homeless, also qualifies**.**

Document verification can be expedited through one of two pathways:

1. **Individual Agency Verification** -- The individual agency verification is an option for providers who already have a relationship with the client and have trained verification staff. ***In-house verification does not guarantee placement in the program that completes the verification***. The process is as follows:
   - Housing provider staff works with the client to obtain verifications that meet HUD guidelines.
   - Completed verification documentation is forwarded to the CAN Housing Coordinator.
   - Staff conducting verifications participates in biweekly Housing Case Conferencing meetings to discuss matches and provide document verification status reports, which should be uploaded to HMIS.
2. **Verification Clinics** -- The verification clinics are designed to maximize the skills and resources of all providers, to be responsive to clients who do not currently have a relationship with a provider and to support providers that have capacity constraints to complete verifications in-house. The clinics will be available to clients/staff of all organizations and the outreach and engagement team. The CAN Housing Coordinator will organize the verification clinics and ensure that staff on duty at the clinics are trained in HUD guidelines and have the capacity to conduct both disability and chronic homelessness verifications. The clinics will be held on the 1st and 3rd Tuesday from 9:30 -11:30 every month.

In order that all clients have adequate support needed to become document ready for housing, the CAN will maintain a process to connect them by:

1) Striving to understand all existing relationships within the community and will:
   - Bring up name during Outreach and Engagement Rounds

- Ask day programs if they know of this individual

2) In the event that an individual is not connected to services they will then be assigned to a Housing Liaison by the CAN Housing Coordinator.

Housing Liaisons

Roles and Responsibilities:
The Housing Liaison works with homeless individuals identified by the CAN Housing Coordinator. The **primary** function is to assist clients, who are disconnected from services, to become document ready. The Housing Liaison will act as a liaison between clients, housing providers and the CAN Housing Coordinator.

The Housing Liaison will:

- Travel to meet with clients and other social service providers in order to secure verification of chronic homelessness and disability for permanent supportive housing
- Communicate with prior case managers of the homeless individual to assess their housing history
- Maintain on-going communication with the CAN Housing Coordinator
- Participate in the Housing Case Conferences twice a month

There may be times when a Housing Liaison is asked to extend duties to further support a client.

The Housing Liaison may be asked to:

- Provide education on options and guidelines for eligibility for permanent supportive housing
- Assist clients in navigating the housing system (both private and public housing) and filling out applications for housing, background checks, etc
- Attend any relevant training as required, as well as inter-agency groups that provide assistance and advocacy to our clients.
- Coordinate with the case manager to secure move-in costs and furniture

Housing Liaisons may come from Day Programs such as: Safe Haven, Fellowship Place, or the Taking Initiative Center; the Outreach and Engagement Team; or Housing Programs for Single Sites

The CAN will examine and analyze 'Potential Chronic Homeless Report' created and distributed monthly by CCEH. This report will provide an updated list of clients listed in HMIS who meet eligibility for chronicity based on homeless history in the state of CT. The CAN will prioritize these clients for outreach at verification clinics in order to verify disability.

Once a client has been completely verified they will be notified by the CAN Housing Coordinator that they are now eligible for placement and are in the process to be matched.

C. Housing Placement

The triage (VI-SPDAT) score, or the reconciled assessment (SPDAT) score, serve as the basis for the housing placement pathways as follows:

- Individuals scoring 10, and above, are ***indicated*** for Permanent Supportive Housing (PSH)

- Individuals scoring 5-9, are ***indicated*** for Rapid Rehousing (RRH)
- Individuals scoring 0-4, are ***indicated*** for mainstream affordable housing

Prioritization for PSH will be based on chronicity (length of time homeless) and a 10+ score on the triage assessment (VI-SPDAT). However all clients who meet the HUD chronic homeless definition can be placed in housing regardless of the triage assessment score. If a client does not clearly meet the HUD definition of chronically homeless (e.g., a client has had extensive period of recent incarceration) and a case can be made for housing, the Housing Case Conference will review the unusual circumstances and make a decision.

In the event that a client is deemed ineligible for housing, they have the right to appeal the ineligibility decision according to the Housing Placement Appeals Policy (Appendix 10: housing placement appeals protocol).

HOUSING PLACEMENT APPEALS POLICY

The CAN Housing Coordinator notifies the applicant and the case manager in writing clearly stating the specific reasons for the ineligibility determination. The applicant must provide written documentation to the CAN Housing Coordinator within two weeks. This documentation will be reviewed at the next Housing Case Conference meeting. The applicant and case manager will be notified in writing of the Housing Case Conference decision about eligibility based on a review of the documentation provided.

If an applicant disagrees with the decision based on a review of the documents, the applicant may request a hearing with the program discharge and placement appeals sub-committee of the Housing Case Conference Housing Case Conference. If the subcommittee and the participant do not reach an agreement or the applicant disagrees with the outcome of the hearing, the agency with the program opening will then assume responsibility for following through with their second level agency/program grievance procedures.

If the subcommittee determines the client is eligible for housing, they will be matched to the next available slot.

Housing Case Conference -- Permanent Supportive Housing (PSH) matches will be conducted through the Housing Case Conference. The Housing Case Conference has three primary functions:

1. Matching completely verified clients to housing and reviewing progress.
2. Maintaining a client verification status list.
3. Conducting housing placement ineligibility appeals hearings and reviewing program discharge grievances.

Matching Completely Verified Clients with PSH -- Every other week, the CAN Housing Coordinator will organize and facilitate the Housing Case Conference meetings. All providers and staff who conducted verifications will participate. The CAN Housing Coordinator maintains an updated list of housing subsidy certificates (and associated eligibility criteria) that have been put forward by the agencies participating in the CAN and pulls a prioritized Registry of assessments from the database.

Any housing openings that are matched will follow the CT Balance of State (BOS) protocols for housing prioritization based on HUD guidance (Appendix 11). More stringent requirement(s) as established by either the program funder or the BOS will take precedence.

When the CAN reaches a Functional Zero for Chronic Homeless, matching will be prioritized based on length of time homeless.

Balance of State (BOS) prioritization for Permanent Supportive Housing

a. Chronically Homeless w/ the Longest History of Homelessness & Most Severe Service Needs
b. Chronically Homeless w/ the Longest History of Homelessness
c. Chronically Homeless w/ the Most Severe Service Needs
d. All other chronically Homeless Individuals & Families

In advance of each Housing Case Conference meeting, the CAN Housing Coordinator will go through every available certificate/unit, and prepare a "client match" list of the highest need individuals who are document ready that meet eligibility and screening criteria using the following process:

Step 1: For every PSH certificate, go down the registry list from top triage assessment (VI-SPDAT) score down and check if they meet the eligibility criteria (Appendix 12 tie breaking criteria).

Step 2: If they meet the criteria, check for criminal history and sex registry screens. If they do not meet the screens, go to the next client on the list.

The CAN Housing Coordinator will also prioritize Housing Certificates based on length of time the certificate has been available.

The "client match" list is presented at each Housing Case Conference meeting. The full group discusses the proposed matches and collectively determines the most appropriate housing placements based on the needs of the client. Once all certificates have been matched, the group reviews the list as a whole to see if any adjustments are needed to create a better fit between certificates and clients. Once the list is finalized, the CAN Housing Coordinator sends the triage assessment (VI-SPDAT) information, and screening form (includes information on sex registry and criminal record) to the matched provider and enters the match information into Greater New Haven CAN Data system.

In the event that Housing Providers do not see enough document ready and verified clients being matched to certificates, they may request CAN Staff to call an emergency Housing provider meeting in order to strategize and plan accordingly.

Maintaining a Client Verification Status List -- A verification status document will be maintained by the CAN Housing Coordinator. All providers who are working to verify clients will routinely report on the status of the verifications at the Housing Case Conference meeting. This data will enable the Housing

Case Conference members (and the Task Force) to better understand the verification barriers and bottlenecks and to track how long it takes to get a client completely verified. At the Housing Case Conference meeting the providers will discuss strategies to expedite the verification process.

D. PERMANENT SUPPORTIVE HOUSING DISCHARGE/TERMINATION

This process is designed to see if there are any systemic issues that cut across programs, to provide an opportunity for peer consultation and problem-solving and to ascertain if system practices need to be modified based on the population being served. Individual agency discharge policies remain intact and will take precedence.

The process is as follows:

1. The provider who has identified a client "at-risk" of discharge/termination notifies the Housing Coordinator of their intent.
2. The provider submits documentation of the reason for the discharge and action steps that were taken to prevent the discharge to the Housing Coordinator.
3. The Housing Coordinator adds the housing discharge to the next Housing Case Conference meeting agenda.
4. The housing provider who is discharging the client is invited to the Housing Case Conference to discuss the discharge case and alternative housing options for the client.
5. If no alternative is identified and the program proceeds with the discharge, the program will follow their agency protocols as applicable and the client will be referred to 2-1-1.

Given that clients are placed in housing through the CAN, the CAN should also review all negative housing discharges/terminations as the client will more than likely continue to need services from the GNH CAN.

On at least an annual basis, the Housing Case Conference will review the quantity, circumstances, and outcomes of negative housing discharges/terminations to inform the continuous improvement of CAN operations and outcomes.

APPENDICES

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APPENDIX 1: Emergency/Cold Weather/After Hours Protocol

A. Family Emergency -- If family calls 2-1-1 in immediate need of shelter:

- Attempt to divert
- If diversion not an option, call the following shelter for provisional procedure:
    - Monday through Friday from 8:30 am to 5:00 pm call the shelter where the CAN Office is operating that day for provisional procedure instructions:
        - Mondays, Life Haven - Contact: BH Care Staff
        - Tuesdays, Beth-El - Contact: Deb Moffa or Armando Rodriguez (10am-3pm)
        - Wednesdays, Life Haven - Contact: Life Haven Staff
        - Thursdays, Spooner House - Contact: Nadine Joyner
        - Fridays, CCA - Contact: Janet Vanterpool or Lillian Marquez
    - Monday through Friday between 5:00 pm and 8:30 am or on weekends, call Life Haven Shelter for provisional procedure instructions
    - 2-1-1 will schedule assessment appointment for next business day
- If presents at shelter:
    - Attempt to divert
    - Register call with 2-1-1; registering call means shelter staff calls 2-1-1 with the client
    - 2-1-1 will set assessment appointment for next day
    - Start provisional procedure
- Provisional Procedure:
    - If shelter has space, keep them overnight
    - If no space at that shelter, call other shelters for overnight space
        - If needed, set up transportation to shelter with available space using taxi voucher
    - If no space at any shelters, arrange for a motel night.
        - Sunday through Thursday, one night stay; Friday, three night stay: Saturday, two night stay
        - Each shelter will have a specific motel to reach out to when setting up a motel stay
        - Billing of motel stay will be through CCA
        - If needed, set up transportation to motel with taxi voucher
        - DSC will report information about the motel family stay at next DSC Team conference call

B. Immediate Need – Year round

- Men - Send to walk-in shelter at ESMS
- Women - Send to Columbus House
    - If client cannot be at Columbus House due to discharge, will be sent to Martha's Place
    - If cannot be at Martha's Place due to discharge, there is no place for that client to go in New Haven

C. Cold Weather Immediate Need - December 15 to March 15

- Men - Call ESMS or Columbus House Overflow up to 8:00 pm
- Women - Call Columbus House up to 8pm.
    - 2-1-1 will schedule assessment appointment for same day or next business day

- If client cannot be at Columbus House due to discharge, will be sent to Martha's Place.
- If cannot be at Martha's Place due to discharge, will be sent to Overnight Warming Center January 15 through March 15 from 10:00pm and on; located at Bethel AME Church, 255 Goffe St

- January 15 through March 15 - Men or Women - 10:00 pm to 6:00 am, send to Overnight Warming Center. Located at Bethel AME Church, 255 Goffe St.

D. Severe Cold Weather Activation – Governor

- Men - Call ESMS or Columbus House Overflow to 8:00 pm up to 8:00 pm
- Women - Call Columbus House up to 8:00 pm
  - 2-1-1 will schedule assessment appointment for same day or next business day
- January 15 through March 15 - Men or Women - 10:00 pm to 6:00 am, send to Overnight Warming Center. Located at Bethel AME Church, 255 Goffe St

APPENDIX 2: Taxi Voucher Protocol

- If a client needs transportation for immediate need to a motel or to another shelter, set up transportation with a Taxi Voucher-see Taxi Vouchers in Appendix

- If a client is in need of a taxi in New Haven or Milford call Metro Taxi to set up transportation for the client, 203.777.7777
  - Have the Taxi Voucher completed before calling Metro Taxi
  - Tell the Customer Service Representative at Metro Taxi this is for a corporate account ride and tell them the following:
    - Account Number: 628
    - Password: 4LM2USE
    - The Customer Service Representative will walk you through the rest of the steps.
- If a client is in need of a taxi in Shelton call Valley Cab to set up transportation for the client, 203.732.8294
  - Have the Taxi Voucher completed before calling Valley Cab
  - Let the Customer Service Representative that this is for transportation on account through Spooner House

- Fax the completed voucher to Christian Community Action, attn. Lisa Magson

- Give a copy of the voucher to the DSC within your agency, so it can be reported on the CAN DSC morning conference call the next business day

APPENDIX 2: CAN Taxi Vouchers

Greater New Haven
OPENING DOORS
A Regional Alliance to Prevent and End Homelessness

Metro Taxi

65 Industry Drive, West Haven, CT 06516
Telephone: 203.777.7777

Greater New Haven CAN Families
c/o Christian Community Action
168 Davenport Ave.
New Haven, CT 06519

Date:_____ Time:_____

Transportation for (First Name, Last Initial):_____

Phone Number:_____

# of Adults:_____ # of Children:_____

From (address):_____

To (address):_____

On (date):_____ At (time):_____

Authorized by:

Agency name:_____

Employee Name:_____

Contact phone number:_____

Instructions:

1. Fill out form completely
2. Call Metro Taxi to set up transportation for the client.
   Account Number: 628. Password: 4LM2USE
3. Fax completed form to Christian Community Action, attn., Lisa Mason, fax # 203.777.7923
4. Give a copy to the DSC within your agency, so it can be reported on the CAN DSC conference call the next business day.

Revised 3.6.15

APPENDIX 2: CAN Taxi Vouchers

Greater New Haven
OPENING DOORS
A Regional Alliance to Prevent and End Homelessness

Valley Cab Company
26 Beavers St., Ansonia, CT 06401
Telephone: 203.732.8294

Greater New Haven CAN Families
c/o Christian Community Action
168 Davenport Ave.
New Haven, CT 06519

Date:_____ Time:_____

Transportation for (First Name, Last Initial):_____

Phone Number:_____

# of Adults:_____ # of Children:_____

From (address):_____

To (address):_____

On (date):_____ At (time):_____

Authorized by:

Agency name:_____

Employee Name:_____

Contact phone number:_____

Instructions:

1. Fill out form completely
2. Call Valley Cab Company to set up transportation for the client
3. Fax completed form to Christian Community Action, attn., Lisa Mason, fax # 203.777.7923
4. Give a copy to the DSC within your agency, so it can be reported on the CAN DSC conference call the next business day

1.29.15

APPENDIX 3: Hotel/Motel Protocol

- In the event a family needs emergency placement in shelter, they literally have no other place to go, and all the beds and emergency cots in the GNH CAN family shelters are full, a motel room can be set up for the family.
  - Sunday through Thursday, one night stay; Friday, three night stay: Saturday, two night stay
  - Billing of motel stay will be through Christian Community Action
  - DSC from the agency that sets up the motel room will report information about the motel family stay at next DSC morning conference call
- A client may present at a shelter, or call through 211
  - If 211 calls looking for placement for a family in immediate need, get the client's ECM ID and any other contact information from 211
  - Find out when the client's CAN assessment appointment is scheduled and have 211 re-schedule the appointment for the next business day
  - Contact the client directly to see if the client has any of their own natural resources before offering them a motel room
  - Once you have determined that the client is in immediate need of a motel room for the night, call the motel closest to where the client is located to see if they have availability
  - Tell the client when and where their re-scheduled appointment will be
- If a client is in need of a motel in the New Haven area call the following motels to find an available room:
  - Three Judges Motor Lodge, 1560 Whalley Ave., New Haven, 203.389.2161
  - Super 8, 7 Kimberly Ave., West haven, 203.932.0595
- If a client is in need of a motel in the Milford area call the following motel to find an available room:
  - Still looking for a motel to work with as of 4/1/15
- If a client is in need of a motel in the Shelton area call the following motel to find an available room:
  - Still looking for a motel to work with as of 4/1/15
- When an available motel room is found, fill out the appropriate Motel Voucher-see Motel Vouchers in Appendix
- Make sure the client knows when and where their re-scheduled CAN Assessment appointment is going to be
- Fax the completed voucher to the motel
- Fax the completed voucher to Christian Community Action, attn. Lisa Magson
- Give a copy of the voucher to the client (if they are present) to give to the motel
- Give a copy of the voucher to the DSC within your agency, so it can be reported on the CAN DSC morning conference call the next business day

CAN Families Motels Vouchers

Greater New Haven
OPENING DOORS
A Regional Alliance to Prevent and End Homelessness

Super 8

7 Kimberly Ave., West Haven, CT 06516
Telephone: 203.932.9000
Fax: 203.932.0595

Greater New Haven CAN Families
c/o Christian Community Action
168 Davenport Ave.
New Haven, CT 06519

Date:_____ Time:_____

Guest First Name and Last Initial:_____

How many people in the party:

Adults:_____ Children:_____ Total:_____

Number of nights authorized:_____

Check in date:_____ Check out date:_____

Total cost:_____

Contact at Super 8 (name)_____

Authorized by:

Agency name:_____

Employee Name:_____

Contact phone number:_____

Instructions:

1. Call Super 8 to see if they can accommodate the client
2. If they have an available room, fill out form completely
3. Fax a copy of the completed form to Super 8, fax # 203.932.0595
4. Fax completed form to Christian Community Action, attn., Lisa Magson, fax # 203.777.7923
5. Give a copy to the client (if they are present) to give to the motel
6. Give a copy to the DSC within your agency, so it can be reported on the CAN DSC conference call the next business day

Revised 3.26.15

CAN Families Motels Vouchers

Greater New Haven
OPENING DOORS
A Regional Alliance to Prevent and End Homelessness

Three Judges Motor Lodge

1560 Whalley Ave., New Haven, CT 06515
Telephone: 203.389.2161
Fax: 203.397.5177

Greater New Haven CAN Families
c/o Christian Community Action
168 Davenport Ave.
New Haven, CT 06519

Date:_____ Time:_____

Guest First Name and Last Initial:_____

How many people in the party:

Adults:_____ Children:_____ Total:_____

Number of nights authorized:_____

Check in date:_____ Check out date:_____

Total cost:_____

Contact at Three Judges (name)_____

Authorized by:

Agency name:_____

Employee Name:_____

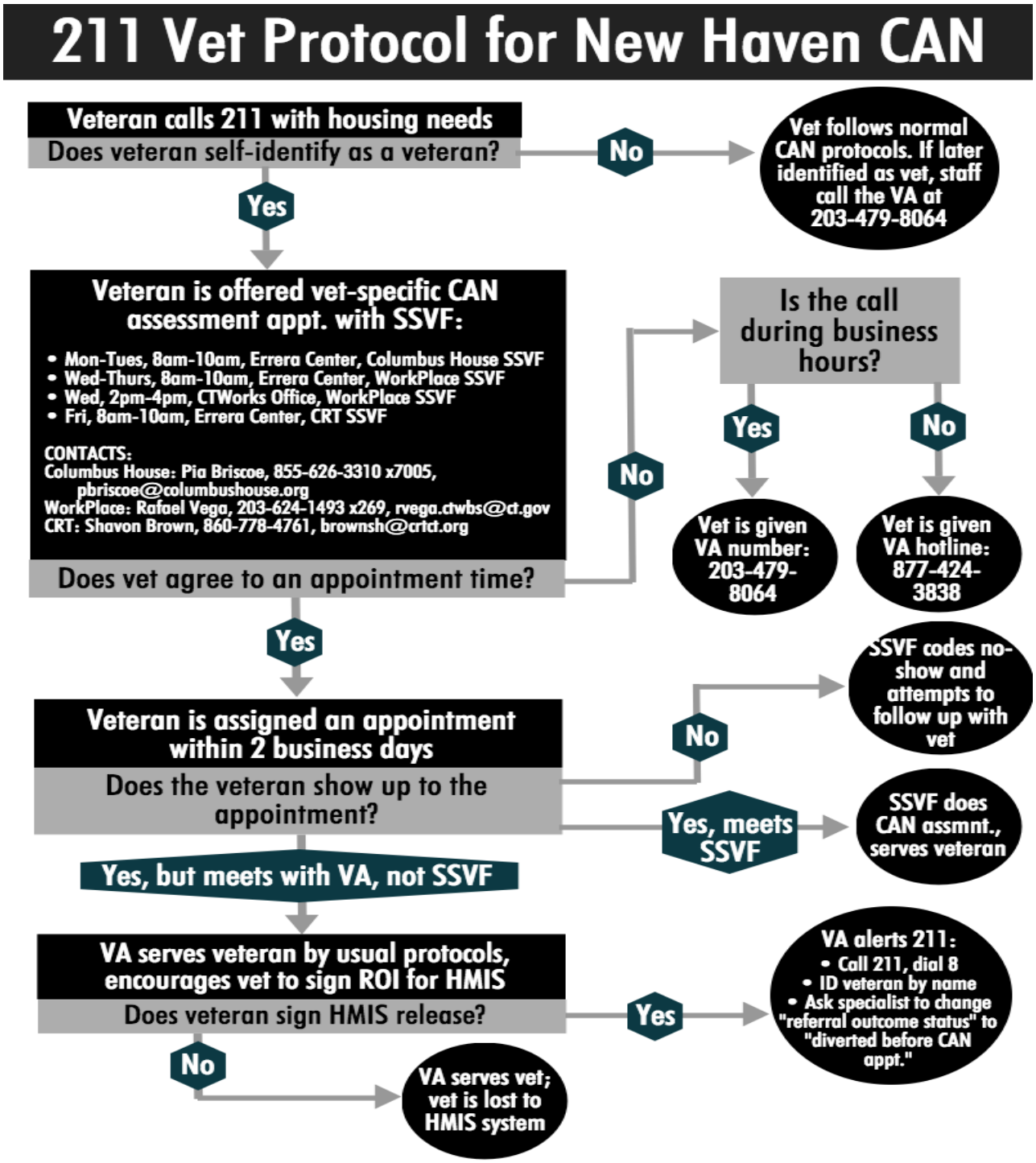
Contact phone number:_____

Instructions:

1. Call Three Judges to see if they can accommodate the client
2. If they have an available room, fill out form completely
3. Fax a copy of the completed form to Three Judges, fax # 203.397.5177
4. Fax completed form to Christian Community Action, attn., Lisa Magson, fax # 203.777.7923
5. Give a copy to the client (if they are present) to give to the motel
6. Give a copy to the DSC within your agency, so it can be reported on the CAN DSC conference call the next business day

Revised 4.6.15

APPENDIX 4: Veterans Protocol



APPENDIX 5: Statewide CAN Diversion Interview and Assessment Protocol

CT Statewide Coordinated Access

Diversion Interview and Assessment

Instructions: The following set of questions are meant to assess whether a household can be diverted from or needs entry to emergency shelter. It is meant to be an exploration of the housing crisis and options available to the household. While it collects basic data elements, it is meant to be more of a conversation than a questionnaire to determine whether diversion is an option. Where the term "you" is used, it refers to the Head of Household unless otherwise indicated.

What type of help is the person seeking or the reason for or circumstances that led him/her to call/come here today?

_____

_____

If person indicates they are having a housing crisis or requests shelter, ask the following:

Basic Household Information:

How many total people are in your household? _____

How many in household are under 18 years old? _____

Recent Housing History:

Where did you stay last night? ***(Do not read responses. Ask question and the choose one)***

☐ Emergency Shelter or hotel / motel paid for with ES voucher
☐ Foster care or foster care group Home
☐ Hospital or other residential non-psychiatric medical facility
☐ Hotel / Motel paid without ES voucher
☐ Jail, prison, or juvenile detention facility
☐ Long-term care facility or Nursing Home
☐ Owned by client, no housing subsidy
☐ Owned by client, with housing subsidy
☐ Permanent housing for formerly homeless persons
☐ Place not meant for human habitation
☐ Psychiatric Hospital or other psychiatric facility
☐ Rental by client, no housing subsidy
☐ Rental by yourself with VASH subsidy
☐ Rental by yourself with GPD TID subsidy
☐ Rental by yourself other ongoing housing subsidy
☐ Residential project or halfway house with no homeless criteria
☐ Safe Haven
☐ Staying or living with Family member
☐ Staying or living with Friend
☐ Substance Abuse treatment facility or detox center
☐ Transitional housing for homeless persons
☐ Other: _____

How long have you been there?

☐ One week or less
☐ More than one week, but less than one month
☐ One to three months
☐ More than three months, but less than one year
☐ One year or longer
☐ Don't Know

APPENDIX 6: Diversion Protocol

Diversion is an emerging practice being tested in communities across the country used to divert people who are experiencing homelessness (who are currently unsheltered/living in a place not meant for human habitation or at immediate risk of homelessness) from emergency shelter when safe and appropriate, by providing individualized support BEFORE people enter the shelter system. Diversion programs assist people seeking shelter to identify immediate, alternate housing arrangements and, if necessary, connect them with services and financial assistance to help them obtain or return to housing.

Diversion services offer light-touch services with minimal financial assistance to people who are homeless, and whose housing options may likely include less-than-ideal housing situations. Diversion services are intended to offer very flexible financial assistance in order to allow creative solutions that may assist the person in obtaining housing and eliminating the need for shelter or other homeless housing resources. Eligible financial assistance includes:

- Utility deposits and arrears
- Previous housing debt/rental arrears
- Transportation (including non-transferable/non-refundable bus tickets, or day bus passes for both local transportation and relocation)
- Landlord fees
- Move-in costs (including deposit and first month's rent; cost of moving truck; storage)
- Negotiated/mediated solution to "divert in place" (landlord, housemates, etc.)
- Work or education related assistance that will assure income for rent
- Other types of financial costs that will help the individual obtain housing
- Food - provided by organization or gift card
- Photo identification card
- Motel assistance (only for families)
- Diapers or other emergency supports for the children in the family
- Mediation services in the event that there is a possibility that a landlord would be willing to develop a "repayment plan" for a rental arrearage

FUNDS CANNOT BE PAID DIRECTLY TO CLIENT.

Examples of Target Populations:

- Individuals or families doubled up with an immediate housing crisis, which may be resolved with financial assistance.
- Individuals or families seeking to reunite into family but for whom transportation costs are a barrier.
- Families with short-term housing needs for when hotel/motel voucher may prevent entry to shelter.
- Individuals or families seeking a Security Deposit for when State guidelines deem them to be ineligible.
- Individuals or families seeking eviction prevention for when assistance offered by the State of Connecticut or other progress is not sufficient.

Singles Application for United Way Diversion Funds
Liberty Community Services, Inc.

Date of request:_____ Date needed: _____
Client Code:_____
Is client homeless? Y or N
Where is client sleeping at night:_____
_____
Has client completed a CAN Intake/Assessment Y or N
How/Who referred the client? _____
Does client have income? Y or N
Income Amount/Source/Frequency:_____
Amount Requested: _____
Proposed use of Diversion Funds:
_____
_____
Follow-up plan for avoiding shelter stay: _____
_____
Name of person completing form: _____
Contact information: _____

TO PROCESS FUNDS IF APPROVED, PLEASE PROVIDE:
Vendor Name: _____
Vendor Phone: _____
Vendor Address_____

ATTACH:
_____ If a Landlord, attach W-9
_____ Documentation of Cost/Price- some ***examples*** are
- Estimate from vendor on vendor form
- Signed letter from Landlord with cos
- Copy of bill indicating costs
- Print out of webpage indicating cost, i.e., for plane ticket, etc.

FOR LCS USE:
Decision:_____
_____
Authorized By:_____ Date:_____

Fax request to the attention of either Michael Hall or Silvia Moscariello at (203) 492-3546 or scan and e-mail to either Michael.Hall@libertycs.org or Silvia.Moscariello@libertycs.org

Families Application for United Way Diversion Funds (Families)
Christian Community Action

Date of request: _____ Date Needed: _____
Head of Household Client Code: _____
Is the family homeless? Y or N
Where is the family sleeping at night: _____
_____
Has the family completed a CAN Intake/Assessment Y or N
How/Who referred the family? _____
Does the family have income? Y or N
Income Amount/Source/Frequency:_____
Amount Requested: _____
Proposed use of Diversion Funds:
_____
_____
Follow-up Plan for avoiding shelter stay: _____
_____
Name of Person Completing Form: _____
Contact Information: _____

TO PROCESS FUNDS IF APPROVED, PLEASE PROVIDE:
Vendor Name: _____
Vendor Phone: _____
Vendor Address_____

ATTACH:
_____ If a Landlord, attach W-9
_____ Documentation of Cost/Price- some ***examples*** are
- Estimate from vendor on vendor form
- Signed letter from Landlord with cos
- Copy of bill indicating costs
- Print out of webpage indicating cost, i.e., for plane ticket, etc.

FOR CCA USE:
Decision: _____
_____
Authorized By:_____ Date:_____

Fax request to the attention of Lisa Magson or Rev. Bonita Grubbs at 203.777.7923 or scan and e-mail to either lmagson@ccahelping.org or bgrubbs@ccahelping.org

Rev. 7/8/15

APPENDIX 7: DSC Daily Call Protocol

Daily Duty Service Coordinator Team conference call is to review waitlist status, current availability of shelter space and challenges from the day before

a. Conference Call placed at 9:00 - 9:30 am Monday through Friday
    - Dial 712-775-7031, Access Code 256-220-047, Host Pin 1778
    - To include Duty Service Coordinator Team, Shelter Leadership and CAN Coordinator
    - Only one DSC from each shelter and /or the CAN Office Coordinator for the day need to be on the call
    - Participants should be sitting by a computer with Google Docs Waitlist open and 2-1-1 Assessment Appointments pulled up for the day in HMIS

b. Agenda Items:
    - Open units for day
    - Emergency bed/cot availability
    - Waitlist
    - 2-1-1 scheduled appointments for the day
    - Challenges from the day before (reviewed from Google Doc spreadsheet)

APPENDIX 8: Release Forms

CT-HMIS AUTHORIZATION FOR RELEASE OF INFORMATION
Connecticut Coordinated Access Network

This authorization is voluntary. The information you authorize us to disclose may be subject to re-disclosure by the recipient and if the person or organization authorized to receive the information is not a health plan or health care provider, the information may no longer be protected by Federal privacy regulations. We may not condition your receipt of treatment, payment, enrollment, or eligibility for benefits on completion of this authorization.

The Connecticut Homelessness Management Information System (CT HMIS) is a shared system. This means that authorized Connecticut homeless service Participating Agencies will enter your information into the CT HMIS database. These participating agencies will have access to the information that you agree to share. Sharing your data allows Connecticut homeless service providers the opportunity to see if they have housing services that fit your needs. It does not guarantee that you will receive housing.

Link for list of participating agencies: http://www.cthmis.com/files/file_detail/1910/ click on "Download File"

NAME (LAST, FIRST): _____ **DATE OF BIRTH:** _____

I hereby authorize the agencies listed below to disclose information provided on the CAN intake form to and exchange the indicated information for the purpose of ensuring effective coordination of services.

- ○ I understand that my information may be used for research, evaluation and advocacy. This may include research projects that match my needs with other agencies or programs that may assist in getting me housing. I will always be protected by federal and state privacy laws. My personal identity will never be part of any research reports.

- ○ A representative of the *Greater New Haven Coordinated Access Network* have explained my rights with regard to the CT HMIS Project to me and given me a written copy of the explanation.

- ○ I can ask to see a document which lists the persons who have updated my client record in the CT HMIS. If I have any concerns about how my personal data is being used or entered into the CT HMIS database I can contact *Sarah Fox*.

I understand that if I need homeless assistance in the future, I will be asked to complete this consent form again.

NOTICE TO RECIPIENT OF INFORMATION

All or a portion of this information may have been disclosed to you from records protected by Federal and/or Connecticut state law which prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law(s). A general authorization for the release of medical or other information is NOT sufficient for this purpose. In addition, Federal rules (42 C.F.R. Part 2) restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand that this authorization will expire two years from the date I sign the authorization. I may revoke this authorization in writing at any time; however, any revocation will not be effective retroactively for information disclosures that have already occurred.

Client Signature: _____ Date: _____

_____
Print Name

Revised 01/20/2015 kc

CT-HMIS AUTHORIZATION FOR RELEASE OF INFORMATION
Connecticut Coordinated Access Network

Note: If you are a legal guardian or representative, you must attach a copy of your legal authorization to represent the member and complete the following:

Signature of Guardian/Representative: _____

Print: _____ Date: _____

Legal Authority: _____

_____	_____	_____
Agency witness signature	*Print Name*	*Date*

If you have any questions or need additional information regarding this form please contact CCEH at 860-721-7876 or on line cceh.org.

Revised 01/20/2015 kc

APPENDIX 9: HUD Chronic Homeless Guidelines

To be chronically homeless an **individual** must:

1) Live in a place not meant for human habitation, a safe haven, or in an emergency shelter (***Note: People living in Transitional Housing are not defined as chronically homeless by HUD.)***; AND
2) Have been homeless and residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least 4 separate occasions in the last 3 years; AND
3) Be diagnosed (or able to be diagnosed) with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability;

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 who was chronically homeless before entering that facility also qualifies.

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 defined above, including a family whose composition has fluctuated while the head of household has been homeless, also qualifies**.**

For participants **currently in RRH** you must provide evidence that they met the criteria prior to entry into RRH. RRH participants retain their chronically homeless status during the time period that they are receiving the RRH assistance.

HUD has determined that once a chronically homeless household has been determined eligible and accepted into a CoC Program-funded permanent supportive housing program, that, ***under limited circumstances***, household may stay with a friend or family, in a hotel/motel, or in a transitional housing bed, while a PSH bed is identified.

APPENDIX 10: Housing Placement Appeals Protocol

Purpose: If the Housing Coordinators find that an applicant is not eligible for housing placement and/or the participant has a dispute or complaint about the administration of a participating CAHP agency/program (e.g., discharge/termination from program, mistreatment by program staff, rent calculation, repair issue, etc.) the applicant has the right to appeal the decision.

Initiating an Informal Hearing:

- If the applicant disagrees with housing placement eligibility determination they may request an informal hearing with the Informal Hearing Subcommittee.
- If a CAHP program participant has a dispute or complaint they may request an informal hearing with the Informal Hearing Subcommittee.

The Informal Hearing Subcommittee Composition and Process:

The Informal Hearing Subcommittee shall be comprised of 4 members of the Housing Coordinator membership (including at least 1 co-chair of the Housing Coordinators committee, 2 Housing Coordinators, and 1 Housing Liaison). It is expected that all Housing Coordination Meeting members will rotate responsibility of taking part in an Informal Hearing as needed.

Step 1: The Housing Coordinator Co-chair shall mail a notice of the informal conference to the participant/applicant and mail/email/fax and the participant's community support provider. The notice of the conference with the Informal Hearing Subcommittee shall include:

- The date, time and place for the conference
- A clear and specific statement of the issues presented
- The participant has a right to review and receive (free of charge before the informal conference) photocopies of the documents in the file upon which the Housing Coordination Sub-Committee based its determination
- The participant has the right to have a representative or advocate present at the informal conference and a list of available advocates
- The participant will be given the opportunity to present written or oral objections at the informal conference.
- The participant has the right to question any witnesses who may be present at the informal conference and to be informed in advance who those witnesses will be.
- The participant has the right to bring his/her own witnesses and/or advocates to the informal conference.

Step 2: The Subcommittee is convened within 30 working days of the receipt of the request.

- At the conference, the participant and the committee may make an agreement.
- If the Subcommittee and the participant do not reach an agreement, the Subcommittee will inform the participant, in writing (mailed first class) the specific reason(s) for the ineligibility determination. Correspondence will also be emailed to the Community Support Provider.

The originating agency/program will review the recommendation of the Informal Hearing Subcommittee and will have the ability to uphold or overturn the recommendation and will provide written notice to the participant and the Community Support Provider.

If the participant disagrees with the outcomes of these processes, the agency with the program opening will then assume responsibility for following through with agency/program grievance procedures.

APPENDIX 11: Housing Placement Tie Breaking Criteria

In cases where two individuals get the same VI-SPDAT score, the following criteria are used to determine who gets "higher" on the universal registry in terms of priority:

Categories	Scoring
Extreme Medical Vulnerability	Documentation supporting serious and debilitating medical conditions= 1
Length of Time Homeless	10 or more years =1
Domestic Violence	Supported by medical or legal documentation=1

If clients are still "tied" after applying the three criteria, then the resource shall be allocated to the person that has been homeless the longest.

Note – due to limited time and technical support, currently we are using the length of time homeless only as a tie-breaker criterion. We will revert to the full spectrum of criteria once we develop an IT-fix that will facilitate the process.

APPENDIX 12: CAN Office Schedule

Family Assessments

- Monday at Life Haven, staffed by BH Care (5 appointments, 45 minutes each, starting at 10:00 am
- Tuesday at Beth-El, staffed by Beth-El (1 appointment, 1 hour, starting at 10:00 am
- Wednesday at Life Haven, staffed by New Reach (5 appointments, 45 minutes each, starting at 10:00 am)
- Thursday at Spooner House, staffed by Spooner House(1 appointment, 1 hour, at 10:00 am)
- Friday at CCA, staffed by CCA (5 appointments, 45 minutes each, starting at 10:00 am)

Single Assessments

- Monday and Wednesday at Columbus House Annex (will have two DSC each day)
  - 16 appointments, 1 hour each, with 8 scheduled at 10:00 am/8 scheduled at 12:30 pm
- Friday at Columbus House Annex (will have one DSC on Fridays)
  - 6 appointments, 1 hour each, with 3 scheduled at 10:00 am and 3 scheduled at 12:30 pm
- Monday through Friday at Liberty Community Services
  - 3 appointments, 1 hour each, 11:00 am, 12:00 pm, 1:00 pm
- Tuesday at Beth-El in Milford
  - 5 appointments, 1 hour each, 10:00 am scheduled for singles and families and 11:00 am scheduled for singles, 12:00 pmscheduled for singles and families.
- Thursday at Spooner House in Shelton
  - 4 appointments, 1 hour each, 10:00 am scheduled for families and 11:00 am, 12:00 pm, 1:00 pm scheduled for singles

CAN Office Closure Due to Severe Weather

It is the responsibility of the DSC to 1) Notify the CAN Entry Coordinator and 2) Inform 2-1-1 **immediately**. The CAN Entry Coordinator will request that 2-1-1 reschedule all appointments throughout the next two weeks not exceeding the maximum daily scheduled appointments.

CAN Office Holiday Closure

The following days the CAN Offices will be closed for holidays:

- New Year's Day
- Martin Luther King, Jr Day
- Good Friday
- Memorial Day
- Independence Day
- Labor Day
- Veteran's Day
- Thanksgiving Day/ Day After Thanksgiving
- Christmas Eve/ Christmas Day
- New Year's Eve

APPENDIX 13: Job Descriptions

1. Coordinated Access Network Manager
2. Coordinated Access Network Entry Coordinator
3. Coordinated Access Network Housing Coordinator
4. Duty Service Coordinator

1. Coordinated Access Network Manager

Reports to: Vice President for Financial Stability, United Way of Greater New Haven

Position Summary:
The CAN Manager supports the mission of United Way by working with Greater New Haven Coordinated Access Network Task Force members, public and private partners and United Way team to develop, implement and measure homeless services that end veteran and chronic homelessness by 2016 and family and all other homelessness by 2020.

The CAN Manager will provide supervision to additional CAN staff; report to the CAN Task Force and Greater New Haven Opening Doors (GNHOD) Steering Committee; work closely with CAN Task Force leadership and represent Greater New Haven CAN in regional and statewide settings.

Position Accountabilities:

- Provides day to day supervision and develops workflow for CAN staff.
- Coordinates CAN functions with staff from participating agencies; motivates team members; assigns tasks.
- Troubleshoots when systems clog or fail.
- Maintains positive, collaborative relationships with United Way employees, CAN members and leadership, and public and private partners.
- Keeps abreast and knowledgeable about issues and trends of homeless services and related social services by networking with local, state and national sector knowledge leaders.
- Facilitates CAN meetings as needed.
- Establishes and maintains communication with administrative staff of United Way 2-1-1.
- Establishes protocols to track and analyze CAN performance and outcome data; creates reports and communicates.
- Completes and monitors comprehensive policies and procedures.
- Interfaces with CT Balance of State, Statewide CAN committee and regional CAN leadership.
- Makes recommendations for additional CAN services and assists with implementation.
- Implements pools of flexible dollars to support implementation of CAN.
- Identifies staffing, budget and funding needs for long-term success.

Knowledge, Skills, Abilities:

- Education: Bachelor's degree required, Master's degree preferred. College degree plus two to three years experience in a related field.
- Management Experience: Demonstrated success in project management, relationship management and supervision.

- Facilitation Skills: Experience with group facilitation, training and working in a collaborative environment.
- Planning Skills: Flexible thinker who can balance systems thinking and on-the-ground implementation.
- Technology Skills: Strong proficiency in Microsoft Office applications including Word, Excel, and PowerPoint.
- Must be able to take initiative, demonstrate leadership, work inter-dependently and produce consistently high quality work.
- Ability to speak and write clearly and concisely for a broad audience.
- Ability to analyze and exercise sound judgment.
- Ability to relate to people of different economic and ethnic backgrounds.
- Ability to balance a variety of perspectives within a politically sensitive environment.
- Knowledge of the challenges and barriers that homeless people face is preferred.
- Local travel is required; candidates must have a driver's license and use of a car during work hours. Out of state travel as needed.

Note: The description given is intended only to provide information about the general nature of the job and is not an all-inclusive list of the job duties, skills or abilities which may change.

2. Coordinated Access Network Entry Coordinator

Reports to: Coordinated Access Network Manager

Position Summary:
The CAN Entry Coordinator supports the mission of the Greater New Haven Coordinated Access Network Task Force members, public and private partners, and United Way team to develop, implement, and measure homeless services that end veteran and chronic homelessness by 2016 and family and all other homelessness by 2020.

The CAN Entry Coordinator will work closely with the CAN Manager, CAN Housing Coordinator, and community providers to assist individuals and families to access emergency shelters. The Entry Coordinator may represent Greater New Haven CAN in regional and statewide settings.

Position Accountabilities:
The Coordinated Access Network Entry Coordinator works in a supportive role to the Greater New Haven CAN providers in securing access to shelter, diversion, and other support services, and coordinates the day-to-day operations of the coordinated entry system, including:

- Coordinate, facilitate, and/or participate in meetings and calls to monitor and remove barriers to shelter and diversion on behalf of the coordinated access system.
- Document the performance and challenges of the coordinated access system.
- Attend and participate in the Operations Workgroup to represent the coordinated access process.
- Assist the stakeholders in the development, implementation, and monitoring of policies and procedures, workflows, and data collection efforts.
- Work with CAN Manager to communicate effectively with 2-1-1 about changes to GNH CAN system.
- Work with CAN Manager and Operations Work Group on any training needs of the Duty Service Coordinators.
- Assist with the development of expanded or enhanced coordinated entry, housing, or other support services.

- Provide excellent customer service to stakeholders in the community including people who are homeless, case managers, housing providers, etc.
- Be cross-trained in Housing Coordinator duties in order to focus efforts based upon changing workflows.

Knowledge, Skills, Abilities:

- Bachelor's degree with two to three years experience in a related field preferred.
- Attention to detail and strong organizational skills required.
- Experience with working with and leading groups in a collaborative environment.
- Strong proficiency in Microsoft Office applications including Word, Excel, and PowerPoint.
- Ability to analyze and exercise sound judgment.
- Ability to relate to people of different economic and ethnic backgrounds.
- Ability to balance a variety of perspectives within a politically sensitive environment.
- Knowledge of the challenges and barriers that homeless people face is preferred.
- Local and statewide travel is required; candidates must have a driver's license and use of a car during work hours. Out of state travel as needed.

Note: The description given is intended only to provide information about the general nature of the job and is not an all-inclusive list of the job duties, skills or abilities which may change.

3. Coordinated Access Network Housing Coordinator

Reports to: Coordinated Access Network Manager

Position Summary:
The CAN Housing Coordinator supports the mission of the Greater New Haven Coordinated Access Network Task Force members, public and private partners, and United Way team to develop, implement, and measure homeless services that end veteran and chronic homelessness by 2016 and family and all other homelessness by 2020.

The CAN Housing Coordinator will work closely with the CAN Manager, CAN E Coordinator, and community providers to assist individuals and families to exit homelessness to a variety of housing options. The Housing Coordinator may represent Greater New Haven CAN in regional and statewide settings.

Position Accountabilities:
The Coordinated Access Network Housing Coordinator works in a supportive role to the Greater New Haven CAN providers and coordinates the day-to-day operations of coordinated housing placement, including:

- Implementation of a common assessment tool.
- Maintenance of a community-wide housing registry by using HUD priorities, and provide timely matches when opening s occur in participating housing programs.
- Coordinating, facilitating, and/or participating in meetings and calls to monitor and improve the performance of the coordinated housing system.
- Identifying and documenting performance and systems challenges, and working with the CAN staff and stakeholders to provide timely resolution to challenges.
- Participation in the Operation Workgroup to represent the coordinated housing process.

- Assistance in the development, implementation, enforcement and monitoring of CAN policies and procedures.
- Monitoring and revising workflow.
- Assuring process for collecting and storing documents are maintained.
- Assisting in the housing eligibility verification process as needed.
- Tracking participants' movement through the coordinated housing system.
- Cataloging housing program criteria in order to facilitate appropriate matches.
- Training provider staff on the housing process and act as resource for questions.
- Overseeing housing appeals process.
- Responding to questions from agency staff/clients about potential housing status.
- Maintaining data and assist with generating reports related to overall system functioning and the number of people housed.
- Being cross-trained in CAN Entry duties in order to focus efforts based upon changing workflows.

Knowledge, Skills, Abilities:

- Education: Bachelor's degree with two to three years experience in a related field preferred.
- Attention to detail and strong organizational skills required.
- Facilitation Skills: Experience with group facilitation, training and working in a collaborative environment.
- Technology Skills: Strong proficiency in Microsoft Office applications including Word, Excel, and PowerPoint.
- Ability to speak and write clearly and concisely for a broad audience.
- Ability to analyze and exercise sound judgment.
- Ability to relate to people of different economic and ethnic backgrounds.
- Ability to balance a variety of perspectives within a politically sensitive environment.
- Knowledge of the challenges and barriers that homeless people face is preferred.
- Local and statewide travel is required; candidates must have a driver's license and use of a car during work hours. Out of state travel as needed.

Note: The description given is intended only to provide information about the general nature of the job and is not an all-inclusive list of the job duties, skills or abilities which may change.

4. Duty Service Coordinator

Position Summary:
The Duty Service Coordinators are deployed by the Greater New Haven Coordinated Access Network's public and private partners to provide assessment services and match clients to emergency shelter services.

Position Accountabilities:

- Participate in daily Duty Service Coordinator Team conference calls
- Facilitate morning conference call on the day they are the DSC in the CAN office
- Log-in to HMIS to review assessment appointments from 2-1-1 for the day
- Provide assessment services for clients scheduled by 2-1-1
- Assess whether client can be diverted from shelter
- Explain data and consumer confidentiality rights to clients

- Have client complete the CAN Authorization for Release of Information forms
- Match clients that require emergency shelter to best-fit shelter openings
- Place client on shelter waitlist if no shelter bed is available and no diversion is possible
- Update HMIS with outcome of client appointment

APPENDIX 14: HMIS Data Entry Procedures

WHO	WHEN	WHAT
2-1-1 Housing Specialist	During call with client	Enter scheduled CAN assessment appointment into HMIS
Duty Service Coordinator	At assessment appointment	Complete workflow into HMIS. Update outcome of appointment into HMIS: no show, diverted, waitlist, accepted for enrollment, refused shelter
Duty Service Coordinator	After VI-SPDAT Assessment	Score should automatically populate into HMIS
Duty Service Coordinator	If client refuses shelter bed	Reason for refusal should be entered into HMIS case-note
Housing Provider	After client receives housing certificate	Mark certificate received in HMIS

APPENDIX 15: CAN Organizational Chart