Coordinated Assessment Model (CAM)
Policies and Procedures Manual
Detroit, Michigan

We would like to extend a special thank you to CSH for assistance in completing these policies and procedures.

Narrative Manual
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I. Purpose and Background

Federal Level Guidance

Coordinated Entry is a centralized and streamlined system for accessing housing and support services to end homelessness in a community, and is required by the U.S. Department of Housing and Urban Development (HUD) for all Continuums of Care (CoC) as stated in 24 CFR 578.7 (a)(8) of the CoC Program Interim Rule.[1] Each community's CoC is designed to "promote community-wide commitment to the goal of ending homelessness; provide funding for efforts to quickly re-house individuals and families who are homeless, which minimizes the trauma and dislocation caused by homelessness; promote access to and effective use of mainstream programs; and optimize self-sufficiency among individuals and families experiencing homelessness."[2] HUD's primary goals for a CoC's Coordinated Entry System "are that assistance be allocated as effectively as possible and that it be easily accessible no matter where or how people present."[3] Operating a Coordinated Entry System is an effective key to federal, state, and local resources. HUD released guidance to CoCs outlining Coordinated Entry requirements in January 2017.[4]

Detroit's Coordinated Entry System, the Coordinated Assessment Model (CAM), aims to work with households to understand their strengths and needs, provide a common assessment, and connect them with housing and homeless assistance based on this information and on availability. By operating a process that is easily accessible to people experiencing homelessness or in a housing crisis and using standardized tools and practices, prioritizing those with the highest service needs from initial engagement through referral, and facilitating exits from homelessness to an appropriate, stable housing resource in the most rapid manner possible, the CAM aims to incorporate the principles of a system-wide Housing First approach. The CAM also provides vital information for the Detroit CoC about service needs and gaps to help the CoC plan its assistance and identify needed resources.

Local Vision and Values

The Continuum of Care (CoC) Coordinated Entry system, serving the Cities of Detroit, Hamtramck, and Highland Park, locally referred to as the Coordinated Assessment Model (CAM), ensures that people experiencing or at-risk of homelessness in the CoC's geographical catchment will be assessed and guided to the appropriate resource that prevents or end their homelessness. The CAM is a systematic approach to homelessness that focuses on aligning the needs of individuals and families experiencing homelessness or at imminent risk of becoming homeless to available shelter and housing resources. The CAM's vision is to orchestrate a community response that creates an accessible, efficient path to housing for households facing homelessness. This community response upholds the principle outlined in HUD's Coordinated Entry guidelines: access, assess, prioritize, and refer. The CAM accounts for the diversity of needs of people experiencing homelessness and urgently responds to these needs through operating navigable entry points for access; standardized utilization of a universal assessment tool to prioritize the most vulnerable households; and appropriate referrals based on community resources and level of support for households experiencing homelessness.

The CAM's goals include: strengthening accessibility for households in need of assistance; ensuring the standardization of intakes and assessments; increasing collaborative community partnerships; and improving the alignment of resources with local need. Underpinning these goals are the CAM's guiding values: collaboration, responsivity, accountability, and continuous quality improvement for efficiency.

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[1] The Department of Housing and Urban Development, Coordinated Entry Policy Brief, (2015)

[2] U.S. Department of Housing and Urban Development, Continuum of Care Duties: Establishing and Operating a Continuum of Care

[3] The Department of Housing and Urban Development, Coordinated Entry Policy Brief, (2015)

[4] HUD Coordinated Entry Notice

Integral to CAM's success is a community wide understanding of what CAM is and is not. The CAM is a process by which homeless households access emergency shelter and housing resources. The CAM is operated through intense collaboration with a coalition of agencies working together to end homelessness. The CAM is a concerted effort to create a standard and uniform process of assessing, prioritizing, and referring households seeking homeless or prevention assistance. The CAM is the CoC's intervention to make best use of the resources in the community. Conversely, the CAM is not a program or housing provider, does not increase the amount of resources available, and is not solely one organization. Lastly, due to the prioritization of limited resources, CAM cannot a guarantee that any individual will receive a referral to a particular housing option.

Due to resource limitations, not every household experiencing homelessness will get access to housing resources, and the CAM cannot directly address the lack of housing resources, but can ensure that the agencies within Detroit's CoC use the resources available in the best possible way.

The Detroit CoC implemented the CAM in 2014. Continuous improvements to the CAM have been made since this time including more intentional coordination of Rapid Re-housing (RRH) referrals, streamlining the Permanent Supportive Housing (PSH) match process, and launching a chronic by-name list. In order to necessitate significant, collaborative, and community-wide change for persons experiencing homelessness or a housing crisis, the CAM transitioned in 2018 from access through shelters and a Call Center Model to an In-Person Access Point Model with entry points for families, singles, youth, and veterans.

Participation Requirements

The U.S. Department of Housing and Urban Development (HUD) and Veteran's Affairs (VA) have recently established guidance that instructs all CoC projects to participate in their CoC's Coordinated Entry System. Any project that receives HUD funding (CoC Program or ESG) or VA funding (Supportive Services for Veteran Families, Grant and Per Diem or Veterans Affairs Supportive Housing) for PSH, RRH, and Transitional Housing (TH) programs must comply with the participation requirements as established by the corresponding CoC jurisdiction. Similarly, the MI Department of Health and Human Services (MDHHS) mandates that Emergency Shelter and PATH grantees utilize and participate in Coordinated Entry. The Michigan State Housing Development Authority (MSHDA) also mandates that its grantees providing homeless and housing services utilize and participate in Coordinated Entry. Finally, the City of Detroit has also required the use of Coordinated Entry for ESG and Community Development Block Grant (CDBG) homeless funded programs.

Governance and Accountability

The Continuum of Care (CoC) Board serves as the governing body for the CoC and is ultimately responsible for operating an effective CAM that is in compliance with HUD's requirements. The CAM Governance Committee is a CoC Committee that reports to the CoC Board and is responsible for providing oversight to the CAM and bringing policy level recommendations to the CoC Board. PSH providers, RRH providers, TH providers, and SSO programs are monitored, depending on their funding, by HUD, the CoC Lead Agency, and/or the City of Detroit. Emergency shelter providers are monitored, depending on their funding, by MDHHS and/or the City of Detroit.

Per HUD's Coordinated Entry Self-Assessment[5], consumers utilizing CAM have the right to file a non-discrimination complaint. Consumers can file a grievance at any point throughout the CAM process based on the CoC-wide Grievance Policies and Procedures. If a consumer feels they have been discriminated against and their complaint is not adequately addressed through the CoC's established grievance process, they are directed to file a complaint with HUD's Fair Housing and Equal Opportunity Office:
https://www.hud.gov/program_offices/fair_housing_equal_opp/complaint-process

[5] https://www.hudexchange.info/resources/documents/coordinated-entry-self-assessment.pdf

Nondiscrimination & Fair Housing

The CAM adheres to all jurisdictionally relevant civil rights and fair housing federal, state, and local laws, regulations and guidance.

All housing and services coordinated through the Detroit Continuum of Care must be available to all eligible persons, regardless of race, color, national origin, religion, sex, age, familial status, disability, marital status, height, weight or, actual or perceived sexual orientation, gender identity, or gender expression. Additionally, the CAM ensures accessibility to all eligible persons experiencing homelessness regardless of limited English proficiency, limited literacy, military discharge status, or source of income. The CAM will take all necessary steps to ensure that housing and services are administered in accordance with all applicable Federal and State civil rights laws, including, but not limited to:

- Fair Housing Act, a Federal law which prohibits discriminatory housing practices based on race, color, religion, sex, national origin, disability, or familial status.
- Section 504 of the Rehabilitation Act, a Federal law which prohibits discrimination on the basis of disability under any program or activity receiving Federal financial assistance.
- Title VI of the Civil Rights Act, which prohibits discrimination on the basis of race, color, or national origin under any program receiving Federal financial assistance.
- Title II of the Americans with Disabilities Act, which prohibits public entities, which including State and local governments, from discriminating against individuals with disabilities in all their services, programs, and activities, which include housing, and housing-related services such as housing search and referral assistance.
- Title III of the Americans with Disabilities Act, which prohibits private entities that own, lease, and operate places of public accommodation, which include shelters, social service establishments, and other public accommodations providing housing, from discriminating on the basis of disability.
- HUD's Equal Access in Accordance with Gender Identity Rule, which prohibits discrimination based on sexual orientation, gender identity, and marital status.

Michigan's Elliott-Larsen Civil Rights Act prohibits discrimination based upon religion, race, color, national origin, age, sex, height, weight, familial status, or marital status. All clients shall be informed of their right to access housing and services without discrimination, and of their right to initiate a grievance if they believe they have been discriminated against.

CAM does not screen consumers out of the coordinated entry process due to perceived barriers related to housing or services, including, but not limited to, too little or no income, active or a history of substance use, domestic violence history, resistance to receiving services, the type or extent of disability-related services or supports that are needed, history of evictions or poor credit, lease violations or history of not being a leaseholder, or criminal record–except where state or local restrictions prevent projects from serving people with certain convictions.

The CAM will use appropriate and inclusive language in communications, publications, trainings, personnel handbooks and other policy documents that consistently affirms the Detroit CoC's commitment to serving all eligible clients in adherence with the HUD Equal Access Rule.

Preventing Family Separation Policy

Families experiencing homelessness should not be separated when receiving services unless the health and well-being of children are at immediate risk. The age and gender of a child under the age of 18 shall not be used as a basis for denying a family's admission to any housing services. In addition, a broad definition of family must be

used that allows for single parent households of any gender identity, two parent households including same sex parents and LGBT parents, and extended families to be served together with their children.
Furthermore, in compliance with HUD's Equal Access in Accordance with Gender Identity Rule, all households that present as a family must be served together as a family, whether that family includes adults and children, or just adults, and regardless of the age, disability, marital status, actual or perceived sexual orientation, or gender identity of any member of the family.

Accessibility

The CoC will ensure that CAM services are physically accessible to persons with mobility barriers. All in-person access points underwent an environmental scan to ensure accessibility and any potential future sites will be reviewed for accessibility as well.

In addition, CAM participating agencies will, to the greatest extent practicable, provide communication accommodation through translation services to effectively and clearly communicate with persons who have disabilities, as well as with any person with limited English proficiency. The CAM Implementing Agency will provide visually and audibly accessible Coordinated Entry materials when requested by agencies or participants in the CAM process.

CAM Participating Agencies

Participating agencies includes all agencies operating housing and homeless programs required to participate in CAM due to funding and/or contract requirements. All CAM participating agencies must comply with Fair Housing and all other funding and program requirements. A list of all CAM participating agencies can be found in Appendix 1.

Data Management and Homeless Management Information System

The Homeless Management Information System (HMIS) is a database that the CAM uses to record and track consumer-level information on the characteristics and service needs of homeless persons. HMIS ties together homeless service providers within a community to help create a more coordinated and effective housing and service delivery system. Per Detroit's CoC HMIS Policies and Procedures, the CAM ensures the protection of consumer data and obtains consumer consent in order to share and store participant information.

Effective October 1, 2020, HUD introduced new data elements for Coordinated Entry to standardize data collection on core components of CE – access, assessment, referral, and prioritization. CoCs with HUD-funded Supportive Services Only (SSO)-CE projects are required to collect CE data elements. As such, the CAM adheres to these data elements. The three new data elements include:

1. CE Assessment: Collects assessment date, location, and results and helps communities understand and monitor the assessment process in more detail and as it relates to participant outcomes.
2. CE Event: Designed to capture access and referral events, as well as the results of those events. It will help communities understand the events that go into achieving desired (and undesired) results through the CE system.
3. Current Living Situation: Designed to capture information on where a person is staying at a point in time. It will help communities track where people are, including those who are not assessed or referred to CE events.

Protection of data for consumers who are domestic violence survivors
Providers funded to specifically serve survivors of domestic violence do not enter data in HMIS. Data for consumers presenting as survivors of domestic violence is entered in HMIS by the CAM to be used for the purposes of matching the household to a housing and/or service intervention.

II. Coordinated Assessment Model Roles and Expectations

Continuum of Care (CoC) General Membership

- Responsible for providing input and feedback about the effectiveness of the CAM

Continuum of Care Board

- Responsible for operating an effective Coordinated Entry System that is in compliance with HUD's requirements

Coordinated Assessment Model (CAM) Governance Committee

- Responsible for providing direct oversight to the CAM
- Responsible for bringing policy level recommendations to the CoC Board

Coordinated Assessment Model (CAM) Internal Work Group

- Comprised of mid-level leadership from CAM Lead Agency and CAM Implementing Agencies and is responsible for managing the day-to-day operations of the CAM and for bringing process level recommendations to the CAM Governance Committee.

Street Outreach Workgroup

- Review and provide feedback about CAM processes and procedures related to street outreach and suggest new procedures to implement
- Participate in case conferencing related to unsheltered consumers
- Bring up concerns or provide a voice for consumers served through street outreach

Shelter and Transitional Housing Provider Work Group

- Review and provide feedback about CAM processes and procedures related to shelter and TH
- Suggest new procedures to implement
- Bring up concerns or provide a voice for consumers served in emergency shelter and transitional housing

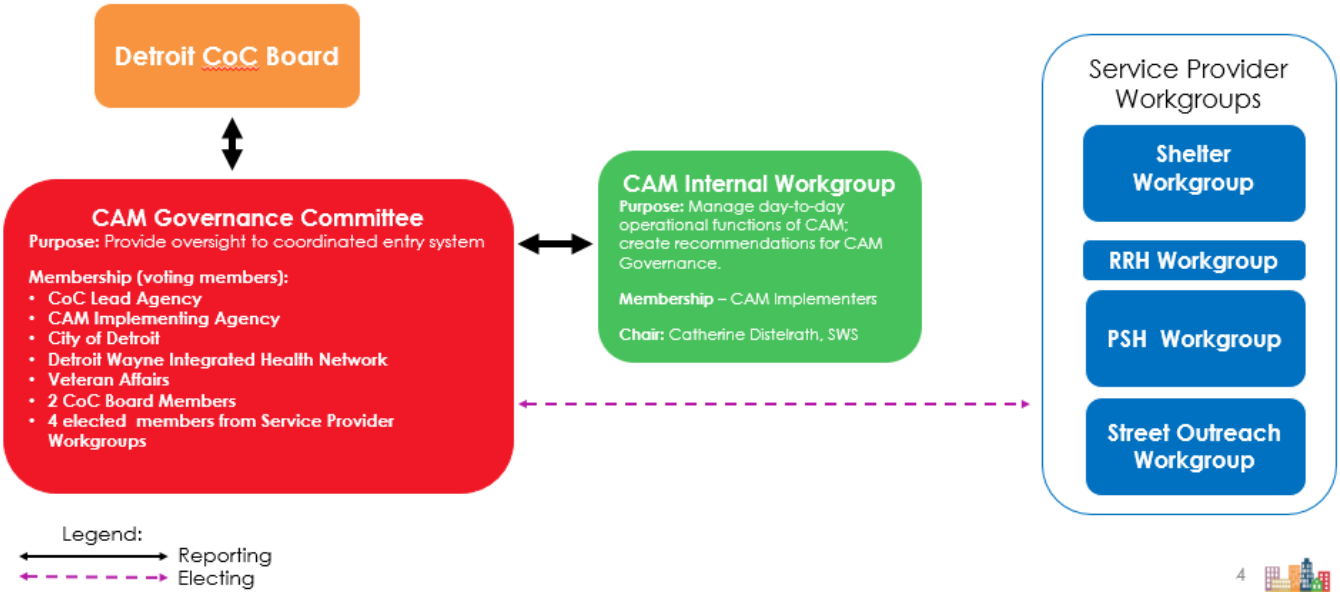
Rapid Re-Housing Provider Work Group

- Review and provide feedback about CAM processes and procedures related to RRH
- Suggest new procedures to implement
- Bring up concerns or provide a voice for consumers served in RRH Projects

Permanent Supportive Housing Work Group

- Review and provide feedback about CAM processes and procedures related to PSH
- Suggest new procedures to implement
- Bring up concerns or provide a voice for consumers served in PSH projects

Below is a visual representation of these relationships. Additional information about committee members can be found at www.camdetroit.org. CAM is only possible when each partner embodies their respective role and continuously develops their relationships with other entities participating in the CoC.



Continuum of Care (CoC) Lead Agency

- Reports to CoC Board
- Responsible for assisting the CoC Board, CAM Governance Committee, and CAM Lead Agency in overseeing and operating the CAM.

Duties include but are not limited to:

- Assist in developing CAM policies and procedures and ensuring CoC-funded RRH & PSH providers and CAM Implementers adhere to CAM policies & procedures
- Handling grievances against CAM (in coordination with CAM Governance Committee and CoC Grievance Committee)
- Chairing CAM Sub-Committees (RRH & PSH)
- Evaluating CAM Lead Agency and participating agencies (in coordination with CAM Governance Committee)
- Communicating information and outcomes about CAM to the CoC and community stakeholders

Homeless Management Information System (HMIS) Lead Agency

- Reports to CoC Board
- Responsible for providing oversight and implementation support to the Detroit CoC's HMIS.

Duties include but are not limited to:

- Managing the HMIS buildout
- Providing the HMIS technical assistance to CAM Implementers and CAM-participating agencies

Coordinated Assessment Model (CAM) Lead Agency

- Reports to CoC Board (via the CAM Governance Committee)
- Responsible for implementing and operating the CAM, in accordance with the CAM Policies and Procedures.

Duties include but are not limited to:

- Operating and staffing the CAM including, but not limited to:
    - Overseeing and making decisions related to day-to-day functions of CAM

    - Making appropriate referrals to shelter and housing resources and tracking consumers through the CAM process into housing
    - Populating the Homeless Preference HCV waitlist
- Coordinating and collaborating with key system partners including, but not limited to:
    - Attending, actively participating in, and staffing and facilitating (as determined by the CAM Governance Committee or CoC Board) the Outreach, Shelter, RRH, & PSH Provider Workgroups;
    - Managing outward communication and PR requests related to CAM; coordinating PR requests with the CoC Lead Agency and CoC Board when necessary;
    - Providing training and communication for CAM staff, CoC partners, and community stakeholders
- Creating system accountability including, but not limited to:
    - Recommending changes and improvements to the CAM
    - Reporting agency-level and system-level CAM-related outputs and outcomes to the CAM Governance Committee, CoC and community stakeholders

Coordinated Assessment Model (CAM) Implementing Partners

- Reports to CAM Lead Agency and CAM Governance Committee

Responsible for providing staff to support CAM designated activities.
Duties may include but are not limited to, providing staff for Diversion, Assessment, and Resource Navigation.

Below is a visual representation of these relationships. CAM is only possible when each partner embodies their respective role and continuously develops their relationships with other entities participating in the CoC.

Prevention Provider

Responsible for providing prevention services. Duties include but are not limited to:

- Closely coordinating with CAM on activities, as outlined in the CAM Partnership MOU and the CAM Operations Manual, such as:
    - Acquiring accurate program vacancies, streamlining eligibility/screening criteria, providing feedback on referrals that are rejected, completing applicable HMIS duties
    - Swift responsiveness to consumers referred to their agency, completing applicable HMIS duties

Street Outreach Provider

- Reports to MDHHS and City of Detroit, depending on funding

Responsible for providing street outreach services. Duties include but are not limited to:

- Closely coordinating with CAM on activities, as outlined in the CAM Partnership MOU and the CAM Operations Manual, such as:
    - Swift responsiveness to consumers referred to their agency, completing applicable HMIS duties, facilitating access to RRH or PSH programs for consumers who are referred to these programs

Shelter Provider

- Reports to MDHHS and City of Detroit, depending on funding

Responsible for providing emergency shelter services. Duties include but are not limited to:

- Closely coordinating with CAM on activities, as outlined in the CAM Partnership MOU and the CAM Operations Manual, such as:
    - Acquiring accurate shelter bed vacancies, streamlining eligibility/screening criteria, providing feedback on referrals that are rejected, completing applicable HMIS duties, facilitating access to RRH or PSH programs for consumers who are referred to these programs
- Collaboration with Rapid Rehousing and Permanent Supportive Housing providers when consumers are referred to these programs

Transitional Housing Provider

Responsible for providing Transitional Housing services. Duties include but are not limited to:

- Closely coordinating with CAM on activities, as outlined in the CAM Partnership MOU and the CAM Operations Manual, such as:
    - Swift responsiveness to consumers referred to their agency, completing applicable HMIS duties, facilitating access to RRH or PSH programs for consumers who are referred to these programs

Rapid Rehousing (RRH) Providers

- Reports to HUD, CoC Lead Agency, and City of Detroit, depending on funding

Responsible for providing Rapid Rehousing activities. Duties include but are not limited to:

- Closely coordinating what with CAM on activities, as outlined in the CAM Partnership MOU and the CAM Operations Manual, such as:
    - Acquiring accurate program vacancies, streamlining eligibility/screening criteria, providing feedback on referrals that are rejected, completing applicable HMIS duties
- Swift responsiveness to consumers referred to their agencies for RRH

Permanent Supportive Housing (PSH) Providers

- Reports to HUD and CoC Lead Agency

Responsible for providing Permanent Supportive Housing activities. Duties include but are not limited to:

- Closely coordinating what with CAM on activities, as outlined in the CAM Partnership MOU and the CAM Operations Manual, such as:
    - Acquiring accurate program vacancies, streamlining eligibility/screening criteria, providing feedback on referrals that are rejected, completing applicable HMIS duties
- Swift responsiveness to consumers referred to their agencies for PSH

CAM Liaisons

Responsible for serving as point person between their respective agency and the CAM; some agencies appoint multiple CAM Liaisons, one for each program "type" the agency operates.

Duties include, but are not limited to:

- Actively participate in applicable CAM sub-committee/workgroup meetings

- Serve as primary point of contact for CAM and relay information learned through sub-committee meetings and other CAM Liaison communications to other staff at their agency
- Communicate CAM-related concerns, issues, recommendations, and/or feedback from their agency to the appropriate CAM sub-committee
- If interested, nominate themselves or other CAM Liaisons to serve as the one individual appointed from each sub-committee to the CAM Governance Committee

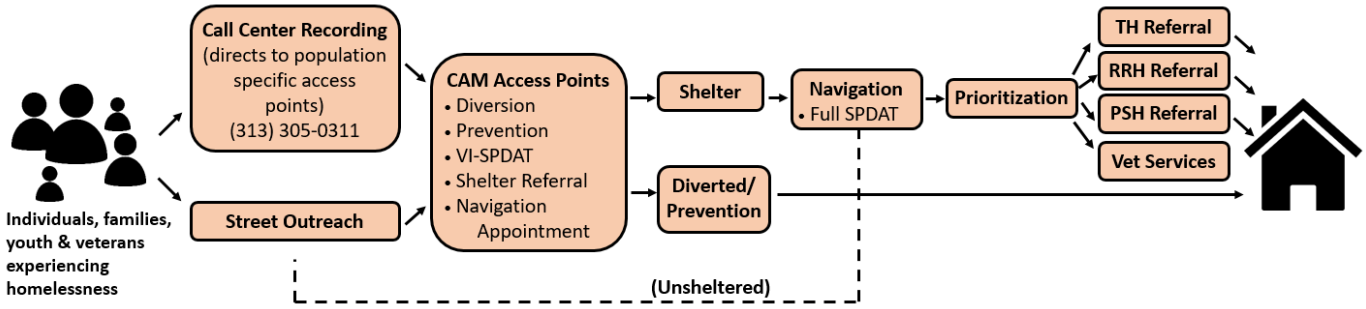
III. Target Population

The CAM is open to all households who meet the HUD definition of homeless under Categories 1, 2, or 4 (see glossary in Appendix for more information), as outlined in the new HEARTH Act regulations, with a focus on prioritizing the most vulnerable households.

IV. System Overview and Workflow

Households experiencing homelessness flow through the following components of the CAM: access, assessment, prioritization, and referral. The policies and procedures that make up these components align and coordinate with other critical system standards including the Continuum of Care Written Standards, the RRH Policies and Procedures, and the PSH Policies and Procedures.

Below is an illustration of the CAM Workflow



Access

The CAM utilizes a Call Center (313-305-0311) and a multisite hybrid approach to provide access to the coordinated entry process. Up-to-date Access Point locations and hours can be found on the CAM website, www.camdetroit.org. Access Points are designed to target specific subpopulations.

The CAM Lead Agency in consultation with CAM Governance Committee may choose to adjust CAM access operations in order to address community need and ensure access throughout the community. All changes to CAM access operations will be reflected on the CAM website and communicated to the CoC.

Consumers can access the coordinated entry process by visiting an in-person site or calling the CAM Call Center. Upon first accessing CAM, consumers complete initial assessment (diversion/prevention and, if necessary, VI-SPDAT). Across all Access Points and populations, diversion or prevention is the first strategy. Translation will be provided for consumers whose first language is not English. Transportation to the Access Point or from the Access Point to the shelter are assessed and addressed on a case by case basis.

During non-operating hours at CAM Access Points, consumers can present at any shelter or warming center and then present at the appropriate Access Point the next business day. While consumers may present at any shelter or warming center during non-operating hours and cannot not be turned away, specific shelters or

warming centers, as designated by the City of Detroit, are advertised on the CAM Call Center recording as after-hours walk-in locations.

All consumers encountered by street outreach are offered the same standardized process as consumers who access the CAM through Access Points. If a consumer is encountered by street outreach during Access Point operating hours, street outreach brings the consumer to an Access Point to be assessed and referred to shelter, if shelter is available. If a consumer is encountered by street outreach after Access Point operating hours and is willing to enter shelter, street outreach transports consumer directly to shelter for the night. The shelter then notifies the client to go to the Access Point the following day to be assessed. Regardless of time of day, if an unsheltered consumer refuses to present at an Access Point and/or refuses shelter for any reason, street outreach attempts to complete the standardized assessment tool with the consumer and report their name, location, and assessment outcome to the CAM for ongoing consumer tracking.

Consumers staying in a hotel paid for by a charitable organization follow the same standardized coordinated entry process as other consumers. The charitable organization may contact CAM to request an assessment for the consumer.

If a consumer presents at an Access Point that is not specifically designated for their household type (ie. a family presents at the single adult access point) every attempt will be made first to assess the household at that Access Point. If the consumer cannot be assessed at that Access Point, the household will be directed to the appropriate Access Point for their household type.

Assessment

Depending on the consumer's unique situation, there can be up to three levels of comprehensive and standardized assessment tools they engage in. All consumers first participate in a diversion assessment. Entering emergency shelter can be a traumatic experience for consumers, especially for families with children. The CAM is committed to preventing consumers from entering emergency shelter whenever possible. To that end, all households seeking to access emergency shelter in Detroit's CoC are first engaged in the shelter diversion process at the Access Points. Staff use the OrgCode Diversion Interview Guide and motivational interviewing to identify diversion opportunities with consumers. This process is sometimes referred to as Rapid Resolution when referring specifically to veteran households.

In some cases, the diversion assessment will lead to an assessment for prevention assistance, in which case the homeless prevention tool is utilized. The prevention tool allows CAM to prioritize prevention resources for those most in need by providing a vulnerability score.

For those that are not able to be diverted or prevented from entering shelter, they are administered the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT). CAM utilizes the youth-specific TAY-VI-SPDAT for consumers ages 18-24. Consumers are then referred to emergency shelter. The CAM obtains and tracks real-time bed/unit availability for emergency shelter. All emergency shelter vacancies are reported to the CAM as they occur in order to facilitate real-time shelter bed availability within the CoC. Depending on the outcome of the VI-SPDAT, some consumers are subsequently scheduled to later be administered the Full Service Prioritization Decision Assistance Tool (Full SPDAT) with a CAM Navigator.

The assessment process does not require disclosure of specific disabilities or diagnoses.

Prioritization

The CAM utilizes prioritization throughout the entire coordinated entry process to allocate and match consumers in need of homeless assistance with the appropriate referral.

The CAM does not discriminate during the prioritization process based on data collected from the assessment process (for protected classes). Determining eligibility is different from determining prioritization. The prioritization process does not require disclosure of specific disabilities for diagnoses. Specific diagnosis or disability information is only obtained for purposes of determining program eligibility to make appropriate referrals.

With the exception of a few unique projects, all TH, RRH, and PSH projects that receive referrals through CAM utilize HUD's minimum criteria for entry into the project. Therefore, consumers are referred to appropriate housing resources using only the prioritization factors described in detail below. Any additional information gathered during the assessment process is not factored into the prioritization and referral process.

The CAM will, to the greatest extent feasible, prioritize available assistance for persons with the greatest service needs and levels of vulnerability before those with less severe needs and lower levels of vulnerability.

Consumers' vulnerability assessment scores and chronic status are used to make a housing intervention recommendation according to acuity level.

Because the CoC prioritizes housing resources for people who are chronically homeless first, staff at Access Points make a preliminary determination (based on HMIS activity and disclosure of a disability) of whether or not a person is chronically homeless before connecting them with CAM Navigation staff. When a CAM Navigator meets with a consumer to conduct the Full SPDAT, they also conduct a housing history interview to determine potential chronic status for the purposes of acuity grouping.

The chart below indicates how acuity groups are determined based on assessment scores and chronicity. Youth (ages 18-24) are assessed using youth-specific tools and follow the same scoring recommendations as the general population. Please see Appendix 4 for information about prioritization for Veterans.

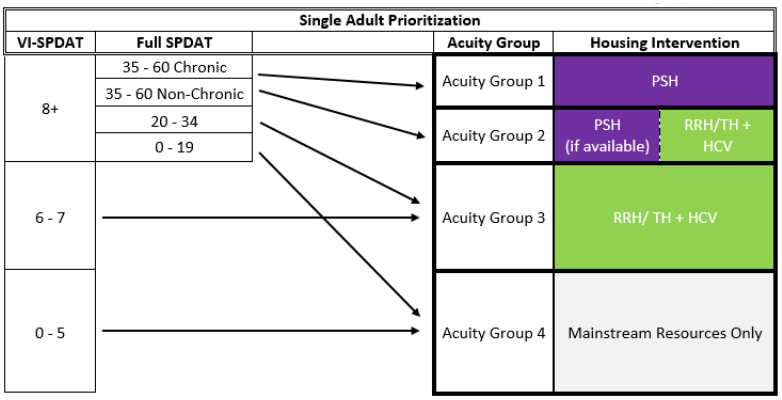
VI – SPDAT/TAY-VI-SPDAT Recommendations			
Single		**Family**	
0-5	Acuity Group 4 – Mainstream Resources Only	**0-5**	Acuity Group 4 – Mainstream Resources Only
6-7	Acuity Group 3 - Recommended for RRH or TH-complete HCV pre-application	**6-8**	Acuity Group 3 - Recommended for RRH or TH-complete HCV pre-application
8+	Complete Full SPDAT to determine acuity group and housing intervention	**9+**	Complete Full SPDAT to determine acuity group and housing intervention
Full SPDAT Recommendations			
Single		**Family**	
0-19	Acuity Group 4 – Mainstream Resources Only	**0-26**	Acuity Group 4 – Mainstream Resources Only
20-34	Acuity Group 3 - Recommended for RRH or TH-complete HCV pre-application	**27-53**	Acuity Group 3 - Recommended for RRH or TH-complete HCV pre-application
35-60 Non-Chronic	Acuity Group 2 – Recommended for either PSH, *or* RRH or TH, and HCV	**54-80 Non-Chronic**	Acuity Group 2 – Recommended for either PSH, *or* RRH or TH, and HCV
35-60 Chronic	Acuity Group 1 – Recommended for PSH	**54-80 Chronic**	Acuity Group 1 – Recommended for PSH

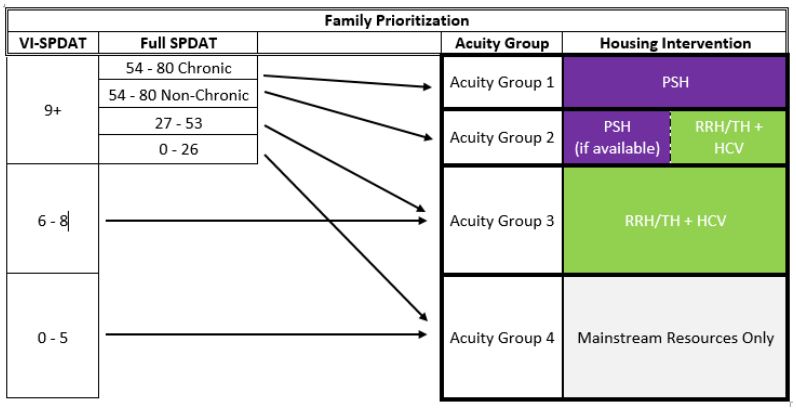
Consumers in Acuity Group 4 are recommended for mainstream resources only and will not be considered for CoC funded housing assistance unless all eligible consumers in the proceeding Acuity Groups have been referred to a housing resource already. Shelter case managers assist this population in developing strategies to resolve their homelessness.

Consumers in Acuity Group 3 are recommended for RRH or TH as well as an HCV. CAM Navigators meet with consumers in this group to complete an HCV pre-application.

Consumers in Acuity Group 2 are recommended for PSH *or* RRH *or* TH, and HCV based upon resource availability. The CAM Lead Agency is responsible for determining what intervention/s households in Acuity Group 2 are navigated for based on analysis of resource supply.

See the charts below for a visual representation of the housing intervention recommendation process.





Available housing assistance is prioritized sequentially by acuity group, and then within acuity group according to the following order:

CAM Housing Resource Prioritization Order
Each of these prioritizing factors will be applied in sequential order. When there are insufficient resources to serve all of the households within a given category, then the next factor in the list will be considered.
1. Chronic Households
2. Unsheltered Households
3. Households Fleeing Domestic Violence
4. VI-SPDAT and/or SPDAT Score
5. Families then singles (**when the vacancy can be flexibly used for either population*)
6. Length of time homeless

Prioritization is used to determine which household will be referred for the next available resource that they are eligible for. Households will not be prioritized for assistance that they are not eligible even if they are higher on the list. For example, if a project serves only youth age 18-24 then someone older than 24 will not be referred even if they are highest on the prioritization list. It is important to note specifically that chronic households will not be prioritized for Transitional Housing.

Referrals

All CoC and ESG funded providers receive referrals strictly through the CAM. The CAM utilizes a streamlined referral process for emergency shelter, Prevention, RRH, TH and PSH based on need and availability. Some consumers receive two referrals, one to an emergency shelter and another to a TH, RRH and/or PSH provider. Referrals to emergency shelter are made directly after the consumer accesses the Access Point and completes a standardized assessment. Referrals to Prevention, TH, RRH and/or PSH are made on an ongoing basis, within 2 business days of vacancy and referral request from a Prevention, TH, RRH or PSH provider.

The CAM values consumer choice. Consumers have the opportunity to decline assistance at various points in the process without it impacting their access to other forms of assistance and/or their ability to continue moving through the CAM. When a consumer reaches the front of the prioritization process, they are referred to the next available resource. Consumers have the right to decline a referral for whatever reason and, upon declining referral, will be re-prioritized with the consumers on the prioritization list at that time. However, after a consumer declines referrals from two separate agencies, they are placed at the bottom of the prioritization process. In the event that a consumer declines a referral, the TH, RRH or PSH provider explains to the consumer the impact of declining a referral.

Reassessment and Case Review

CAM has a process for reassessment and case review for cases in which there is reason to believe someone's assessment recommendation is not accurate or appropriate for their situation. See Appendix 3 for details.

Marketing

The CAM is marketed to consumers and to the general public through various outlets. The CAM maintains a website (www.camdetroit.org) and newsletter meant to provide homeless service providers and the general public with timely updates on process changes, training meetings, and data on progress toward the shared goal of ending homelessness. The CAM maintains relationships with local news outlets in an effort to keep the general public informed of current activities within Detroit's homeless system. The CAM staff present regularly at the CoC general membership meetings as a way to keep homeless service providers and mainstream service providers who attend those meetings informed of current CAM activities. An open invitation for new CoC members to attend an annual training is offered at general membership.

Considerations for Special Populations

The CAM provides specific accommodations and processes for the following populations: veterans, persons fleeing or attempting to flee domestic violence including human trafficking, and persons seeking asylum.

Veterans

While all veterans access CAM in the same way as non-veterans, there are some specific policies and procedures for coordinating housing resources for homeless veterans. In particular, the housing resources that are available and the prioritization used for these resources can vary between veterans and non-veterans. Appendix 4 outlines policies and procedures that apply specifically to veterans.

Persons fleeing or attempting to flee domestic violence including human trafficking

The CAM adheres to and enforces a domestic violence policy to ensure that victims of domestic violence cannot be denied access to the CAM process. People who are fleeing or attempting to flee domestic violence are directed to the local domestic violence specific shelter for assessment. If the consumer is not eligible to enter the domestic violence shelter, staff at the domestic violence shelter connects the consumer to an Access Point or another shelter. Consumers fleeing/attempting to flee domestic violence, are also prioritized for TH, RRH and PSH services.

Additionally, the Detroit CoC honors emergency transfers for victims of domestic violence, dating violence, sexual assault, or stalking. In accordance with the Violence Against Women Act (VAWA), Detroit CoC and ESG funded programs allows tenants who are victims of domestic violence, dating violence, sexual assault, or stalking to request an emergency transfer from the tenant's current unit to another unit. Tenants requesting a transfer for this reason are prioritized for the next available unit. The ability to request a transfer is available regardless of sex, gender identity, or sexual orientation. The CAM staff are trained in trauma informed care and in working specifically with people who have experienced domestic violence.

Persons seeking asylum
People seeking asylum are directed to Freedom House, the only transitional housing program in Detroit serving asylum seekers.

Safety, Privacy, and Confidentiality
The CAM staff meet consumers in a safe, private, and trauma-informed environment. The CAM staff adhere to requirements set forth by Michigan's HMIS Policies and Procedures which ensure protections of consumer data and is compliant with HIPAA, and all Federal and State laws and codes. Consumer consent will be obtained in order to share and store participant information as evident by a completed Release of Information. All hard copy consumer data is stored in locked filing cabinets.

V. Conflict of Interest

In the event that a conflict of interest occurs between a household and CAM staff, emergency shelter staff, or housing provider, the staff must inform their supervisor, who will assign another staff to work with the household as appropriate. Members of the CoC Board, CAM Governance Committee, and CAM implementing agencies are mandated to recuse themselves when a decision is being made at any level that could potentially impact their program or organization.

VI. Evaluation and Continuous Improvement

CAM implementation necessitates significant, community-wide change. To help ensure that the system will be effective and manageable for people experiencing homelessness and for the housing and service providers tasked with meeting their needs, the Detroit CoC anticipates adjustments to the processes described in this manual. To inform those adjustments, CAM will be evaluated at least annually by the CoC Lead Agency in consultation with the CAM Governance Committee, and there will be ongoing opportunities for stakeholder feedback, including but not limited to Service Provider Workgroups, focus groups, and surveys. Evaluation outcomes and results will be shared broadly with CoC General Membership, funders, and other stakeholders.

Specifically, the CoC Board or its designated entity is responsible for:

- Leading periodic (at least annual) evaluation efforts to ensure that the CAM is functioning as intended and to make any adjustments to the CAM as determined necessary;
- Ensuring that evaluation and adjustment processes are informed by a broad and representative group of stakeholders which will include projects participating in Coordinated Entry and households engaged in Coordinated Entry within the last year;
- Ensuring that participants selected to provide feedback in the evaluation process are representative of participating providers and households
- Ensuring that CAM is updated as necessary to maintain compliance with all state and federal statutory and regulatory requirements.

Evaluation results will be reviewed by the CAM Governance Committee and used to recommend changes to the CAM Policies and Procedures and to inform the CoC Project Application process. This evaluation is intended to

review and provide analysis on Detroit Continuum of Care's (CoC) Coordinated Entry Model (CAM). The evaluation will use information from Coordinated Entry Partners, Coordinated Entry consumers, and data.

The evaluation will strive to answer the following questions:

1. Does our system meet the HUD requirements?
2. Does our system follow our own policies and procedures?
3. Are there trends of success that we can highlight?
4. Are there trends of challenges that we can address with technical assistance support?

At least annually, HAND will:

1. Survey all local Partners to solicit feedback on how well the CE Partnership is being implemented,
2. Collect feedback on the coordinated entry process from consumers through a focus group or survey,
3. Review and determine compliance of HMIS data standards
4. Review HMIS reports, spreadsheets, Salesforce, Prioritization list Reports, and
5. Review and determine compliance of Policy and Procedures from CAM.

The CAM Policies and Procedures Manual will be reviewed and revised at least annually by the CoC Board or its designated entity.

VII. Glossary & Acronyms

By-Name List (BNL) is used to track the progress of Veterans as they move through the homelessness response system from homeless to housed and track progress against USICH Benchmarks.

Chronically Homeless To be considered chronically homeless, an individual or head of household must meet the definition of "homeless individual with a disability" from the McKinney-Vento Act, as amended by the HEARTH Act and have been living in a place not meant for human habitation, in an emergency shelter, or in a safe haven for the last 12 months continuously or on at least 4 occasions in the last 3 years where those occasions cumulatively total at least 12 months. An in-depth definition is available in the Final Rule "Chronically Homeless."

Coordinated Assessment Model (CAM) is an organized process that helps individuals and families experiencing homelessness access available shelter & housing resources & helps the Detroit CoC prioritize limited resources.

CAM Lead Agency refers to the agency selected through a competitive RFP process to implement and operate the coordinated entry system for Detroit.

CAM Implementing Partner is an entity selected to provide staffing support to the CAM.

CAM Participating Agencies are all entities participating in CAM (ie. taking referrals through Coordinated Entry), either on a voluntary basis or through a funding mandate.

Disability is a Physical, Mental or Emotional Impairment, including impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury that is expected to be long-continuing or of indefinite duration, sustainably impeded the individual's ability to live independently, and could be improved by the provision of more suitable housing conditions. An in-depth definition is available in the Final Rule "Chronically Homeless."

Emergency Shelter is low barrier, site based, temporary shelter to deal with an individual's or family's immediate housing crisis.

Family/Household A family or household includes, but is not limited to, the following, regardless of actual or perceived sexual orientation, gender identity, or marital status:
(1) A single person, who may be an elderly person, displaced person, disabled person, near-elderly person, or any other single person; or
(2) A group of persons residing together, and such group includes, but is not limited to: (i) A family with or without children (a child who is temporarily away from the home because of placement in foster care is considered a member of the family). 24 CFR 5.403

Grant and Per Diem (GPD) provides transitional housing for Veterans experiencing homelessness in a community program for up to 24 months while the Veteran receives case management services through the community program staff.
Bed Types:

- *Bridge Housing* — Short-term stay in transitional housing for homeless Veterans with pre-identified permanent housing destinations, when that housing is not immediately available. The allowance is locally made for those who don't have a pre-identified housing destination but have high income, no/few barriers, and report the desire to move into housing immediately.

- *Low Demand* — Accommodates homeless Veterans experiencing homelessness, who were unsuccessful in traditional housing/residential programs. Chronic and a certain percentage of non- chronic homelessness is allowed. Poly-morbid issues are required and it is clear that Veteran is pre- contemplative re: treatment.
    - *Hospital to Housing* — addresses the housing and recuperative-care needs of homeless Veterans who have been hospitalized and/or evaluated in an emergency room. Veterans assigned to this bed type MUST have a pre-coordinated discharge plan where it is determined who/which entities will provide the additional supports for the Veteran who is transitioning from hospital, emergency room, or residential placement.
    - *Clinical Treatment* — Ensures coordination and compliance with residential substance use and/or mental health treatment in conjunction with services to help homeless Veterans secure permanent housing and increase income through benefits and/or employment.
    - *Service-intensive Transitional Housing* — Residential services that facilitate stabilization and transition to permanent housing. In Detroit, this bed type is used minimally, when no other bed type which is more appropriate is available.

Health Care for Homeless Veterans (HCHV) is a program that provides a gateway to VA and community-based supportive services for eligible Veterans who are homeless.

Housing Choice Voucher (HCV) is a federal program that provides rent subsidies for very low income people who find their own housing in private homes and apartment buildings.

Homeless Operations Management and Evaluation System (HOMES) is an online data collection system that tracks homeless Veterans as they move through VA's Homeless Programs.

Homeless The definition of "homeless" under the HEARTH Act consists of four categories:
Category 1 - Literally Homeless
- Individuals and families who lack a fixed, regular, and adequate nighttime residence and includes a subset for an individual who resided in an emergency shelter or a place not meant for human habitation and who is exiting an institution where he or she temporarily resided

Category 2 - Imminent Risk of Homelessness
- Individuals and families who will imminently lose their primary nighttime residence

Category 3 - Homeless under other Federal Statutes
- Unaccompanied youth and families with children and youth who are defined as homeless under other federal statutes who do not otherwise qualify as homeless under this definition

Category 4 - Fleeing/Attempting to Flee Domestic Violence
- Individuals and families who are fleeing, or are 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.[2]

A more in-depth definition is available within the HEARTH "Homeless" Final Rule.

Homeless Management Information System (HMIS) is a database that allows agencies within the homeless system to collect basic demographic information, track services, update case plans, and track outcomes at the project and participant level. The Michigan Coalition Against Homelessness is the vendor for HMIS and uses ServicePoint software. HUD and other planners and policymakers at the federal, state, and local levels use aggregate HMIS data to obtain better information about the extent and nature of homelessness over time. Specifically, HMIS can be used to produce an unduplicated count of homeless persons, understand patterns of service use, and measure the effectiveness of homeless programs.

Housing First is an approach to homeless assistance that prioritizes rapid placement and stabilization in permanent housing and does not have service participation requirements or preconditions such as sobriety or a minimum income threshold. Projects using a Housing First approach often have supportive services; however, participation in those services is based on the needs and desires of the program participant. The Detroit CoC should review system- and project-level eligibility criteria to identify and remove barriers to accessing services and housing that are experienced by homeless individuals and families.

Housing and Urban Development-Veterans Administration Supportive Housing (HUD VASH) is a collaborative program between HUD and VA which combines HUD housing vouchers with VA supportive services to help Veterans who are homeless and their families find and sustain permanent housing.

- *Application Meeting:* Held at VA with Engagement Team to verify initial HUD VASH eligibility
- *Housing Voucher Briefing*: Held at RPI for final HUD VASH screening and obtaining voucher

Lead Case Manager (LCM) is the designated case manager assigned to a Veteran who takes primary responsibility in navigating Veterans to permanent housing. The LCM is identified on the BNL and has the primary responsibility of updating the BNL at least every 2 weeks.

Permanent Supportive Housing is non time-limited housing that is safe and stable where the household has a lease or sub-lease in their name, a subsidy is provided, and voluntary services (as determined by assessment) are offered to help in retaining the housing.

Rapid Re-Housing (RRH) provides short-term rental assistance and services to individuals and families to quickly exit homelessness. Consumers receive RRH assistance and services regardless of employment status, income, criminal record, or sobriety. Resources and services provided are personalized to the unique needs of the household. As noted in the Detroit Written Standards document, Detroit has limited the length of RRH financial assistance to a maximum of 18 months.

SPDAT and VI-SPDAT: The SPDAT is an evidence-informed approach to assessing an individual's or family's acuity. The tool, across multiple components, prioritizes who to serve next and why, while concurrently identifying the areas in the person/family's life where support is most likely necessary in order to avoid housing instability. While the SPDAT is an assessment tool, the VI-SPDAT is a survey to help prioritize participants.[6]

Street Outreach is a type of program that enables the CoC to help individuals experiencing homelessness move from an unsheltered situation to an emergency shelter or to permanent housing.

Transitional Housing Review Team (THRT) is an interdisciplinary team in homeless programming that reviews all Veterans requesting a VA-funded transitional housing placement who have already had two VA-funded transitional housing placements.

Transitional Housing (TH) is short-term temporary housing to facilitate the movement to permanent housing. Homeless persons may live in transitional housing programs for up to 24 months and receive supportive services that enable them to live more independently.

United States Interagency Council on Homelessness (USICH) coordinates and directs the federal response to homelessness, working in close partnership with senior leaders across 19 federal member agencies. UISICH organizes and supports leaders such as Governors, Mayors, Continuum of Care leaders, and other local officials, to drive action to achieve the goals of the federal strategic plan to prevent and end homelessness.

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[6] OrgCode Consulting, Inc.

Veteran: An adult who served on active duty in the armed forces of the United States, including persons who served on active duty from the military reserves or the National Guard. For the purposes of these criteria, a Veteran is any person who served in the armed forces, regardless of how long they served or the type of discharge they received.
https://www.usich.gov/resources/uploads/asset_library/Vet_Criteria_Benchmarks_V3_February2017.pdf

Written Standards: This document outlines the programs that comprise Detroit's Homeless System. The purpose of this document is to establish policies and procedures for evaluating eligibility for program types, prioritization guidelines for persons entering into a homeless assistance program, duration of assistance, and to determine the minimum or maximum contribution of households receiving rental assistance. The document also includes Essential Elements that apply to all programs within the system either current or in the future.

Appendix 1: CAM Participating Agencies

Emergency Shelter Providers	Transitional Housing Providers	Rapid Rehousing Providers	Permanent Supportive Housing Providers
Alternatives for Girls	Community Social Services of Wayne County	Alternatives for Girls	Cass Community Social Services
Cass Community Social Services	Freedom House	Central City Integrated Health	Central City Integrated Health
Creating Opportunities to Succeed (COTS)		Community & Home Supports	Community & Home Supports
Covenant House		Neighborhood Legal Services Michigan	Creating Opportunities to Succeed (COTS)
Detroit Rescue Mission Ministries		Neighborhood Service Organization	Development Centers, Inc.
Mariners Inn		Southwest Counseling Solutions	Detroit Rescue Mission Ministries
Neighborhood Service Organization		Wayne Metro Community Action Agency	Mariners Inn
Operation Get Down			Neighborhood Legal Services Michigan
Saint John Community Center			Neighborhood Service Organization
Salvation Army (Booth)			Southwest Counseling Solutions
Love Outreach			Travelers Aid Society
YWCA			

Appendix 2: Ensuring Equal Access

Equal Access Rule

On October 21, 2016 final rule entitled "*Equal Access in Accordance with an Individual's Gender Identity in Community Planning and Development Programs*" took effect. This rule ensures that all individuals, including transgender individuals and other individuals who do not identify with the sex they were assigned at birth, have access to programs, benefits, services, and accommodations in accordance with their gender identity without being subjected to intrusive questioning or being asked to provide documentation.

The CAM ensures equal access to its services for all eligible consumers regardless of actual or perceived sexual orientation, gender identity, or gender expression.

Understanding the Terms[7]

Sexual orientation describes a person's physical, romantic, and/or emotional attraction to another person (for example: straight, gay, lesbian, bisexual). Gender identity describes a person's internal personal sense of being a man or a woman, or someone outside of the gender binary. Simply put: sexual orientation is about who you are attracted to; gender identity is about who you are. A person's gender identity is outwardly expressed (their gender expression) through behavior, clothing, hairstyle, mannerisms, makeup, body language, voice, speech patterns, and social interactions that are perceived as masculine, feminine, or androgynous.

Transgender people identify as or express a gender different from the gender associated with their sex assigned at birth (assumption that male=boy/man, female=girl/woman). Included in the protected class of gender identity are people who identify as androgynous, genderqueer, genderfluid, bi-gender and transgender, as well as anyone who falls outside of gender norms or the gender binary

LGBTQ+ Terms related to protected classes of gender, sex, sexual orientation, and gender identity

Sexual Orientation

- **Sexual Orientation:** Sexual orientation describes a person's physical, romantic, and/or emotional attraction to another person (for example: straight, gay, lesbian, bisexual). It is usually defined by who you are physically, romantically, or emotionally attracted to in relation to your own sex/gender.
- **Aromantic:** experiencing little or no romantic attraction to others and/or has a lack of interest in romantic relationships/behavior. Asexual: experiencing little or no sexual attraction to others and/or a lack of interest in sexual relationships/behavior.
- **Bisexual:** a person who is emotionally, physically, and/or sexually attracted to people of their gender and another gender. Also an umbrella term for people who experience sexual and/or emotional attraction to more than one gender.
- **Gay**: Typically refers to men whose emotional, romantic, and sexual attractions are primarily for other men. In some contexts, still used as a general term for gay men and lesbians.
- **Lesbian:** a woman whose emotional, romantic, and sexual attractions are primarily for other women.
- **Pansexual:** Capable of being attracted to many/any gender(s).
- **Queer:** a historically derogatory term for a gay man, lesbian, or gender-nonconforming person. The term has been widely re-claimed, especially by younger LGBT people, as a positive social and political identity. It is sometimes used as an inclusive, or umbrella, term for all LGBT people. More recently, queer has become common as a term of self-identification for people who do not identify with the restrictive and binary terms that have traditionally described sexual orientation (for instance, gay, lesbian, or bisexual only). Some LGBT community members still find queer an offensive or problematic term.

[7] Information in this section is borrowed the Fair Housing Council of Oregon's "Guide to Fair Housing for Homeless and Domestic Violence Shelter Providers 2018"

Gender Identity

- **Gender Identity:** The way in which people identify their own gender or inner sense of being male, female, or something else. It is an internal, personal, innate sense of being a girl/woman, boy/man, or another gender outside of the gender binary. One's gender identity may or may not align with their assigned gender role, and gender identity is not necessarily visible to others. Both cisgender and transgender people have a gender identity.
- **Gender Expression:** External expression of gender identity exhibited through behavior, clothing, hairstyle, mannerisms, makeup, body language, voice, speech patterns, and social interactions that are perceived as masculine, feminine, or androgynous.
- **Perceived Gender Identity:** the gender with which a person is perceived (viewed by others) to identify based on that person's appearance, behavior, expression, other gender related characteristics, or sex assigned to the individual at birth or identified in documents. HUD's Equal Access Rule requires that individuals not be discriminated against based on actual or perceived gender identity.
- **Transgender/Trans:** umbrella term encompassing many gender identities of people whose gender identity is different from the gender associated with their assigned sex (female=girl/woman; male=boy/man). Transgender is an adjective, not a noun and can be both an individual and group identifier; "I am transgender," "She is transgender," "All the youth in that group are transgender."
- **The Gender Binary:** A system of viewing gender as consisting solely of two, opposite categories, termed "male and female", in which no other possibilities for gender or anatomy are believed to exist. This system is oppressive to anyone who defies their sex assigned at birth, but particularly those who are gender-variant or do not fit neatly into one of the two standard categories.
- **Gender Role:** Cultural expectations for what people should do with their lives, what activities they should enjoy or excel at, and how they should behave, based on their gender.
- **Agender:** An umbrella term encompassing many different genders of people with no (or very little) connection to the traditional system of gender, no personal alignment with the concepts of either man or woman, and/or someone who sees themselves as existing without gender.
- **Bigender:** Refers to those who identify as two genders. Can also be a person who fluctuates between traditionally "woman" and "man" gender-based behavior and identities, identifying with both genders.
- **Cisgender:** Someone whose gender identity matches the gender role they were assigned at birth; a person who is not transgender. The Latin prefix 'cis' means "on the same side of." Cisgender is preferable to "biological," "genetic" or "real" male or female.
- **Genderfluid:** A changing or "fluid" gender identity. A person who is gender fluid may always feel like a mix of the two traditional genders, but may feel more man some days, and more woman other days.
- **Genderqueer:** An identity commonly used by people who do not identify or express their gender within the gender binary. Those who identify as genderqueer may identify as neither male nor female, may see themselves as outside of or in between the binary gender boxes, or may simply feel restricted by gender labels.
- **Non-binary:** Non-binary people don't neatly fit into the categories of "man" or "woman," or "male" or "female." For example, some people have a gender that blends elements of being a man or a woman, or a gender that is different than either male or female. Some people experience a gender that is "both" man and woman and some experience it as "neither". Some people don't identify with any gender. Some people's gender changes over time.
- **Transgender man:** a person whose gender identity is male but who was assigned female at birth.
    - *FTM/F2M/Female-to-Male*: Refers to someone with a female birth sex and assigned gender role but who identifies as male. While still commonly used, it is considered inaccurate and disrespectful by many transgender men. This term puts the emphasis on changing a physical state or becoming something 'other' than what you already are.

- **Transgender woman**: a person whose gender identity is female but who was assigned male at birth.
    - MTF/M2F/Male-to-Female: Refers to someone with a male birth sex and assigned gender role but who identifies as female. While still commonly used, it is considered inaccurate and disrespectful by many transgender women. This term puts the emphasis on changing a physical state or becoming something 'other' than what you already are.

Respecting a Person's Self-Identification of Their Gender

At initial intake, consumers have the right to self-identify their gender. Staff should be careful not to make assumptions about a person's gender based on their voice, appearance or legal name. Access to shelter or services may not be based on a consumer's appearance, ability to "pass", or legal documentation. As with any consumer, staff should not ask questions or otherwise seek information or documentation about a transgender person's anatomy or medical history, including asking about a person's sex reassignment surgery or hormone treatment.

Transgender and gender non-conforming people presenting for services shall not to be turned away or referred elsewhere because of their transgender status, the length or extent of their gender transition, and/or because they do not meet the expectations the gender stereotypes of what a man or woman is supposed to look like.

Addressing Consumers with the Names, Titles and Pronouns of Their Choice

Consumers shall be referred to according to their self-reported gender identity regardless of appearance, physical characteristics, or inconsistent legal documentation (such as a driver's license). All written documentation about a transgender consumer shall use and clearly indicate the consumer's preferred name as well as note the consumer's legal name. State-required filing systems may not provide a field for entering a name or gender outside of the name and sex assigned at birth; however, that information should be noted repeatedly within case notes and other paperwork.

Experiences of poverty and homelessness often present barriers to obtaining identification and to accessing transition-related medical care. Providers should understand that people may not have updated identification and accept residents according to their self-identified gender. Due to poverty and lack of access to transition related care, transgender people may not "look like" the people they feel they are. For example, transgender women's lack of grooming supplies leads to facial hair. Additionally, it is not always safe for people to express their gender identity publicly and transgender women may present as more masculine to avoid street harassment or violence.

All consumers regardless of their perceived gender identity should be asked their name, pronouns and titles they would like to be used (these may not match their legal ID or gender markers). This can be modeled by the staff person offering their own name and pronouns first.

Avoiding Assumptions, Biases and Myths

In general, fair housing laws mandate that providers make decisions based on facts and not assumptions, characteristics, or inconsistent legal documentation. There are many biases toward and myths about transgender and non-gender conforming people. For example, it is an inaccurate conclusion that transgender consumers threaten the health or safety of other consumers solely based on their non-conforming gender expression.

Staff will avoid words that convey common misconceptions about sexual orientation, gender identity and expression (SOGIE), such as referring to LGBTQ status as a 'lifestyle' or 'preference.'

Staff should avoid making assumptions about the SOGIE of consumers or using heteronormative language – meaning language that assumes that everyone is heterosexual or that heterosexuality is preferable or superior to any other identity. An example is asking a boy, "Do you have a girlfriend?" A neutral alternative is, "Are you dating anyone?' It is incumbent upon CAM staff to confront their own biases and ensure that policies are implemented equitably without basis on consumer's identities.

Non-Harassment

Statistics reveal that transgender people are at high risk of experiencing harassment and violence. To know of such harassment and neglect to take action is a violation of federal fair housing law. All service providers should institute policies to address resident-on-resident harassment.

Harassment includes abuse, assault and threats, but also includes a range of behaviors that are experienced as offensive, aggressive, or intimidating regardless of physical location or proximity to the project. For LGBTQ clients this can include: consistently or maliciously not using the client's affirmed gender pronoun, asking any questions about a client's body or appearance, disclosing that a client is transgender or gender non-conforming, or physical intimidation.

Different people have a different level of tolerance. Even if someone does not intend to harass, if their words have the effect of making a consumer feel uncomfortable, disrespected or fearful, this could be harassment and should be stopped. Staff will take immediate action to resolve inappropriate behavior, harassment, or equal access issues by any person (staff, volunteers, contractors or consumers).

Staff should also check in with transgender consumers after an incident of harassment or suspected harassment to make sure that they feel safe, offer resources and referrals, and see if they require any change in their accommodations.

Confidentiality

CAM staff should respect confidentiality and privacy concerns of all consumers. There are particularly important confidentiality and privacy concerns for transgender and gender non-conforming consumers.
A consumer's transgender status should be kept confidential unless the consumer instructs otherwise. Transgender people face serious risks of danger, including verbal harassment and physical assault, when their transgender status or gender identity is revealed without their consent.
CAM Staff will ensure that consumer's confidentiality is protected by:

1. Treating a consumer's transgender status and/or transition, sex assigned at birth and legal name as confidential medical information
2. Safeguarding all documents and electronic files
3. Containing this information and having conversations about these topics in privacy to prevent disclosure
4. Only informing essential staff will be told of a client's transgender status
    a. This includes intake worker, navigator and supervisory staff working with the consumer
5. Obtaining specific, time-limited written consent from the consumer to disclose this information and confirming the consumer understands the manner and extent to which this information will be used.
    a. This includes disclosure to non-essential staff and to staff within other agencies (including shelter providers)

Referral to Single-Sex Shelter

Consumers shall be referred to shelter based upon their self-identified gender identity. Staff will offer to assist the consumer to ensure they are able to access the services for which they are eligible. Staff will listen to and respect the consumer's assessment of what feels safe to them when determining the referral options. When

making a referral to shelter, staff should only disclose an individual's status as transgender or gender non-conforming to shelter staff if the client has provided consent to do so. If consent is obtained, only necessary information should be shared when making the referral.

All clients should be informed of what to expect in a shelter environment and their rights. This is especially important for transgender and gender nonconforming individuals who are at a higher risk to be the subject of harassment and assault. If a project rejects the consumer based on gender expression, staff will report the violation to their manager while continuing to work with the consumer.

Appendix 3: Reassessment and Case Review Policy

Reassessment

If a homeless service provider believes that a client's VI or Full SPDAT score does not accurately reflect the client's situation then that staff person can submit a request for reassessment. Clients will only be reassessed if:

1. It has been more than 6 months since the initial assessment, *or*
2. The client has experienced a major life change that may alter their score, *or*
3. There is a demonstrable reason why the initial assessment did not accurately reflect the client's situation

Example of change in client's circumstances that warrant a reassessment include:

- Medical emergency
- Health related diagnosis
- Increased interactions with law enforcement or institutions
- Drug or alcohol related relapse
- Change in family status

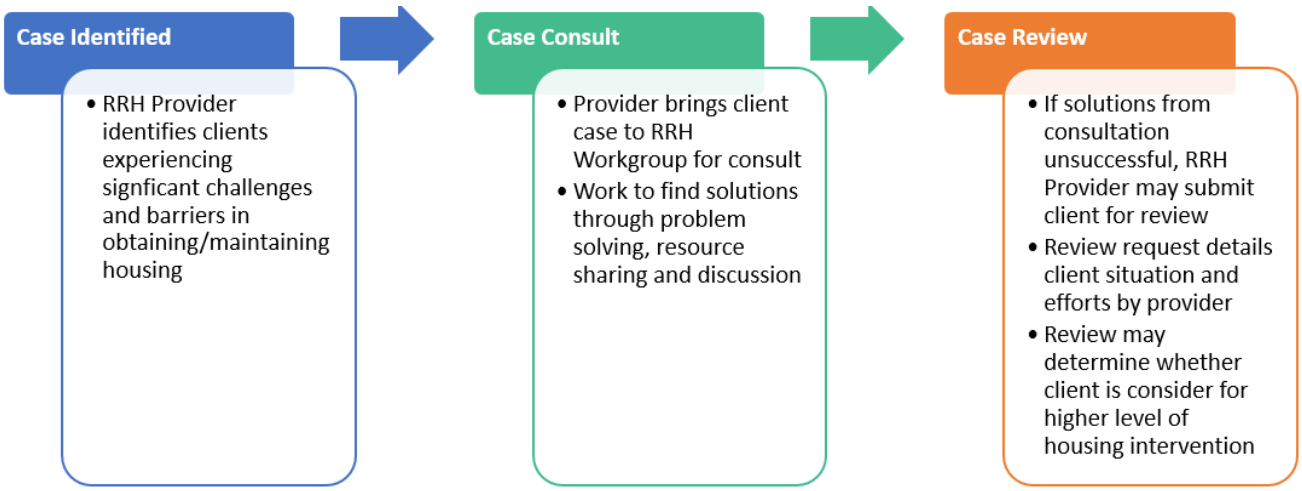
This reassessment process only pertains to clients who are unsheltered or in shelter prior to a referral a housing program. Staff working with clients in a housing program who believe the client needs a different intervention may follow the Case Review policy.

Procedure for Reassessment:

1. Staff requesting a second VI or Full SPDAT should complete the "Request for SPDAT Reassessment" form.
    a. Include detailed information on what has changed or was not discussed at the time of the original VI or Full SPDAT
    b. Be sure to fill out each section of the form or it will be rejected. If you do not have the information, please put N/A or Unknown.
2. Submit the request form using the: online form
3. CAM staff will review the submitted request and any supporting documents provided to a make a determination within 3 business days of submission.
4. Once the determination is made, CAM will notify the requesting staff of the outcome via email and attach the request form with comments.
5. If the reassessment is approved, CAM will assign an Intake Specialist to reassess the client.
    a. The Intake Specialist will coordinate with the submitting staff to contact and meet with the client
6. CAM staff will notify the submitting staff of the outcome.

Rapid Re-Housing Case Consult and Review

Rapid Re-Housing providers who are working with households experiencing significant challenges or barriers to obtaining or maintaining housing can brings these cases for consult and review. Case Consult provide a means for a provider to work together to come up with solutions to best support clients. Case review provides an avenue, after case consultation, for providers to request a review when they believe a client will not be successful in Rapid Re-Housing and needs a higher level of intervention.



If a RRH provider would like to request that a case be reviewed, they must first submit the case for consultation with the RRH Case Consult Group. An assigned RRH Provider will serve as facilitator for the case consultation. Case consult will be used to discuss the client's unique situation, problem-solve, share resource and work to identify potential solutions the provider could use to best support the client. If the RRH Provider implements the solutions identified in case consult and still believes the client needs a higher level of intervention, they may submit the case for review.

To submit a case for review, a provider will complete an online form which includes the following information:

- Household characteristics and assessment score/s
- How long the client been in the program (must be at least 90 days)
- The housing plan that was developed
- What steps in the plan have been carried out
- Why those steps have not successfully led to securing/maintaining housing
- Whether the issue of securing/maintaining housing is related to rent or services
- Why the case manager believes a more intensive intervention is required
- Why the client would like to pursue a more intensive intervention
- The case manager's identified barriers and strengths about the client
- The client's identified barriers and strengths about themselves
- What other steps could be taken instead of a more intensive resource type
- Documentation of the housing status (ie. if they are still homeless where they have been staying; or where they are housed if housed)

Requirements for a case to be reviewed:

1. The client has been enrolled in the RRH program for at least 90 days prior to request
2. The providers has brought the case to the RRH Workgroup for consultation
3. The provider has demonstrated efforts to implement solutions from consultation

Cases will be reviewed by a group appointed by the CAM Governance Committee with representative members from:

- CAM Lead Agency
- City of Detroit
- HAND

- PSH Provider
- RRH Provider
- Shelter Provider
- Street Outreach Provider

This group will meet on an as needed basis, and will review all cases which have been submitted at least one week ahead of meeting, as time allows. The submitting provider will have an opportunity to present the case to the group, and the group will be able to ask the provider questions. The group will make a determination based on a majority vote.

If the group decides the client needs a level of care beyond RRH, then the client will be placed back in the appropriate acuity group while remaining enrolled in the RRH program. If the client comes up for a PSH referral then the client could be transferred to the PSH program. This will be based on the client's situation as detailed below:

1. Household was chronic prior to being referred to RRH or has reached chronicity prior to being housed in RRH program
    a. Place household onto Acuity Group 1 list. Household will be prioritized on list according to standard criteria. *And,*
    b. Household remains enrolled in RRH program. If households comes up for referral on AG1 list, the household may be transferred to PSH program
2. Household was non-chronic prior to being housed in RRH program & was in Acuity Group 2
    a. Place household back in Acuity Group 2 list so they are in queue for referral to PSH if the Acuity Group 1 list is depleted. *And,*
    b. Household remains enrolled in RRH program. If households comes up for referral on AG2 list, the household may be transferred to PSH program
3. Household was non-chronic prior to being housed in RRH program & was in Acuity Group 3
    a. Re-do SPDAT; potentially place them on Acuity Group 2 List if have disability and score for AG2. *And,*
    b. Household remains enrolled in RRH program. If households comes up for referral on AG2 list, the household may be transferred to PSH program

Notes: Any household in any of these categories who meets the DedicatedPLUS definition prior to being housed in RRH program would fall into the DedicatedPLUS category within the CAM prioritization

Appendix 4: Veteran-Specific Policies and Procedures

Leadership and Coordination

"Our Goal is to End Veteran Homelessness by making it rare, brief, and non-recurring".

The Veteran Leadership Team's purpose is to act towards achieving this common goal by providing direction and support for the community at large who serve Veterans experiencing homelessness. This is accomplished by providing resources and trainings to equip the community with the tools and understanding of the decision-making process. It allows community partner's views to be expressed and incorporated into future development and planning. This process looks to strengthen the community's capacity to identify opportunities and address crises in innovative ways to end Veteran homelessness.

Leadership Team: The Leadership Team oversees the Detroit Plan to End Veteran Homelessness (DPEVH) and consists of a broad range of critical representatives, including the City of Detroit, John D. Dingell Medical Center, HAND, CAM, Detroit CoC Board, and representatives from the Grant and Per Diem programs (GPD), Contract Residential (CR), Housing and Urban Development-Veterans Administration Supportive Housing (HUD VASH), and Supportive Services for Veteran Families programs (SSVF). This group sets the course for homeless crisis response system for Veterans; serves as a group of "barrier busters" receiving information about systems barriers that need resolution by collaboration; implements appropriate policies and protocols as needed; establish goals; strategies and indicators/benchmarks related to preventing and ending Veteran homelessness consistent with the national standards, providing related oversight; and is tasked with communicating key decisions to key stakeholders.

The Leadership Team communicates their actions and decisions to the Continuum of Care (CoC) Board and CoC general membership on an ongoing basis, and shares system changes as needed.

By-Name List Case Conference Group (BNLCCG): The By-Name List Case Conferencing Group (BNLCCG) is led by the BNLC and Health Care for Homeless Veterans Coordinated Entry Specialist (HCHV CES) and includes representatives of Transitional Housing (TH) providers, shelters, Rapid Re-Housing (RRH) providers and Permanent Supportive Housing (PSH) providers including the Department of Veterans Affairs (VA). This team's purpose is to ensure that each Veteran household is appropriately served through CES matching; monitors each Veteran's progress toward housing for efficiency and effectiveness; and assists the providers to provide support and accountability in their work to rapidly house Veterans experiencing homelessness in Detroit.

Each provider appoints staff to attend who have in-depth knowledge about the status, needs and preferences of each Veteran being reviewed and who are also able to make decisions regarding provision of shelter, services, or housing assistance. This may be a program director, program manager, coordinator, housing specialist, case manager and/or outreach workers. Agencies with multiple programs can have representatives from each project or identify one or two staff members to share updates and insights on Veterans across their programming.

The work of the BNLCCG is done through bi-weekly meetings which begin with a review of the current data related to Veterans becoming homeless and getting housed followed by a review of a specific sub-population of Veterans experiencing homelessness to assess their progress and work as a team to resolve any barriers to success. Sub-population discussions include:

- Veterans experiencing chronic and long-term homelessness
- Unsheltered Veterans

- Veterans who have been on the BNL for 100+ days
- Veterans enrolled in RRH and not yet housed
- Veterans who are matched to PSH and are not yet housed
- Veterans in TH; Bridge Bed over 90 days
- Veterans who are matched to a Housing Track but need another Track match

Review is done through case conferencing that works to ensure holistic, coordinated, and integrated assistance across providers for all Veterans experiencing homelessness in the community; provides a forum for reviewing progress and barriers related to each Veteran's housing goal; identifies and tracks systemic barriers and strategizes solutions across providers and to clarify roles and responsibilities to reduce duplication of services. In the event that a program or project is not able to attend, the program is responsible for providing any updates or requests for assistance to the BNL Coordinator in advance of the meeting.

The BNLCCG will bring critical system-barriers that have been identified as affecting Veterans' progress toward housing to the Leadership Team as needed for discussion and potential resolution. The type of information discussed at this meeting includes the following:

- **Current status:** Where the Veteran is currently located and what the homelessness status is, including active in shelter, active unsheltered, missing and whether that status has changed since the last case conference review
- **Veteran Preferences:** Housing plans and next steps guided by the Veteran's preferences.
- **Critical Housing Placement Barriers***:* Review and problem-solving of any barriers to housing placement.
- **Critical Service Barriers:** Review and problem-solving of any challenges with connecting Veterans to critical services.
- **Current Safety:** Ensuring any unsheltered Veteran has a safe place to stay tonight in the interim.
- **Next Steps:** Identification of any immediate or critical action items related to the Veteran, including roles and timelines.

The BNL Coordinator will provide the Criteria and Benchmark data to the BNLCCG Team at the bi-weekly meetings to ensure staff understand the importance of their role in meeting these goals.

System Facilitation: The CAM was selected to provide support to the DPEVH by managing the BNL (reviewing HMIS reports for missing information, completing updates to the BNL when received as applicable, etc.), attending BNLCCG meetings, pulling names for BNLCCG and sending the names to all Veteran community homeless providers for review, preparing and presenting data at the Leadership Team meetings and taking notes and distributing them afterward. The CAM also assists in coordinating with the VA in implementation and operation of the CES for Veterans who are experiencing homelessness. The BNLC is responsible for sharing data with the Leadership Team. The Leadership Team reports this data to the Detroit CoC.

Policies and Procedures

Offers of Permanent Housing Intervention

The practices described here comply with the guidance provided by United States Interagency Council on Homelessness (USICH) Federal Benchmarks and Criteria. https://www.usich.gov/tools-for-action/criteria-for-ending-veteran-homelessness. The offer of permanent housing intervention must be made to all Veterans experiencing homelessness at the time of, or soon after the date of identification. *Please see below for a script that should be used when making the offer*.

OFFER OF PERMANENT HOUSING INTERVENTION SCRIPT

I'm wondering how you are feeling about getting an opportunity to move into permanent housing? In Detroit we have a number of different types of permanent housing assistance available to Veterans who are in your situation. All of the programs have people who would help you with the process of finding housing, negotiating with the landlords and some even have limited or longer term rental assistance. Even if you don't currently have any income, we can connect you to an appropriate program. If you would like to begin the process of getting into housing, we can make that connection for you within a couple of days depending on what you may be eligible for and what is available. If you want to explore this, you can still access shelter, transitional housing, and/or other services while you are working on getting into housing with the assistance of one of the housing programs. Would you like me to make that connection for you?

Policy: By-Name List Management

A registry called the By-Name List (BNL) is managed by the BNL Coordinator. This list is used to track the progress of Veterans as they move through the system from homelessness to housed. By using this list, we know how many Veteran households are experiencing literal homelessness in Detroit, the programs in which they are currently enrolled (e.g., emergency shelters, transitional housing, outreach affiliations), the Housing Track to which they have been matched, and their progress towards permanent housing.

This registry includes both an active list of all Veterans in the process of moving towards permanent housing as well as an inactive list of Veterans. Inactive defined Veterans are those who are permanently housed or if there has been no contact and unknown whereabouts after 90 days. Veterans who move to inactive status and then re-appear will have a new date of ID based on the last date of the most recent contact as homeless verses the earlier date of ID preceding switch to inactive. This is a way of maintaining data on Veterans in the event they are found again.

Procedure:

Veterans who are assessed will appear on the BNL within 48 hours of receiving the HMIS referral. The Veterans date of identification will be the date the Veteran is identified as homeless. The BNL Coordinator will be responsible for placing Veterans on the BNL. The Veteran's Housing Track will be noted on the BNL and assigned Lead Case Managers and Housing Program Case Managers (SSVF, HUD VASH) are responsible for providing updates on the status of where the Veteran is during their housing search.

The BNL will be sent out to the community the Monday after the BNLCCG for updates. The BNL updates are due to be entered into HMIS by the provider by the following Friday. Lead Case Manager(LCM)s and Housing Program Staff are expected to provide updates on Veteran's progress towards permanent housing at least every two weeks.

The Tuesday of the BNLCCG, a list will be sent out of the Veterans who will be reviewed. The Lead case managers (LCM) and Housing Program staff are expected to attend the BNLCCG

Lead Case Manager Role:

1. Assist Veterans in obtaining necessary documents for their identified Housing Track
2. Support Veteran in housing searches
3. Ensure Veterans attend necessary housing meetings based on their identified Housing Track
4. Update the BNL at least bi-weekly in HMIS

a. Fields to update include: Housing Case Notes, Enrollment in Program, Assigned Social Worker/Case Manager, Current Living Situation, Voucher/Briefing Date, and Date of Lease Signing.

5. Connect Veteran with community resources as needed such as security deposit assistance, furniture needs, etc.

Cross-County Identification

If a Veteran reports wanting to reside in an out-county, but is currently residing in temporary housing in Detroit, then the Veteran will remain on Detroit's BNL.

However, if a homeless Veteran has been assigned to an out-county provider and wants to live in an out-county, but his/her only temporary housing option is in Detroit, the Veteran will remain on the out-county's BNL. The Veteran will continue receiving assistance from the out-county staff. The HCHV Coordinated Entry Specialists are available to navigate any concerns that may arise and the LCM's will provide the daily supports necessary to ensure the Veteran is housed efficiently and not lost in the system between counties. BNL Leads will double check the BNL to ensure the Veteran is not counted on two BNL's.

The BNLC will track out-county Veterans who are temporarily residing at a Detroit TH site because of lack of shelter in the out-county in HMIS.

Policy: Unit and Voucher Availability Tracking

All providers will track their availability (PSH Units, HUD VASH Vouchers, Landlord availability) through various measures in order to provide up to date data as needed to Leadership and within the continuum.

Procedure:

- *CoC Permanent Supportive Housing:* Permanent Supportive Housing Providers complete an online survey *each time a new unit or set of units become available* in order for CAM staff to send them a referral from the PSH prioritization list.
- *HUD VASH:* Data of available vouchers is tracked by the HUD VASH team at the John D Dingell Medical Center and the information is reported to the community during Leadership, BNLCCG and CoC meetings. VHA eligible Veterans needing PSH will be prioritized for HUD VASH first and if there are no HUD VASH vouchers available, the Veteran will be referred to CoC PSH.
- *Rapid Rehousing Providers:* SSVF programs maintain a centralized list of landlords that work with RRH programs. This list is accessible to all SSVF case managers for use as a resource for RRH placement.

Policy: Veteran Status Confirmations

All Veterans will be verified for VHA eligibility to determine the highest level of services available to them. The John D Dingell Medical Center has staff available at the VCRRC to respond to requests for VHA eligibility. VA-funded programs must verify that the Veteran meets eligibility criteria by reviewing the Veteran's DD214 paperwork. This can be obtained in person at the VA Regional office or through the mail. For Non-VA funded resources, Veterans may have any discharge status and any length of active military service.

Procedure:

When conducting assessments, CAM staff will run a report in SQUARES to determine the following information about the Veteran's status:

- Discharge status
- Eligibility for various Veterans' programs including CR, GPD, VASH, SSVF, VA Medical Care
- HMIS for Chronic Status and date of that status

POLICY: BNL Inactive - Loss of Contact: Follow-up Policy

A Veteran is considered to be Inactive Unknown/Missing when s/he is no longer in contact with our system and HMIS reflects no active engagement or a change in status. The *Inactive –loss of contact* designation indicates that there has been no documented contact over 90 consecutive days after continual attempts by the LCM to contact the Veteran. Veterans remain on the Inactive List indefinitely.

Business rules to determine Date of ID when a Veteran has a break in a shelter/TH/CR stay:

1. Exits to unknown, homeless, or institutional settings: if Vet returns within less than 90 days, then use original ID date. If 90 days or more, reset ID date to indicate new episode. Assumption being that the episode is continuing if return in less than 90 days, since last exit data indicates or could suggest Vet was still literally homeless at exit.
2. Exits to PH or non-homeless temporary situations (e.g., friends/family-temporary): if Vet returns within 7 days or less, then use original ID date. If Vet returns in more than 7 days, reset and use new ID date. Assumption being that last homeless episode ended at exit and after 7 days, another homeless occurrence = new episode, consistent with chronic homeless definition.

PROCEDURE:

The LCM will attempt to make contact with the Veteran using the following procedures:

- *1 week out of contact*: at least one call or direct in-person attempt is made to the Veteran
- *2 weeks out of contact*: at least 2 calls ***and*** the staff responsible for the Veteran reaches out to the BNL Coordinator to determine whether the Veteran is connected somewhere else in the non-VA system and will contact HCHV Coordinated Entry Specialist to determine if the Veteran is connected to a VA service. If the Veteran is connected to the VAMC, the staff will contact the VCRRC for assistance with outreach and engagement. If the Veteran is matched to a SSFV, the staff will notify SSVF that the Veteran has not been in contact and request support to search for the Veteran.
- *3 weeks out of contact*: in addition to calling the Veteran, a call or letter to the Veteran's emergency contact shall be made, outreach efforts are continued, and the staff person will bring up the Veteran for review at the BNLCCG Meeting to inform the community of the need to locate the Veteran.
- *4 weeks out of contact*: same as above (3rd week)
- *After 4 weeks*: there should be 3 distinct attempts to contact made every thirty days.
- *8 weeks out of contact*: Staff reach out to the VCRRC if they can be found anywhere in the VA system and reengage outreach efforts.
- *8-12 weeks out of contact*: 3 distinct attempts to contact made including outreach to emergency contact again.
- Veteran will return to active status on the BNL once any provider reengages with the Veteran.
- This list will be reviewed during the BNLCCG meeting and housing providers will be reminded of protocols around engagement.

Once a Veteran in the Inactive Status is found or re-engaged, and they are still experiencing homelessness, the Veteran is immediately reactivated on the BNL to receive support in pursuing permanent housing. If the Veteran was matched to a Housing Track prior to becoming inactive, the last assigned LCM will be notified of the recent activity and will proceed with engaging the Veteran so long as that provider has capacity to do so; otherwise, the Veteran will be matched to another Case Manager by the BNL Coordinator based on eligibility and availability.

POLICY: BNL Inactive – Housed

A Veteran is considered to be housed when s/he has obtained a permanent residence and HMIS reflects the destination at exit in HMIS. Veterans remain on the Inactive List indefinitely.

PROCEDURE:
When a Veteran is permanently housed, the permanent housing provider updates HMIS with the housing placement date within 48 hours.

- If Veteran is housed via HUD VASH, it is the responsibility of the HUD VASH Social Worker to notify the BNL Coordinator via email within 48 hours of lease signing.
- If Veteran is housed via SSVF it is the responsibility of the SSVF Case Manager to notify the BNL Coordinator via email within 48 hours of lease signing.
- If the Veteran is housed without a permanent housing provider, the GPD/CR/Shelter staff then update HMIS with the permanent housing date within 48 hours.
- Each entity notifies the BNL Coordinator within 48 hours of housing placement via email.
- The BNL Coordinator updates the BNL indicating Veteran as permanently housed and status is changed to inactive.

POLICY: BNL Updates

The BNL must be updated at least bi-weekly. All providers must notify the BNL Coordinator within 48 hours when a Veteran is permanently housed. This will successfully place the Veteran as Inactive on the BNL and will help Detroit track housing outcomes.

PROCEDURE:
An offer of permanent housing must be offered and updated in HMIS:

- Every two weeks until the offer is accepted
- Once the offer is accepted staff does **NOT** need to update the offer unless circumstances change and the Veteran decides to decline permanent housing assistance at this time.
- Once a Veteran is permanently housed, the LCM notifies the BNLC within 48 hours of housing placement
- The BNLC updates the BNL to reflect Veteran as being permanently housed and is noted as Inactive.

POLICY: Unsheltered Veterans

All Veterans experiencing literal homelessness in Detroit will be immediately identified. All Unsheltered Veterans will be provided immediate access to a community shelter if available. Unsheltered is defined as those Veterans who do not use shelters and are typically found on the streets, in abandoned buildings, or in other places not meant for human habitation.

PROCEDURE:

- When first encountered, an unsheltered Veteran experiencing homelessness will be asked if they would like to have a bed in a shelter today.
- Anyone encountering an unsheltered Veteran will offer to assist that Veteran to go to a local emergency shelter. If the Veteran accepts this offer, Outreach will transport Veteran to a shelter (depending on time of day) or will transport to an access point.
- If local shelters are full, SSVF providers may pay for a temporary stay in a local hotel/motel for the unsheltered Veteran, where the Veteran is eligible and following SSVF requirements. (see EHA Policy in Appendix) If unsheltered Veterans decline the shelter offer because of challenges to entry, program staff working with the Veteran will work to resolve the challenges.
- If the issues with local shelter challenges to entry cannot be immediately resolved, SSVF grantees may pay for a temporary stay in a local hotel/motel for the unsheltered homeless Veteran. If an unsheltered Veteran declines a shelter offer for reasons other than challenges to entry, outreach providers will continue to make offers of shelter on no less than a biweekly basis. In extreme weather situations, shelter offers must be made no less than every three days.

POLICY: Assessment

All Veterans experiencing homelessness will be assessed by CAM staff. Once the CAM referral is sent to the VA, the Veteran will be clinically assessed by specifically trained HCHV/VCRRC Social Workers to determine if the Veteran should be referred to a GPD/CR program and/or other VHA support services.

Process:

Option 1: (Preferred method)

- The Coordinated Access Model (CAM) has hired a full time case manager to work at the Detroit VA to improve Veteran experience with connecting to CAM.
- This staff person is located in: B2230 (the former swing office) on the main corridor of B2South. They can see Veterans face to face and field phone calls at a VA phone line: 313.576.1414.
- Veterans walking into VCRRC may choose to call this identified CAM staff person for an assessment or travel to B2South to be seen in person, whichever is preferred and convenient for the Veteran.

Option 2:

- Vets can still call the CAM phone line as a second option.
- Vets will still be placed on an immediate prioritized call. When calling CAM they need to dial the hotline at 313.305.0311 and then press the appropriate option. They will need to say they are a Veteran and were referred from the VA for assessment. This will prioritize them ahead of the waiting line.

Please visit www.camdetroit.org for up to date CAM hours and locations.

Prevention/Rapid Resolution: Best Practice for Prevention of New Entry or Return to Homelessness: Detroit providers offer support, information, and targeted assistance to all Veterans who have been previously assisted or are newly homeless to help minimize entries/returns to homelessness.

TH, PSH, SSVF and other RRH grantees, have policies and procedures that allow for Veterans to be assisted with housing services that provide access to additional information and resources designed to ensure long-term housing stability. This includes providing contact information and resources to Veterans as it relates to diversion and homelessness prevention.

POLICY: Housing Tracks

PROCEDURE:

If Rapid Resolution is not successful, CAM completes:

- HMIS assessment, shelter offer/placement, VISPDAT
- HMIS Assessment flags BNLC to ensure Veteran is added to the BNL.
- BNLC adds Veteran to BNL with identified Housing Track based on VISPDAT score/Chronicity.
- CAM emails the Coordinated Entry Specialist the CAM referral form noting that a Veteran was referred to shelter.
- Coordinated Entry Specialist forwards the referral to HCHV/VCRRC staff for clinical assessment.
- VA Staff accepts referral by replying to all.
    - Referrals are accepted on a rotational basis internally between VCRRC and HCHV staff.
    - If a Social Worker has a hx with the Veteran, they will connect with the Veteran.
- VA Staff contacts Veteran to schedule VA Assessment.
    - This is done either in person or by phone.
- VA Staff completes:
    - VA Assessment
        - Veterans who enter GPD/CR need full VA assessments.

        - Humanitarian Only Veterans or Veterans who do not qualify for VHA services do not need a VA assessment if **NOT** placed at GPD/CR site.
    - HOMES
    - VA ROI
    - Referral to GPD/CR, if clinically appropriate.
        - Veterans who are in need of clinical support and significant case management can be referred to a GPD/CR bed. This decision is made based on the clinical assessment of the social worker.
        - If a Veteran does not appear to need services offered by a GPD/CR placement, then Veteran will remain in the shelter bed.
        - Bridge Beds: SSVF will have a housing plan in place within the designated timeframe and thus Veterans should be referred to this bed type unless a clinical need is identified.
    - If applicable, SW completes referral to GPD/CR and cc's CES and BNLC.

Shelter Placements: Veterans who are over income ($2300 single) for HUD VASH or SSVF RRH will remain in shelter unless a significant clinical need has identified a need for GPD/CR placement. Veterans who score between a 1-3 on the VISPDAT will remain in shelter.

Self-Resolve Housing: Veterans who score in the "Mainstream Resources Only" range on the VI-SPDAT (0-3) are least likely to require intensive services, are most likely to self-resolve and/or are over income and therefore are not prioritized for any CoC-funded resources. Veterans in this category are still referred to SSVF by the BNLC for further screening and will be evaluated on eligibility and/or level of need. If SSVF determines Veteran does not need any support from SSVF, TH Site Case Managers or Shelter case managers will assist this population in developing strategies to resolve their homelessness through an individualized housing plan.

1. The BNLC will place Veteran on BNL within 48 hours indicating Veteran is homeless
2. It is the responsibility of the assigned LCM to provide updates to the BNL on at least a bi-weekly basis.

Rapid Rehousing Track: Veterans are offered RRH referrals if they score between 4-7 on the VI-SPDAT for singles and 5-8 for families. The Veteran will be screened by SSVF to determine the level of services needed. *If a Veteran scores a 0-3 but are not over income BNLC will still refer to SSVF RRH for further eligibility

1. BNL Coordinator receives CAM assessment via HMIS and places Veteran on the BNL assigning Veteran to an SSVF provider on a rotating basis based on grant numbers.
2. SSVF becomes the Veteran's LCM throughout the housing process.
3. SSVF LCM ensures Veteran completes a HCV application for all Veterans in the RRH Track if Veteran meets the income guidelines.
4. It is the responsibility of the SSVF LCM to provide updates to the BNL Coordinator at least bi-weekly.

Shallow Subsidy –Need to add when implemented

Permanent Supportive Housing Track: If a Veteran scores an 8 or above on the VI-SPDAT for singles and 9 or above for families, indicating a need for intensive case management services then the Veteran would be placed on the Permanent Supportive Housing Track. Chronically homeless Veterans will also be placed on the PSH Track regardless of VI-SPDAT score.

1. The BNLC will place Veteran on BNL within 48 hours with prioritization based on VI score
2. If PSH and VHA eligible, BNLC will send email to Engagement Team for Veteran to be screened for VASH within 48 hours of receiving the referral.
3. If Veteran is determined as PSH but Non VHA-Eligible the BNLC will refer Veteran to CAM staff to complete full VI-SPDAT to determine eligibility for community PSH.

    - If there is no community PSH, Veteran is referred to SSVF to offer the next best available options per VA/HUD expectations and best practices.
4. The Veteran is assigned a LCM based on where s/he resides during the housing process.
5. The assigned LCM provides updates to the BNL on at least a bi- weekly basis.

See Detroit CES Flow Chart

POLICY: Providing TH to Veterans Experiencing Homelessness Only in Limited Instances

The VA will prioritize Veterans for the use of TH including VA GPD and/or CR as a short-term link to permanent housing.

Detroit TH programs have the following Bed Type Models:

- Bridge Housing — short-term stay in transitional housing for homeless Veterans with pre-identified permanent housing destinations, when that housing is not immediately available.
- Low Demand — to accommodate homeless Veterans experiencing chronic homelessness, who were unsuccessful in traditional housing/residential programs.
- Hospital to Housing — addresses the housing and recuperative-care needs of homeless Veterans who have been hospitalized and/or evaluated in an emergency room.
- Clinical Treatment — provides residential substance use and/or mental health treatment in conjunction with services to help homeless Veterans secure permanent housing and increase income through benefits and/or employment.
- Service-intensive Transitional Housing — residential services that facilitate stabilization and transition to permanent housing.

Veterans experiencing homelessness are only assisted with TH in the following situations:

- VA staff have identified a significant clinical need via the clinical assessment.
- The Veteran has declined an offer of permanent housing assistance because Veteran is experiencing some challenges that could be addressed and resolved by a particular VA TH program. This is reported by the LCM and noted in the BNL notes section.
- The Veteran accepted an offer of permanent housing, either PSH or RRH, but the permanent housing unit is not immediately available.
    - In this situation, a Veteran may be moved into a TH unit while waiting for the permanent housing unit to become available, rather than remaining in the emergency shelter or in an unsheltered location. The Veteran would be identified as a Bridge Bed.

PROCEDURE:

1. HCHV or VCRRC completes an assessment and the level of need is determined (Bridge, Clinical Bed, Low Demand, etc.).
2. HCHV/VCRRC staff reviews the available beds via the daily census and/or consults with the site/liaison.
3. If preferred/required bed is available, HCHV/VCRRC staff executes a referral and release and faxes or emails information to TH site.
4. Transportation is then arranged to facilitate Veteran's entry to TH site.

Once a Veteran is residing at the TH site, the TH program's LCM is responsible for offering permanent housing and providing updates in HMIS on at least a biweekly basis. The Veteran is assigned a Bed Type upon entering a TH program. The Veteran is responsible for following the criteria and expectations of that Bed Type. The goal is to move Veterans to permanent housing as swiftly as possible. However, if there are mitigating circumstances that arise such as an unexpected illness, emergency etc. the Veteran may determine that s/he is unable to

pursue permanent housing for a period of time. This will be discussed and address by TH staff. The LCM will update HMIS as not having accepted a permanent housing offer. The LCM does not need to wait until the bi-weekly check in to record an offer of permanent housing in HMIS.

Policy: Transitional Housing Review

The transitional housing review team (THRT) is an interdisciplinary team in VA homeless programming that reviews all Veterans requesting a VA-funded transitional housing (TH) placement who have already had two VA-funded TH placements. The team includes GPD and CR Liaisons, Supervisors, and other VAMC homeless staff members. For the purposes of the Detroit community, VA-funded transitional housing placements are CR and GPD. The national VA office considers CR as emergency shelter and it is noted as such in HMIS.

PROCEDURE

Veterans must present to a HCHV or VCRRC social worker to be referred to THRT for review. The meeting lasts 30-45 minutes with each Veteran. During the meeting, the THRT works with the Veteran to determine if VA-funded transitional housing is a suitable option. If the Veteran is approved for an additional TH stay, VA staff will notify the Coordinated Entry Specialist by adding him/her to the CPRS note. The GPD/CR site will enter the Veteran as placed at their location in HMIS which will update the BNL. The LCM will provide bi-weekly updates in HMIS case notes on Veteran's permanent housing progress. If VA-funded transitional housing is not suitable, the THRT will provide Veteran and referring social worker with other treatment/service recommendations.

POLICY: Domiciliary Residential Rehabilitation Treatment Program

This 50 bed co-ed residential treatment facility is available to assist Veterans who may be homeless and in need of structured treatment to assist them in preparing for a move into permanent housing. Each Veteran works with a multidisciplinary team of staff to develop their own personal treatment plan, addressing the issues and concerns unique to that Veteran.

If a literally homeless Veteran will be admitted to the DOM, a complete VA assessment needs to be completed by HCHV or VCRRC staff prior to admission to the DOM for purposes of maintaining their homeless status. A Veteran maintains his/her homeless status for 90 days while at the DOM. After 90 days, the Veteran will no longer be considered homeless or eligible for homeless services.

PROCEDURE:

Veteran's experiencing homelessness will meet with CAM and HCHV or VCRRC staff for a complete assessment prior to admission to the DOM

- CAM assessment in HMIS notifies BNLC to add Veteran to the BNL.
- HCHV/VCRRC staff complete VA clinical assessment, ROI and HOMES assessment
- The Veteran is referred to the DOM for admission
- The Program Director at the DOM becomes the Veteran's LCM throughout the housing process and provides bi-weekly updates to the BNLC
- Veterans who exceed his/her 90 days will be placed as inactive on the BNL due to no longer qualifying as homeless

POLICY: HUD VASH Protocols

The HUD-VASH Program is reserved for Veterans experiencing chronic homelessness and a disability who have few resources and require long-term case management to either obtain or maintain permanent housing. The goal of this protocol is to create transparency and coordination in the process of assisting eligible Veterans to access available HUD-VASH vouchers through the CES and to ensure that all Veterans served by the HUD-VASH program are appropriately represented and tracked on the BNL. These policies and procedures should assist

homelessness service providers, the VA, the Leadership Team, and others by providing a clear explanation of the process by which Veterans are matched to the HUD VASH Program.

The John D Dingell Medical Center is committed to taking referrals for HUD-VASH vouchers through the CES process. The HUD VASH team makes the final determinations on the appropriateness of any referrals that come from CES based on their clinical judgement and Veteran eligibility as it relates to discharge status.

If a Veteran scores an 8 or above (single) or 9 or above (families) on the VI-SPDAT, they will be considered for a HUD-VASH voucher. Referral for HUD-VASH vouchers will follow the CES prioritization process in this order:

1. Chronic Homelessness regardless of VI-SPDAT score
2. Long Term regardless of VI-SPDAT
3. VI Score
4. Number of days homeless
5. Date Identified for BNL

PROCEDURE:

1. Once the CAM assessment is completed and referral is sent to the BNLC, the Veteran will be added to the BNL within 48 hours.
2. If Veteran appears to qualify for HUD VASH, Veteran will be referred to the Engagement Team within 48 hours of their CAM assessment.
3. The HUD-VASH Engagement Team will attempt to contact the Veteran to arrange an initial meeting with the HUD-VASH staff within 3 business days of receiving the referral from the BNLC. The HUD VASH team will update the BNL bi-weekly in HMIS of attempted contact.
4. If accepted, a HUD VASH Case Manager is assigned to Veteran to navigate the HUD VASH process.
    a. The HUD VASH team will enter the date the Veteran is accepted to HUD VASH in HMIS within 48 hours. The HUD VASH Case Manager is responsible for notifying the Veteran of the HUD VASH acceptance.
5. If the Engagement Team has experienced 3 unsuccessful attempts at engaging the Veteran in the vouchering process, they will notify the BNLC of these unsuccessful attempts.
6. The BNLC will update the BNL and the Veteran will be referred to SSVF to determine if Veteran is eligible and interested in RRH supports.

Project-Based VASH Programs

If a Veteran is referred to one of the Project-Based HUD-VASH projects from CES and the Veteran meets all of the stated entry requirements of that housing provider, they are expected to accept the application. If the PSH provider believes that the referred Veteran does not meet their stated eligibility requirements, the HUD VASH Engagement Team will be notified.

A Veteran assigned to one project-based program cannot transfer to another project-based program without being issued a new voucher.

POLICY: Piquette Square Project-Based HUD VASH Vouchers

Piquette Square has 25 HUD VASH Project-Based units and 125 Project-Based Voucher units and is managed by Southwest Housing Solutions. The Piquette Square building serves Veterans who are homeless and have a disability. Piquette Square has a preference to utilize the CES process to ensure HUD VASH units are filled from the BNL as quickly as possible.

PROCEDURE: At the time of HUD VASH's assessment, staff will inquire if a Veteran would be interested in project-based housing vs. tenant-based housing. The Veteran's answer will be noted in HMIS.

HUD VASH PSH Identified Veterans:

1. The Property Manager will notify the BNLC, HCHV CES, HUD VASH Engagement Team Lead via email of upcoming unit availability.
2. The LCM and HUD VASH Engagement Team Lead will be notified via email of a Veteran being pulled from the list for a Piquette Square opening.
3. Piquette Square applications are completed online.

When the Veteran obtains the project-based HUD VASH voucher:
HUD VASH Engagement Team will:

1. Assist veteran with completing the application process for both the project-based building and the MSHDA application for the housing agent's office, RPI Management
   The link for Piquette Square application is: bit.ly/piquette-sq
2. Assist with appeal: If the Engagement Team assisted with the initial application then the Engagement Team will assist with the appeal; however if the Veteran's initial application was submitted by a LCM at a TH or shelter site then the Leasing Manager at Piquette will follow up with the Veteran and the LCM.
3. Following approval by both the project-based building and the housing agent's office, schedule Veteran for Project-Based Briefing
4. Assist Veteran with completing and submitting request for security deposit from other agencies.
5. Transport Veteran following briefing to leasing office of project-based housing to complete lease signing
6. Initiate warm hand off with social worker assigned to case manage Veterans in project-based housing.

Piquette Square does not accept*:

- Criminal Sexual Conduct Charge

Following must be uploaded to process the online application:

- Valid State Id or Driver's License
- SS Card
- Birth Certificate
- DD214
- Homeless Verification
- All sources of income - dated within the last 30 days (ex: SS, SSI, VA Pension)
- Or if employed - last 6 paystubs

*Piquette requests that the applicant has help applying and uploading documents. It's best if the Veteran has all proper documents prior to starting the application. Please remember to write down all email and password information when starting the application, if it is lost Piquette Square cannot retrieve it for the Veteran.

*Veteran may appeal a denial in writing within 7 days with a letter explaining history behind reason for denial. If appeal is granted Veteran's application will move to MSHDA. If denied, Veteran can appeal the denial with an in-person conference. Support staff are encouraged to attend as advocates.

POLICY: Bell Building Project-Based HUD VASH Vouchers

Bell has 10 HUD VASH Project-Based units and 145 CoC PSH units. The building serves persons who are homeless and have a disability. The Bell Building will utilize the CES process to ensure HUD VASH units are filled from the BNL as quickly as possible.

PROCEDURE: At the time of HUD VASH's assessment, staff will inquire if a Veteran would be interested in project-based housing vs. tenant-based housing. The Veteran's answer will be noted in HMIS.

HUD VASH PSH Identified Veterans:

- The Property Manager will notify the BNLC, HCHV CES, HUD VASH Engagement Team Lead as via email soon as they are aware of an upcoming available unit
- The LCM and HUD VASH Engagement Team Lead will be notified via email of the Veteran being pulled from the list for a Bell Building opening within 48 hours

When the Veteran obtains their project-based HUD VASH voucher, the Engagement Team will:

1. Assist veteran with completing the application process for both the project-based building and the MSHDA application for the housing agent's office, RPI Management
2. Assist with appeal: If the Engagement Team assisted with the initial application, then the Engagement Team will assist with the appeal; however if the Veteran's initial application was submitted by a LCM at a TH or shelter site then the Leasing Manager at Bell will follow up with the Veteran and the LCM.
3. Following approval by both the project-based building and the housing agent's office, schedule Veteran for Project-based Briefing
4. Assist Veteran with completing and submitting request for security deposit from other agencies.
5. Transport Veteran following briefing to leasing office of project-based housing to complete lease signing
6. Initiate warm hand off with social worker assigned to case manage Veterans in project- based housing.

CoC PSH Identified Veterans: Will follow CoC PSH protocol as noted in the Detroit CoC Permanent Supportive Housing Policies and Procedures Document found here:

The Bell Building does not accept:

- Criminal Sexual Conduct Charge
- Arson
- Methamphetamine Manufacturing
- Criminal charge within the past 3 years

The Bell Building is flexible in accepting:

- Past evictions
- Poor credit history

Documents needed to process Bell Building Application:

- DD214
- State Picture ID
- Income verification (if Veteran only has a Direct Express Card they will need to do an inquiry at an ATM and choose balance only printout. Bell will accept this as proof of income)
- Completed application

POLICY: Veterans Porting a VASH voucher into the Detroit Area

The HUD-VASH tenant-based vouchers are portable. Portability allows Veterans to live in the community of their choice (with some limitations) by taking a previously issued voucher with them. HUD-VASH participants may only port their voucher into those jurisdictional areas that have available HUD VASH Case Management services. The John D Dingell Medical Center is responsible for determining the appropriateness of accepting a porting request by a Veteran.

PROCEDURE:

When the HUD-VASH Program considers a port request from another catchment area, the treatment team will use its clinical judgment to approve or deny the Port request. *At this time all port request are being approved*.

- The PHA/ MSHDA must be notified of the port request and a voucher is not issued until a final approval from the PHA. This requires communication between the outgoing PHA and incoming PHA in order to complete documentation.
- It is the responsibility of the VA staff to direct the Veteran to CAM for an assessment if the Veteran is homeless and in need of shelter.
- Availability of vouchers and needs within the continuum will be taken into consideration if vouchers become limited.
- VA staff will consult with CoC CES Veteran Leadership Team to determine a criteria for accepting or denying ports if vouchers become limited.

POLICY: SSVF

As part of community-wide outreach efforts, and in line with SSVF program outcomes, Detroit SSVF grantees will work together to coordinate targeted outreach plans to locate and assess Veterans who are experiencing unsheltered homelessness. At a minimum, all grantees will conduct targeted outreach once a week. If a Veteran does not qualify for SSVF due to income or other requirements, the Veteran will be connected to a PATH team.

PROCEDURE

SSVF staff members will qualify Veterans to their SSVF program by using the following conditions:

- The Veteran meets SSVF eligibility criteria.
- The Veteran meets the definition of literal homelessness.
- For all SSVF grantees, Veteran households must have a discharge other than dishonorable, and must be below 50% of the AMI.
- The single Veteran has a VI score of 0 to 7 and the family has a score of 0 to 8 (if under income) and appears to be an appropriate fit for a RRH intervention.

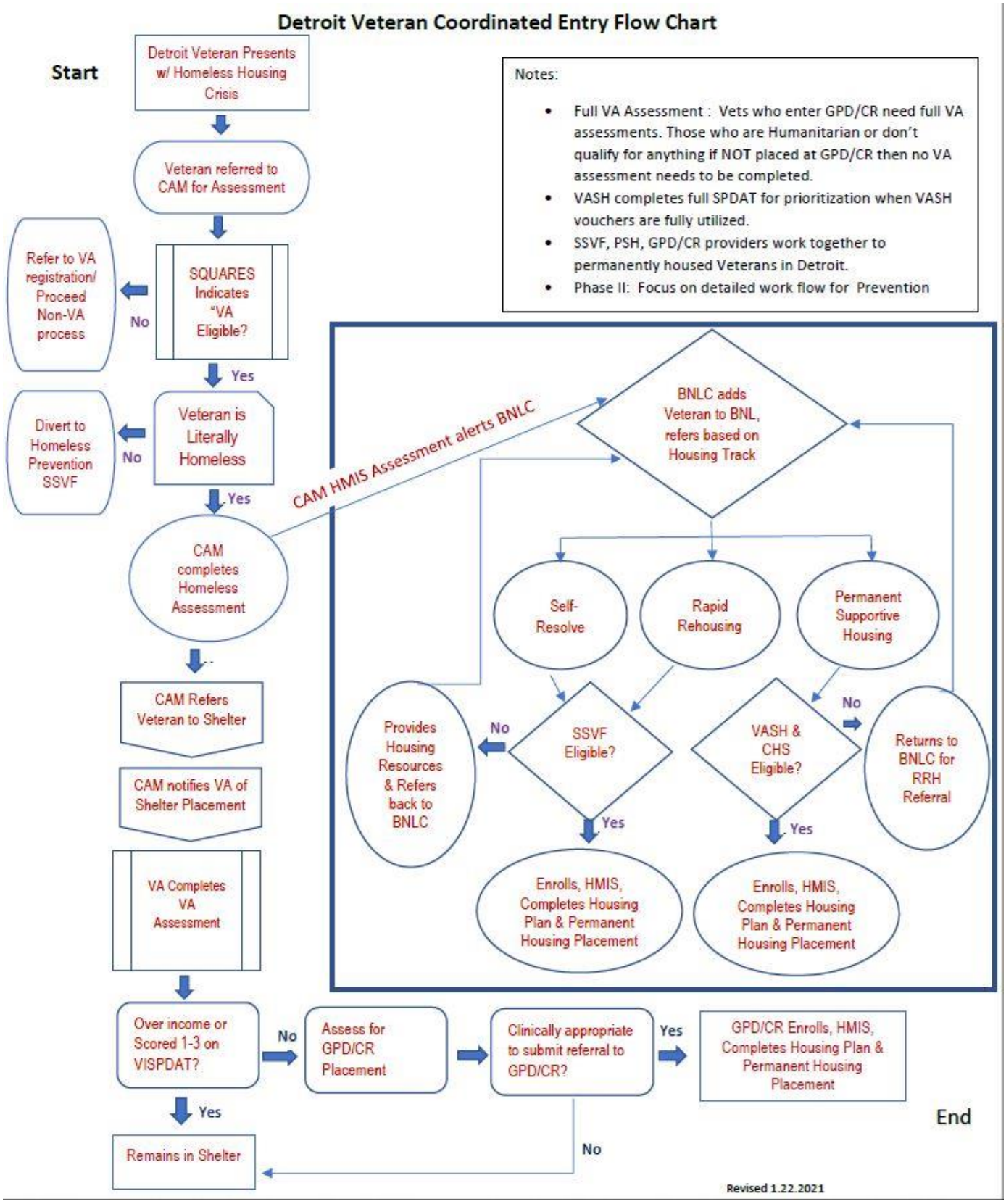
PROCEDURE: VOA and SWS SSVF Process:

Non-HUD VASH

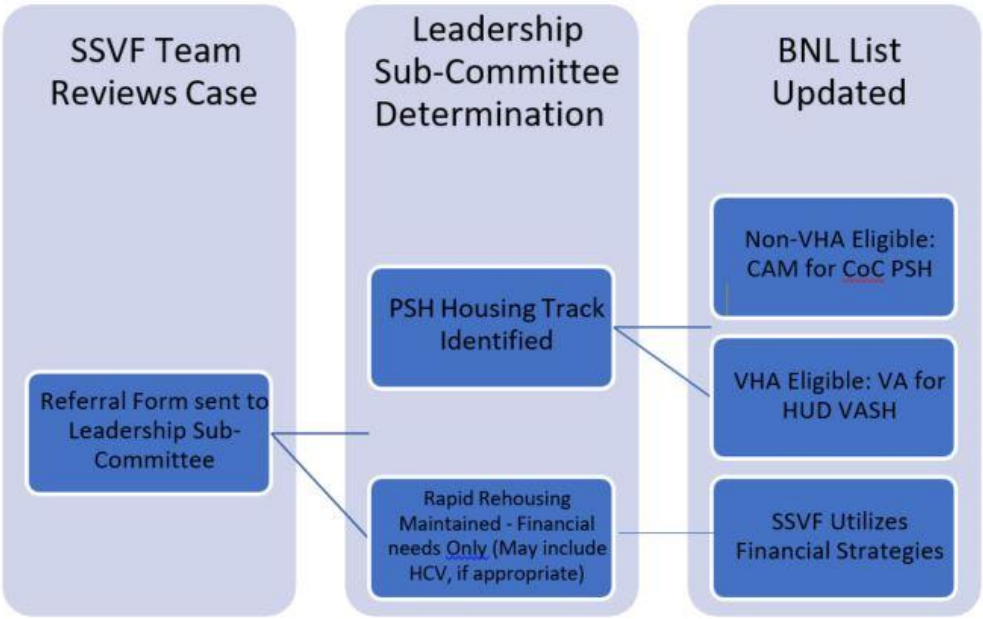
1. Veteran and SSVF Case Manager meets face to face to complete enrollment packet and HMIS entry
2. Discussion of expectations, cost-sharing, time frames, barriers, needs, legal, etc...
3. Begin to seek and discuss housing options if Veteran does not have housing leads prior to enrollment.
4. Once housing has been identified, begin housing application and provide Temporary Financial Assistance(TFA) for application fee, if needed
5. Collaborate with Landlord and obtain W9/Lease. (Lease does not need to be signed. Lease must include Veteran's name, address, Landlords name, address, amount of Security Deposit and monthly rent)
6. Identify moving date and schedule housing inspection prior to signing of the lease
7. Discuss any other needs that would require TFA such as allowable household items, utility assistance, moving cost, etc.
8. Once Veteran has been housed, discuss other needs and services that Veteran may require.

9. Housing stabilization services are offered for as long as the Veteran needs.
10. SSVF Case Manager completes referrals as needed.
11. SSVF Case Manager completes exit survey and provides a VA link to complete online survey
12. SSVF Case Manger exits Veteran from HMIS

There is no limit to how long a veteran can be enrolled in SSVF as long as there is a need for extended case management and there is a recertification completed every 90 days. If there is no longer a need for continued SSVF service, the case is usually closed at the 90 day period. SSVF needs an updated income statement to confirm the Veteran still meets income requirements every 90 days.


Detroit Veteran Coordinated Entry Flow Chart
Start
Detroit Veteran Presents w/ Homeless Housing Crisis
Veteran referred to CAM for Assessment
SQUARES Indicates "VA Eligible?
No
Refer to VA registration/ Proceed Non-VA process
Yes
Veteran is Literally Homeless
No
Divert to Homeless Prevention SSVF
Yes
CAM completes Homeless Assessment
CAM HMIS Assessment alerts BNLC
CAM Refers Veteran to Shelter
CAM notifies VA of Shelter Placement
VA Completes VA Assessment
Over income or Scored 1-3 on VISPDAT?
No
Assess for GPD/CR Placement
Clinically appropriate to submit referral to GPD/CR?
Yes
GPD/CR Enrolls, HMIS, Completes Housing Plan & Permanent Housing Placement
Yes
Remains in Shelter
No
End
Notes:
Full VA Assessment : Vets who enter GPD/CR need full VA assessments. Those who are Humanitarian or don't qualify for anything if NOT placed at GPD/CR then no VA assessment needs to be completed.
VASH completes full SPDAT for prioritization when VASH vouchers are fully utilized.
SSVF, PSH, GPD/CR providers work together to permanently housed Veterans in Detroit.
Phase II: Focus on detailed work flow for Prevention
BNLC adds Veteran to BNL, refers based on Housing Track
Self-Resolve
Rapid Rehousing
Permanent Supportive Housing
SSVF Eligible?
No
Provides Housing Resources & Refers back to BNLC
Yes
Enrolls, HMIS, Completes Housing Plan & Permanent Housing Placement
VASH & CHS Eligible?
No
Returns to BNLC for RRH Referral
Yes
Enrolls, HMIS, Completes Housing Plan & Permanent Housing Placement
Revised 1.22.2021

SSVF Progressive Engagement Flow Chart



SSVF Progressive Engagement Referral Form

Please complete all boxes on both pages or it will be returned back to submitter

Veteran Name:		**Date:**	
SSN:		**HMIS:**	
HOMES:			
Contact number:		**DOB:**	

County/CoC:	☐ Detroit/Wayne ☐ Out-Wayne ☐ Oakland ☐ Macomb ☐ St. Clair

All vital documents must be attached to the referral. If all documents are not submitted, the referral will be declined and send back to the individual who submitted the request

A new VISPDAT must be completed by HCHV/VCRRC staff and score submitted for referral.

Current Address:	
Move-In Date *(if applicable)*:	

Summary: (What specific barriers suggest Veteran may benefit from a higher level of care? What efforts have already been made to address those barriers? How will participation in HUD VASH increase the Veteran's chances of achieving housing stability?)

Old VISPDAT Score:

New VISPDAT Score:

SSVF Staff Name:	
SSVF Program:	
GPD/CR Staff:	
GPD/CR Liaison	
HUD VASH Staff (if applicable)	
Other Staff	

HUD VASH Document Checklist

Veteran Name	Phone Number	HOMES ID	HMIS ID
Other Household Members:			

Type of Document	Yes	No	N/A
State ID/Driver's License - for each household member over 18 (This only applies to additional household members, it is not required for the veteran)			
Birth Certificate - for each household member (This only applies to additional household members, it is not required for the veteran if the birthdate is clear on the DD214)			
Social Security Card - for each household member (This only applies to additional household members, it is not required for the veteran if the social security number is clear on the DD214)			
DD214 (If this is presented with a clear name, birthdate, and social security number please move forward with the application process) 1. Check for Honorable, Under Honorable Conditions as the discharge and 2 years of consecutive active service after September of 1980 (unless the veteran is service connected)			
• VA Benefit Statement dated within the last 60 days			
• Social Security Benefits dated within the last 60 days			
• Other Income (CWT, Employment, Etc.) 3 consecutive pay stubs			
• Bank Statement (last statement)			
• Food Assistance Printout *not a requirement PHA has access to obtain			
VRAP/Educational Enrollment Letter dated within the last 60 days			
Financial Aid Letter dated within the last 60 days			

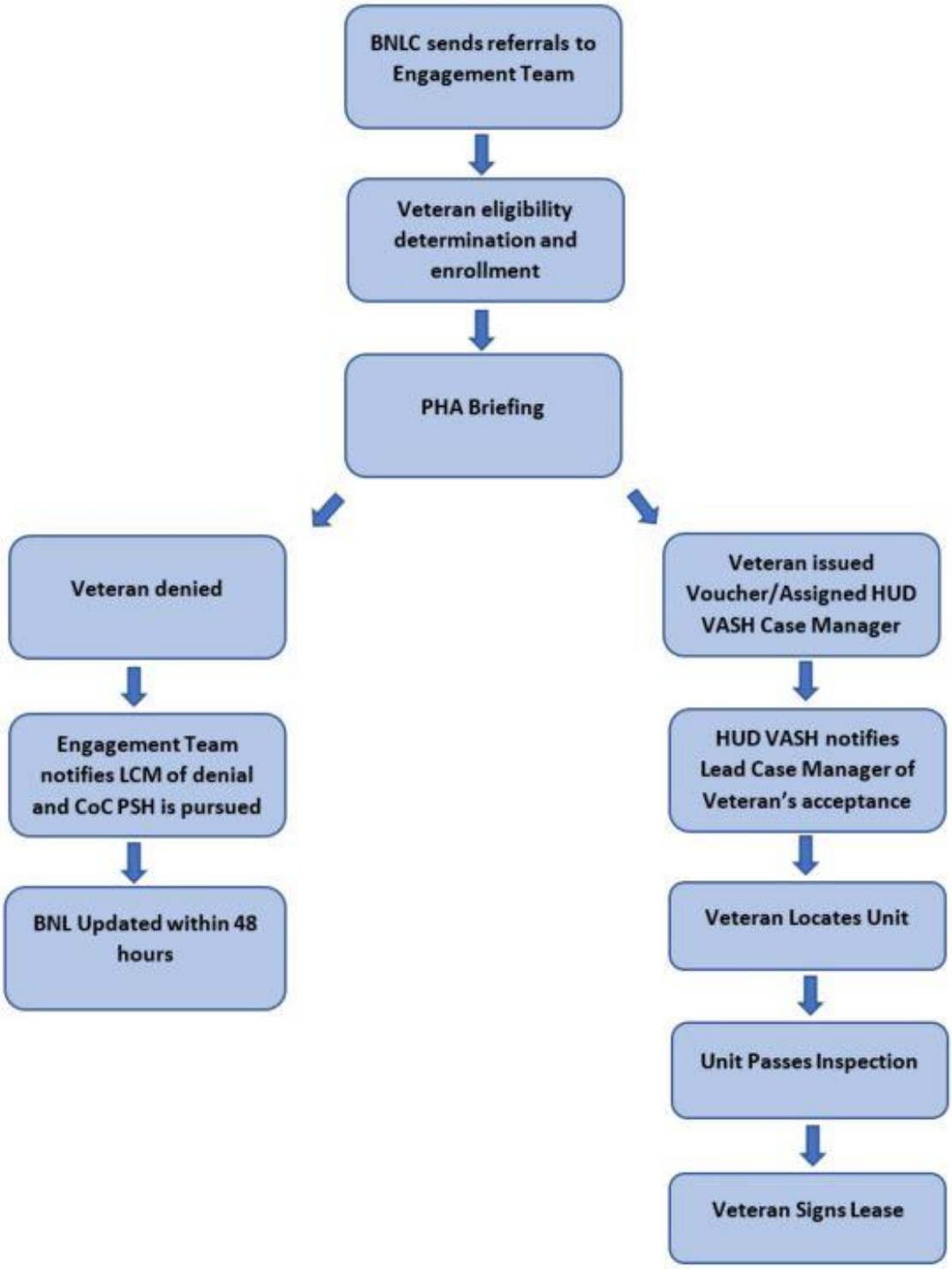
- *Income verification*: If a household member receives VA Benefits and/or Social Security Benefits, the letter must be dated within the last 30 days (VA Letters can be obtained from the Federal Building or through EBenefits.Gov and Social Security Award Letters can be obtained from any local branch)
- *If a household member receives child support*: please provide documentation regarding child support as well dated within the last 30 days.
- *If a household member is employed:* present with the last 3 consecutive paystubs or provide a letter from the employer dated within the last 30 days indicating the wages per hour and the hours worked per week.
- *Verification of benefits through Department of Human Services (food stamps)*: if applicable, and letter must be dated within the last 30 days.
- Last Bank Statement from each household member over 18 Income for each household member must be reported during the application process and while a past criminal history of a misdemeanor or felony does not prohibit entry into the program, individuals that are listed as lifetime registered sex offenders are not eligible for HUD/VASH.

Signature of Veteran acknowledging receipt of above checklist Date

Staff Signature Date

Updated 3/26/2021

HUD VASH Process Flow Chart



Updated 9.8.2021

SSVF Documentation Checklist

Veteran Name	Phone Number	HOMES ID	HMIS ID
Other Household Members:			

Type of Document	Yes	No	N/A
State ID/Driver's License - for each household member over 18			
Birth Certificate – Only needed for minor in the household			
Social Security Card - for each household member			
Proof of Veteran Status: (Only One from the list below is needed)			
➢ SQUARES 2.0 Printout			
➢ Veteran Health Administration (VHA) Veteran's Identity card			
➢ VA Veterans Choice Card			
➢ VA Photo ID Card			
➢ Veterans Benefits Administration (VBA) Statement of Service (SOS) • VISTA printout from VHA healthcare provider			
➢ VA Hospital Inquiry System (HINQS)			
➢ VBA award letter of service connected disability payment or non-service connected pension			
➢ NA Form 13038			
➢ DD Form 214 Certificate of Release Discharge from Active Duty			
Proof of Income:			
➢ VA Benefit Statement			
➢ Social Security Benefits			
➢ Employment – Last two pays stubs			
Homeless Verification letter			

- *Income verification*: If a household member receives VA Benefits and/or Social Security Benefits, letter must be dated within the last 30 days (VA letters can be obtained from the Federal Building or through EBenefits.Gov and Social Security Award Letters can be obtained from any local branch)
- *If a household member receives child support*: please provide documentation regarding child support as well dated within the last 30 days.
- *If a household member is employed:* present with the last 2 consecutive paystubs or provide a letter from the employer dated within the last 30 days indicating the wages per hour and the hours worked per week.

_____

Signature of Veteran acknowledging receipt of above checklist Date

_____

Staff Signature Date

Detroit and Out-County Contact List

BNL Leads, SSVF, VA Coordinated Entry Specialist Contact Information

Wayne County

Detroit COC (Detroit, Hamtramck, Highland Park)

HCHV Coordinated Entry Specialist	Email	Phone
Jennifer Tuzinsky	jennifer.tuzinsky@va.gov	(313) 702-3735
BNL Lead		
Nona Ingram	noingram@swsol.org	(313) 963-6601
SSVF Contact		
VOA: Danilo Tuazon	dtuazon@voami.org	(313) 635-4530
Southwest Solutions: Alexis McFadden	amcfadden@swsol.org	(313) 335-2010
SWS Prevention: Shant'e Jamerson	sjamerson@swsol.org	(313) 481-7915
Disability Network: Linda Staley	lstaley@dnom.org	(586) 268-4160 x 6615

Outer Counties

VHA

HCHV Coordinated Entry Specialist	Email	Phone
Janet Smith	janet.smith4@va.gov	(313) 657-8479

Macomb COC

BNL Lead	Email	Phone
Macomb Homeless Coalition	mhchmishelp@gmail.com	(586) 213-5757
SSVF Contact		
Disability Network: Sian Washington Disability Network: Gina Schaefer **(Back Up)**	swashington@dnom.org gschafer@dnom.org	(586)-268-4160 x 6618 (586)268-4160 x 6612 or mobile 313-329-3447
Macomb Community Action: Elizabeth Sergent	elizabeth.sergent@macombgov.org	586)463-2405 office
Macomb Community Action: Kathy Koths	Kathy.koths@macombgov.org	313-530-1956
Macomb Community Action: Emily Allen	Emily.Allen@macombgov.org	586-469-6050

Oakland COC

BNL Lead	Email	Phone
Holly Ellis	Hellis-alliance@oaklandhomeless.org	(248) 934-1965
SSVF Contact		
Disability Network: Sian Washington Disability Network: Gina Schaefer **(Back Up)**	swashington@dnom.org gschafer@dnom.org	(586) 268-4160 x 6618 (586) 268-4160 x 6612 or mobile: 313-329-3447
OLHSA: Jamar McKenzie	jamarm1@olhsa.org	(517) 599-6954
OLHSA: Megan LaForge	meganlf@OLHSA.ORG	517-599-0130
OLHSA: Donna Bunin	donnabn@olhsa.org	517-599-4406

Out-Wayne COC

BNL Lead	Email	Phone
Amy Bielby	abielby@waynemetro.org	(734)778-8570
Francesca Vitale: WM SSVF Supervisor	fvitale@waynemetro.org	(313) 463-5525
SSVF Contact		
Wayne Metro: Martha Esquivel-Leon	mesquivel-leon@waynemetro.org	(313) 324-7916
Disability Network: Linda Staley Disability Network: Gina Schaefer **(Back-Up)**	lstaley@dnom.org gschafer@dnom.org	(586) 268-4160 x 6615 (586) 268-4160 x 6612 or mobile: 313-329-3447
Southwest Solutions: Alexis McFadden	amcfadden@swsol.org	(313) 335-2010

St. Clair COC (part of Balance of State)

BNL/HMIS Lead	Email	Phone
Angela Shand Brianna Kammer-Walsh	angelashand@bwcil.org Brianna.kammer-walsh@bwcil.org	(810) 987-9337 (810)-987-9337
SSVF Contact		
Terry Nichols Brianna Kammer-Walsh	terrynichols@bwcil.org Brianna-kammer-waslh@bwcil.org	(810) 987-9337 (810)987-9337

Updated: 9.8.2021