Systems Manual
FL-520 Continuum of Care

Prepared by Mid Florida Homeless Coalition serving as Lead Agency to the FL-520 Continuum of Care

Prepared by the Mid Florida Homeless Coalition serving as Lead Agency to the FL-520 Continuum of Care and the Lead Agency for the Coordinated Access System.

Disclaimer: The *Coordinated Access System* uses a potential two-step assessment process to first triage for the best housing intervention (Permanent Supportive Housing [PSH] or Rapid Re-housing [RRH]), and then to determine prioritization based on vulnerability. It is not a guarantee that the individual will meet the final eligibility requirements for - or receive a referral to - a particular housing option.

The materials within this Coordinated Access System Operations Manual have been developed locally for the FL-520 Continuum of Care (including Citrus, Hernando, Lake, and Sumter Counties) and are not evidence based. They are intended to offer an example of how tools can be simplified and tailored to meet the objectives of a system that coordinates access to housing for homeless individuals, youth, and families. The tools are still in development and will continue to be refined locally based on feedback from assessors, providers, and participants.

FL-520 Continuum of Care

Coordinated Access System Operations Manual

Table of Contents

I.	Purpose and Background	-4-
II.	Definitions	-6-
III.	Staffing Roles and Expectations	-11-
IV.	Target Population	-12-
V.	System Overview and Workflow	-12-
a)	System Workflow Diagram	-14-
VI.	Coordinated Access Policies and Procedures	-15-
a)	Connecting to the Coordinated Access System	-15-
b)	Housing Assessment Process	-20-
c)	Housing Matching	-22-
d)	Housing Referral	-23-
e)	Case Conferences	-26-
VII.	Fair Housing, Tenant Selection Plans and Other Statutory and Regulatory Requirements	-26-
VIII.	Evaluating and Updating Coordinated Access System Policies and Procedures	-27-
IX.	Termination	-28-
X.	Appendices	-29-

I. Purpose and Background

Under the requirements of the Homeless Energy Assistance and Rapid Transition to Housing: Continuum of Care Program (HEARTH Act), the Citrus, Hernando, Lake, Sumter Counties Continuum of Care has implemented a Coordinated Access System. Coordinated Access is a powerful tool designed to ensure that homeless persons and persons at risk of homelessness are matched, as quickly as possible, with the intervention that will most efficiently and effectively end their homelessness. The Coordinated Access System described in this manual is designed to meet the requirements of the HEARTH Act, under which, at a minimum, Continuums of Care must adopt written standards that include:

a. Policies and procedures for providing an initial housing assessment to determine the best housing and services intervention for individuals and families;
b. A specific policy to guide the operation of the Coordinated Access System on how the system will address the needs of individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking, but who are seeking shelter or services from non-victim service providers;
c. Policies and procedures for evaluating individuals and families' eligibility for assistance;
d. Policies and procedures for determining and prioritizing which eligible individuals and families will receive rapid re-housing assistance;
e. Policies and procedures for determining and prioritizing which eligible individuals and families will receive permanent supportive housing assistance;
f. Policies and procedures for determining and prioritizing which eligible individuals and families will receive Transitional Housing are not being addressed at this time.

The Citrus, Hernando, Lake, Sumter Counties Continuum of Care has designed the *Coordinated Access System* described in this manual to coordinate and strengthen access to housing for families and individuals who are homeless or at risk of homelessness within the continuum of care. The *Coordinated Access System* institutes consistent and uniform assessment and referral processes to determine and secure the most appropriate response to each individual or family's immediate and long-term housing needs.

The *Coordinated Access System* is designed to:

- Allow anyone who needs assistance to know where to go to get that assistance, to be assessed in a standard and consistent way, and to connect with the housing/services that best meet their needs;
- Ensure clarity, transparency, consistency and accountability for homeless participants, referral sources and homeless service providers throughout the assessment and referral process;
- Facilitate exits from homelessness to stable housing in the most rapid manner possible given available resources;
- Ensure that participants gain access as efficiently and effectively as possible to the type of intervention most appropriate to their immediate and long-term housing needs;
- Ensure that people who have been homeless the longest and/or are the most vulnerable have priority access to scarce permanent supportive housing resources.

To achieve these objectives the *Coordinated Access System* includes:

- A **uniform and standard assessment process** to be used for all those seeking assistance and procedures for determining the appropriate next level of assistance to resolve the homelessness of those living in shelters, on the streets, or places not meant for human habitation;
- Establishment of **uniform guidelines** among components of homeless assistance (Rapid Rehousing, and Permanent Supportive Housing (Transitional Housing not being addressed at this time)) regarding: eligibility for services, priority populations, expected outcomes, and targets for length of stay;
- Agreed upon **priorities for accessing homeless assistance**;
- Referral policies and procedures from the system of coordinated access to homeless providers to facilitate access to services;
- The **policies and procedures manual** contained herein and detailing the operations of the *Coordinated Access System*.

The implementation of the *Coordinated Access System* necessitates significant, community-wide change. To help ensure that the system will be effective and manageable, a comprehensive group of stakeholders was involved in its design. In addition, particularly during the early stages of this implementation, the Citrus, Hernando, Lake, Sumter Counties Continuum of Care anticipates adjustments to the processes described in this manual. A periodic evaluation of the *Coordinated Access System* will provide ongoing opportunities for stakeholder feedback. Mid Florida Homeless Coalition, as the *Coordinating Entity*, will be responsible for monitoring the *Coordinated Access System*.

II. Definitions

Terms used throughout this manual are defined below:

By-Name-List:
Every household that is identified as literally homeless is added to the By-Name-List. Every person that meets the imminently at-risk definition and is assessed, is placed on the Homeless Prevention By-Name-List. Once a person completes a housing assessment their information is updated to reflect the type of housing that would be appropriate: Permanent Supportive Housing or Rapid Re-housing or RRH Homeless Prevention.
The By-Name-List is prioritized by:

- Permanent Supportive Housing participants are prioritized based on their SPDAT score and chronicity. Veterans meeting the definition of chronically homeless will be given prioritization in this case. DD-214 must be documented in order to establish Veteran priority.
- Rapid Re-housing participants are prioritized by their VI-SPDAT score, Veteran status, Chronic Homelessness, and then Family Status (minor children in the household). DD-214 must be documented in order to establish Veteran priority.
- In the event that multiple participants being considered for a referral have the same VI-SPDAT score, and are unable to be prioritized by the preceding, the following sub-categories have been approved as a secondary level of prioritization. They are listed in order: Tri-Morbidity, Currently Fleeing Domestic Violence, and Elderly (age 62+).

The By-Name-List is partially maintained by the HMIS Entity pulling utilization reports weekly. The list is monitored on a monthly basis for participant accuracy. If any participant is shown to not have active services in HMIS or has failed to contact the Coordinating Entity for a period of over 90 days, an attempt will be made to contact the participant via any or all of the following methods; phone call or text to last known telephone number, email to last known email, phone call or personal visit to last known location or frequented agency. If no contact is able to be made in this attempt, the participant will be removed from the Active portion of the BNL until the participant is reestablished to be homeless. All efforts will be made to document the most accurate current status of the participant.

Chronically Homeless (HUD Definition):

1) *An individual who:*
   - *(i) Is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and*
   - *(ii) Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions totaling 12 months in the last three (3) years; and*
   - *(iii) Can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000 (42 U.S.C. 15002)), post-*

traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability.

2) *An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital or other similar facility, for fewer than 90 days and met all the criteria in paragraph (1) of this definition, before entering that facility; or*
3) *A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.*

Disability (HUD Definition):
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, substantially impedes the individual's ability to live independently, and could be improved by the provision of more suitable housing conditions; includes:

Developmental Disability:
Defined in §102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 USC 15002). Means a severe, chronic disability that is attributable to a mental or physical impairment or combination AND is manifested before age 22 AND is likely to continue indefinitely AND reflects need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. An individual may be considered to have a developmental disability without meeting three or more of the criteria listed previously, if individual is 9 years old or younger AND has a substantial developmental delay or specific congenital or acquired condition AND without services and supports, has a high probability of meeting those criteria later in life.

HIV/AIDS Criteria:
Includes the disease of acquired immunodeficiency syndrome (AIDS) or any conditions arising from the etiologic agent for acquired immunodeficiency syndrome, including infection with the human immunodeficiency virus (HIV).

Literally Homeless (HUD Homeless Definition Category 1): Individual or family who lacks a fixed, regular, or adequate nighttime residence, meaning: (i) has a primary nighttime residence that is a public or private place not meant for human habitation; (ii) is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or (iii) Is exiting an institution where (s)he has resided for 90 days or less and who has resided in an emergency shelter or place not meant for habitation immediately before entering that institution.

At imminent risk of homelessness (HUD Homeless Definition Category 2):
Individual or family who will imminently lose their primary nighttime residence, provided that: (i) Residence will be lost within 14 days of the date of application for homeless assistance; (ii)

No subsequent residence has been identified; and (iii) The individual or family lacks the resources or support networks needed to obtain other permanent housing

Housing under other Federal statutes (HUD Homeless Definition Category 3):
Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who: (i) Are defined as homeless under the other listed federal statutes; (ii) have not had a lease, ownership interest, or occupancy agreement in permanent housing at any time in the past 60 days immediately preceding the date of application for homeless assistance; (iii) Have experienced persistent instability as measured by two moves or more during the 60-day period immediately preceding the date of applying for homeless assistance; and (iv) can be expected to continue in such status for an extended period of time due to special needs or barrier.

Fleeing domestic abuse or violence (HUD Homeless Definition Category 4):
Any individual or family who: (i) Is fleeing, or is attempting to flee, domestic violence; (ii) Has no other residence; and (iii) Lacks the resources or support networks to obtain other permanent housing.

Veteran- An adult who served on active duty in the armed forces of the United States, including persons who served active duty from the military 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.

Harm Reduction:
Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs. Harm reduction incorporates a spectrum of strategies from safer use, to managed use to abstinence to meet drug users "where they're at," addressing conditions of use along with the use itself. Because harm reduction demands that interventions and policies designed to serve drug users reflect specific individual and community needs, there is no universal definition of or formula for implementing harm reduction.

Homeless Management Information System
A Homeless Management Information System (HMIS) is a database used to record and track participant-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. The U.S. Department of Housing and Urban Development (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.

The Citrus, Hernando, Lake, Sumter Counties Continuum of Care's HMIS is staffed by Mid Florida Homeless Coalition. The software provider is Clarity. The HMIS staff is responsible for

the administration of the HMIS software and providing technical assistance to participating agencies and end-users. Agencies that participate in HMIS are referred to as “participating agencies”. Each participating agency needs to follow certain guidelines to help maintain data privacy and accuracy.

SPDAT:

The Service Prioritization Decision Assistance Tool (SPDAT) was developed as an assessment tool for front- line workers at agencies that work with homeless clients to prioritize which of those clients should receive assistance first. The SPDAT tools are also designed to help guide case management and improve housing stability outcomes. They provide an in-depth assessment that relies on the assessor’s ability to interpret responses and corroborate those with evidence. As a result, this tool may only be used by those who have received proper, up-to-date training provided by OrgCode Consulting, Inc. or an OrgCode certified trainer.

Vulnerability Index - Service Prioritization Decision Assessment Tool:

The **VI**-**SPDAT** (Vulnerability Index - Service Prioritization Decision Assistance Tool) is a survey administered both to single adults, families, and transition aged youth to determine risk and prioritization when providing assistance to homeless and at-risk of homelessness persons.

The Final FY 2017 Fair Market Rates for All Bedroom Sizes

Final FY 2019 & Final FY 2019 FMRs By Unit Bedrooms					
	Efficiency	**1-Bedroom**	**2-Bedroom**	**3-Bedroom**	**4-Bedroom**
Citrus County	$620	$640	$846	$1,191	$1,486
Hernando County	$800*	$850*	$1,055*	$1,390*	$1,675*
Lake County	$932	$919	$1,190	$1,576	$1,879
Sumter County	$626	$640	$847	$1,152	$1,157

***varies by zip code**

FY 2019 Income Limits Summary –effective 08/14/19

FY 2019 Income Limit Category	**Citrus County** – Median Income $52,700 -- Persons in Family							
	1	2	3	4	5	6	7	8
30% ELI	$12,490	$16,910	$21,330	$25,750	$28,500	$30,600	$32,700	$34,800
50% VERY LOW	$18,450	$21,100	$23,750	$26,350	$28,500	$30,600	$32,700	$34,800
80% LOW	$29,550	$33,750	$37,950	$42,150	$45,550	$48,900	$52,300	$55,650

FY 2019 Income Limit Category	**Hernando County** – Median Income $66,900 -- Persons in Family							
	1	2	3	4	5	6	7	8
30% ELI	$14,050	$16,910	$21,330	$25,750	$30,170	$34,590	$39,010	$43,430
50% VERY LOW	$23,450	$26,800	$30,150	$33,450	$36,150	$38,850	$41,500	$44,200
80% LOW	$37,450	$42,800	$48,150	$53,500	$57,800	$62,100	$66,350	$70,650

FY 2019 Income Limit Category	**Lake County** – Median Income $65,100 -- Persons in Family							
	1	2	3	4	5	6	7	8
30% ELI	$14,600	$16,910	$21,330	$25,750	$30,170	$34,590	$39,010	$43,430
50% VERY LOW	$24,300	$27,800	$31,250	$34,700	$37,500	$40,300	$43,050	$45,850
80% LOW	$38,850	$44,400	$49,950	$55,500	$59,950	$64,400	$68,850	$73,300

FY 2019 Income Limit Category	**Sumter County** – Median Income $71,300 -- Persons in Family							
	1	2	3	4	5	6	7	8
30% ELI	$15,000	$17,150	$21,330	$25,750	$30,170	$34,590	$39,010	$43,430
50% VERY LOW	$25,000	$28,550	$32,100	$35,650	$38,550	$41,400	$44,250	$47,100
80% LOW	$39,950	$45,650	$51,350	$57,050	$61,650	$66,200	$70,750	$75,350

III. Staffing Roles and Expectations

Continuum of Care - recognizing the need to stimulate community-wide planning and coordination of programs for individuals and families who are homeless, the U.S. Department of Housing and Development (HUD) in 1994 instituted a requirement for communities to come together to submit a single, comprehensive application for HUD funds for housing and support services for people who have experienced homelessness. The organizational concept to embody this effort is the Continuum of Care (CoC), which is governed by a Governing Board composed of representatives from across the community. As a result of its strong leadership, access to resources and high visibility in the community, Mid Florida Homeless Coalition serves as this region's lead for the CoC. The Citrus, Hernando, Lake, Sumter Counties Continuum of Care's purpose is to:

- Help create integrated, community-wide strategies and plans to prevent and end homelessness;
- Provide coordination among the numerous regional organizations and initiatives that serve the homeless population, and
- Create the region's single, comprehensive grant application to HUD for McKinney-Vento funding.

Coordinating Entity - Mid Florida Homeless Coalition is the designated Coordinating Entity. The Coordinating Entity is responsible for the day-to-day administration of the Coordinated Access System, including but not limited to the following:

- Creating and widely disseminating materials regarding services available through the Coordinated Access System and how to access those services;
- Designing and delivering training at least annually to all key stakeholder organizations, including but not limited to the required training for Coordinated Access Staff;
- Ensuring that pertinent information is entered into HMIS for monitoring and tracking the process of referrals including vacancy reporting and completion of assessments;
- Managing case conferences to review and resolve rejection decisions by receiving programs and refusals by participants to engage in a housing plan in compliance with receiving program guidelines;
- Managing an eligibility determination appeals process in compliance with the protocols described in this manual;
- Managing manual processes as necessary to enable participation in the Coordinated Access System by providers not participating in HMIS;
- Designing and executing ongoing quality control activities to ensure clarity, transparency, and consistency in order to remain accountable to participants, referral sources, and homeless service providers throughout the coordinated access process;
- Periodically evaluating efforts to ensure that the Coordinated Access System is functioning as intended;
- Making periodic adjustments to the Coordinated Access System as determined necessary;

- ❖ Ensuring that evaluation and adjustment processes are informed by a broad and representative group of stakeholders;
- ❖ Updating policies and procedures;
- ❖ Managing all Public Relation requests related to the Coordinated Access System.

Project Coordinator - The Coordinating Entity staffs the Coordinated Access Project Coordinator position. The project coordinator role includes coordination of the Coordinated Access System, including but not limited to the following:

- ❖ Serving as point person to all workgroups and transition teams;
- ❖ Providing Coordinated Access training to participating agencies;
- ❖ Liaison with HMIS Administrator for database administration and report generating;
- ❖ Communicating to user agencies and outreach case managers;
- ❖ Ensuring the deactivation/reactivation of participants on the By-Name-List;
- ❖ Responding to requests by Receiving Program for participant denial;
- ❖ Responding to email generated questions;
- ❖ Assisting the Coordinated Access Committee in monitoring system performance (Coordinated Access Staff, Database, Providers, etc.)

Assessment Hubs - Agencies selected to serve as Assessment Hub sites are responsible for ensuring that all participants experiencing homelessness and at-risk of homelessness have prompt access to Intake and Assessments, and that Assessments are administered in a safe, welcoming environment.

Housing Assessors – See 2.1 of the Housing Assessment Process.

Receiving Program - All Rapid Rehousing and Permanent Supportive Housing programs are Receiving Programs and are responsible for reporting vacancies to the Coordinating Entity in compliance with the protocols described in this manual. All programs that receive a referral from the Coordinated Access System are responsible for responding to that referral and participating in case conferences, in compliance with the protocols described in this manual.

Authorized User Agencies - Housing providers who wish to or are required to participate in the Coordinated Access System.

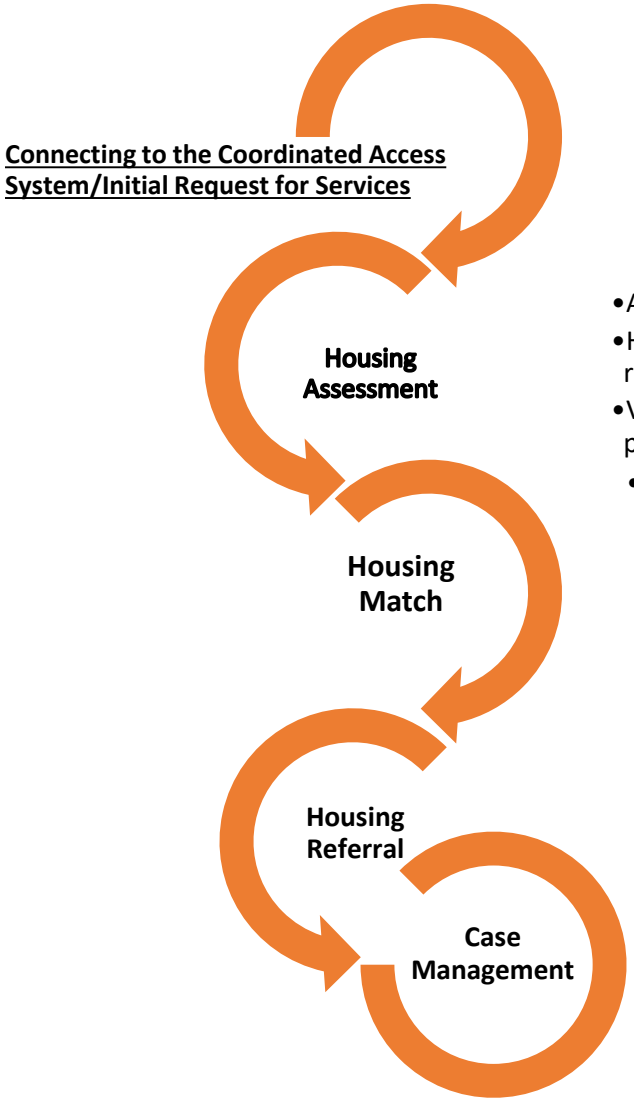
III. Target Population

The Coordinated Access System is open to all participants who meet the HUD definition of homeless, as outlined in the new HEARTH Act regulations, and have income that is at or below 30% Area Median Income for those imminently at-risk of homelessness.

IV. System Overview and Workflow

To illustrate how the Coordinated Access System functions, the following overview provides a brief description of the path a participant would follow from an initial request for housing through permanent housing placement. The overview also describes roles and expectations of the key partner organizations that play a critical role in the system. Additional details can be found in the subsequent sections of this manual and the Coordinated Access workflow.

- **Step 1: Connecting to the Coordinated Access System/Initial Request for Services** - To ensure accessibility to participants in need, the Coordinated Access System provides access to services from multiple, convenient physical locations. Participants in need may initiate a request for services in person through designated Assessment Hubs, the call center, and/or community outreach teams. Detailed information regarding Hub locations and hours of operation are posted on Mid Florida Homeless Coalition's website http://www.midfloridahomeless.org.
- **Step 2: Housing Assessment -** Housing Assessors are available at Assessment Hubs, the call center, and through community outreach teams to conduct the Coordinated Access Housing Assessment. The VI-SPDAT assessment is completed using HMIS and/or paper documentation. The SPDAT Assessment is utilized for all participants identified as a match for Permanent Supportive Housing to prioritize referrals. Once the recommended intervention has been identified, the household name is placed on the By-Name-List.
- **Step 3: Housing Match -** Information gathered from the assessment is used to determine which housing intervention is best suited to end the participant's homelessness (Permanent Supportive Housing or Rapid Rehousing). The Coordinated Entity team determines the specific housing program based on program eligibility and the VI-SPDAT and/or SPDAT when applicable.
- **Step 4: Housing Referral -** Once the Coordinated Access Team receives an email request from a Receiving Agency, an electronic referral is made to the Receiving Agency. Or, once the Housing Locator is notified by a landlord that a unit is available, an electronic referral is made to the Receiving Agency when Receiving Agency confirms that funding is available.
- **Step 5: Case Management -** After being referred to a Receiving Agency, participants will complete appropriate paperwork. This process may include but is not limited to the following activities: obtaining ID, obtaining social security cards, obtaining homeless verification documents. Providing that housing has not already been identified, the Receiving Agency then makes a referral to the Housing Locator along with a Housing Locator Form. The Housing Locator begins the process of identifying a unit or works with the participant for the unit that has already been identified. **The process from program entry to move in should be completed within 30 days.**



- Participants in need may initiate a request for services in person through any of the designated Assessment Hubs, through the call center, and/or through community outreach teams

- At-risk - assessment conducted via telephone
- Homeless - assessment is completed at Assessment Hub or referral is sent to Coordinating Entity
- VI-SPDAT score used to determine if person qualifies for grant projects in CoC
  - SPDAT is used to determine the appropriate housing type if VISPDAT score reflects PSH and/or a "conflict of interest" is identified.

- Person is placed on By-Name-List awaiting notification that a housing unit via a landlord is available, or notification is received by Referring Agency

Above is an illustration of the CA Workflow:

VI. Coordinated Access Policies and Procedures

1. Connecting to the Coordinated Access System

1.1. Locations & Hours - Assessments are conducted at designated Assessment Hubs, public sites, and agreed upon locations between the Assessor and potential participants. The call center has been established at the office of Mid Florida Homeless Coalition. Current Assessment Hub locations and assessment hours can be found on Mid Florida Homeless Coalition's website http://www.midfloridahomeless.org.

1.2. Eligibility - The Coordinated Access System is intended to facilitate access to the most appropriate housing intervention for each household's immediate and long-term housing needs and ensure that scarce permanent supportive housing resources are targeted to those who are most vulnerable and/or have been homeless the longest. The Coordinated Access System uses the following criteria to accurately match needs to the appropriate housing intervention**:** *see the charts below.*

1.3. Marketing/Advertising - As needed, the Coordinating Entity will send information & updates regarding the Coordinated Access System via email to stakeholders, the 211 system, and the general public. The Coordinating Entity also distributes flyers and brochures and maintains information available on its website http://www.midfloridahomeless.org.

Permanent Supportive Housing

Permanent Housing that is coupled with supportive services that are appropriate to the needs and preferences of residents.
Individuals have leases, must abide by rights and responsibilities, and may remain with no program-imposed on time limits.
Housing may include various combinations of subsidy resources and services. Supportive housing in the Citrus, Hernando, Lake and Sumter Counties CoC is housing first, and follows a harm-reduction philosophy.

Program Description	Essential Program Elements	Time Frame	Population	Desired /Expected Outcomes
Rental assistance with supportive services for persons who are coming from the street or shelter/interim housing. Majority of programs serve households with a disabled head of household, but disability requirement will be based on subsidy source requirements. Programs can operate on a project-based or scattered-site model.	**Case Management** • Assistance with lease process; • Provision of or linkage to: Assessment, Intervention, link to mainstream resources, community building, peer to peer and all other services that assist a person in remaining stably housed; • Services are voluntary to the participants and are not a condition of the lease. **Rental Subsidy** • Provides a rental subsidy to make the unit affordable; • Provides assistance in accessing housing relocation resources/supports (security deposits, utilities, furnishings, etc.); • Ensure coordination between property manager or landlord. **Health Care Access** • Wellness services; • Physical and mental health services. **Harm Reduction and Housing First** • All supportive housing embraces and practices Harm Reduction and Housing First; • Incorporate proven best practices and evidence-based practices; • Programs do not require sobriety or medication/treatment compliance as a condition of housing attainment or retention.	No time limits.	• Any high needs individual with multiple barriers to housing who is literally homeless (lease-based program). • Specialized eligibility requirements for subsidies including veterans, disabled, long-term homeless, or domestic violence. **Prioritizing:** Disabling condition and long-term, multiple episodes of homelessness (Vulnerability Index score of 10 or higher) and veterans. **Unique Populations:** ○ Families with Children	**Outcome: Participants will remain in permanent housing.** **Indicators:** **Permanent Supportive Housing** The MFHC CoC Threshold: 80% of households will exit to permanent housing. The MFHC CoC Threshold: 80% of household remain housed six months after exit. The MFHC CoC Threshold: 20% of adults in the household will have increased or sustained employment income; OR 54% of adults will have increased or sustained other cash income; OR 56% of adults in the household will have increase or sustained mainstream non-cash benefits; OR 10% of adults in household shall have improved education by program exit.

Rapid Re-Housing Program of stabilization and assessment, focusing on re-housing all persons, regardless of disability or background, as quickly as possible in appropriate permanent housing.				
Program Description	**Essential Program Elements**	**Time Frame**	**Population**	**Desired /Expected Outcomes**
Rapid re-housing is an intervention, informed by a Housing First approach that is a critical part of a Community's effective homeless crisis response system. Rapid re-housing is intended to rapidly connect families and individuals experiencing homelessness to permanent housing through a tailored package of assistance that may include the use of time-limited financial assistance and targeted supportive services.	**Case Management** ○ Housing location; ○ Housing stabilization planning using common tools ○ Employment assistance; ○ Linkage to mainstream resources; ○ Linkage to mental health services as appropriate; ○ Linkage to medical services as needed; ○ Linkage to substance use treatment services as appropriate; ○ Transportation assistance; ○ Financial management. **Domestic Violence Specific Considerations** • Access to crisis intervention services; • Safety planning; • Legal advocacy. **Temporary Financial Assistance** • Rental assistance based on lease and housing stabilization plan; • Need based rental assistance; • Utility assistance; • Childcare; • Job Training. **Housing Relocation** • Provision of a formalized partnership to housing referrals and placement services; • Linkage to community supports and/or wraparound system of services in relation to housing placement; • Temporary financial assistance (security deposits, utility deposits, furniture, household supplies). **Harm Reduction and Housing First** • All supportive housing embraces and practices Harm Reduction and Housing First; • Incorporate proven best practices and evidence-based practices; • Programs do not require sobriety or medication/treatment compliance as a condition of housing attainment or retention.	Up to 24 months of rent subsidy and supportive services, during which households are stabilized. RRH can be short term, medium term, or long term.	Literally homeless households or those residing in shelters. Households that show the ability to become self-sufficient in a short period of time as evidenced by: having income potential, and do not need intense services to remain housed, recently became homeless; no serious known disabilities. May be used as a bridge to PSH. Priority populations: Veteran households who are not eligible for VA-funded RRH; households with children residing on streets or in emergency shelters; youth residing on streets or in emergency shelters; and an exception may be made for single households that score for RRH and are close to reaching the chronicity time period.	**Outcome: Households will secure and maintain appropriate, affordable permanent housing.** **Indicators:** **RRH & RRH Prevention** The MFHC CoC Threshold: 80% of households will exit to permanent housing. The MFHC CoC Threshold: 80% of household remain housed six months after exit. The MFHC CoC Threshold: 20% of adults in the household will have increased or sustained employment income; OR 54% of adults will have increased or sustained other cash income; OR 56% of adults in the household will have increase or sustained mainstream non-cash benefits; OR 10% of adults in household shall have improved education by program exit. **RRH-Homeless Prevention** The MFHC CoC Threshold: 80% of household did not become homeless within six months of program exit.

Rapid Re-Housing for Young Adults (ages 18-24 years old)

Program of stabilization and assessment, focusing on re-housing all persons, regardless of disability or background, as quickly as possible in appropriate permanent housing.

Program Description	Essential Program Elements	Time Frame	Population	Desired /Expected Outcomes

Rapid re-housing is an intervention, informed by a Housing First approach that is a critical part of a Community's effective homeless crisis response system. Rapid re-housing is intended to rapidly connect families and individuals experiencing homelessness to permanent housing through a tailored package of assistance that may include the use of time-limited financial assistance and targeted supportive services.	**Case Management**
	• Housing navigation;
	• Housing stabilization planning using common tools;
	• Linkage to mainstream resources;
	• Linkage to mental health, medical, and substance use treatment services as appropriate;
	• Transportation assistance;
	• Financial, lease, household management;
	• Negotiating housemate agreements.
	
	Peer Specialist
	
	Employment Assistance
	• Rapid Employment Model;
	• Job coaching;
	• Emphasis on retention methods.
	
	Temporary Financial Assistance
	• Rental assistance based on lease and housing stabilization plan;
	• Utility assistance;
	• Childcare.
	
	Best Practices/Evidence-Based Practices
	• Developmentally appropriate program models are employed;
	• Trauma-informed programming and housing;
	• Self-Sufficiency focused case planning;
	• Job coaching, rapid employment and job retention practices are incorporated into program.
	  ○ Housing embraces and practices Harm Reduction and Housing First;
	  ○ Incorporate proven best practices and evidence-based practices;
	  ○ Programs do not require sobriety or medication/treatment compliance as a condition of housing attainment or retention.
		Up to 24 months of rent subsidy and supportive services, during which households are stabilized. RRH can be short term, medium term, or long term.	Literally homeless 18-24-year-old households or those residing in shelters. *LGBTQI* young adults, pregnant and parenting young adults, young adults with extensive involvement in juvenile justice system and/or child welfare system.
			
			May be used as a bridge to PSH.
			
			Priority populations: Households who are transgender, pregnant and parenting, or lesbian, gay or bisexual.
				Outcome: Young adult households will secure and maintain employment and permanent housing.
				
				Indicators:
				RRH & RRH Prevention
				The MFHC CoC Threshold: 80% of households will exit to permanent housing.
				The MFHC CoC Threshold: 80% of household remain housed six months after exit.
				
				The MFHC CoC Threshold: 20% of adults in the household will have increased or sustained employment income;
				OR
				54% of adults will have increased or sustained other cash income;
				OR
				56% of adults in the household will have increase or sustained mainstream non-cash benefits;
				
				RRH-Homeless Prevention
				The MFHC CoC Threshold: 80% of household did not become homeless within six months of program exit.
				
				OR
				10% of adults in household shall have improved education by program exit.

Transitional Housing

Time-limited housing where individuals that are homeless may stay and receive supportive services and that are determined to enable individuals to move into permanent housing.

TRANSITIONAL HOUSING IS NOT CURRENTLY A PART OF THE FL-520 - CITRUS, HERNANDO, LAKE, SUMTER COUNTIES C0C COORDINATED ACCESS SYSTEM. THERE ARE NO TRANSITIONAL FACILITIES BEING FUNDED BY THE COC.

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2. The Housing Assessment Process

2.1. Housing Assessors

2.1.1. Roles and Responsibilities - Housing Assessors are staff from designated community agencies. Housing Assessors may "office" (work out of another organization's office) out of Assessment Hubs, be designated as the Assessor for his/her agency, or may be part of a community outreach team. All Housing Assessors are required to complete a HMIS intake and VI-SPDAT with individuals in need of housing. The Housing Assessor will then submit a referral to Mid Florida Homeless Coalition for a SPDAT unless the Housing Assessor is trained and authorized to complete the SPDAT, if the VI-SPDAT score reflects that they may be eligible for further assessments. The Housing Assessor's responsibilities include, but are not limited to the following:

- ❖ Operating as the initial contact for the Coordinated Access System;
- ❖ Conducting the VI-SPDAT and intake packets;
- ❖ Participant notification of Eligibility, Rights and Responsibilities, and next steps;
- ❖ Submission of referrals to Mid Florida Homeless Coalition;
- ❖ Collecting and uploading all documents available at assessment;
- ❖ Participation in case conferences;
- ❖ Responding to requests by the Coordinating Entity.

2.1.2. Training Requirements - Housing Assessors are trained by the Coordinating Entity. The training consists of the 2.5 hour "Housing Assessor Orientation" in addition to potential HMIS training on the Coordinated Access workflow. There is also a requirement of either Trauma Informed Care or Domestic Violence training that will take place before Orientation. Certificates of completion for the HIPAA and Deaf & Hard of Hearing training must be submitted to the Coordinating Entity prior to the training date.

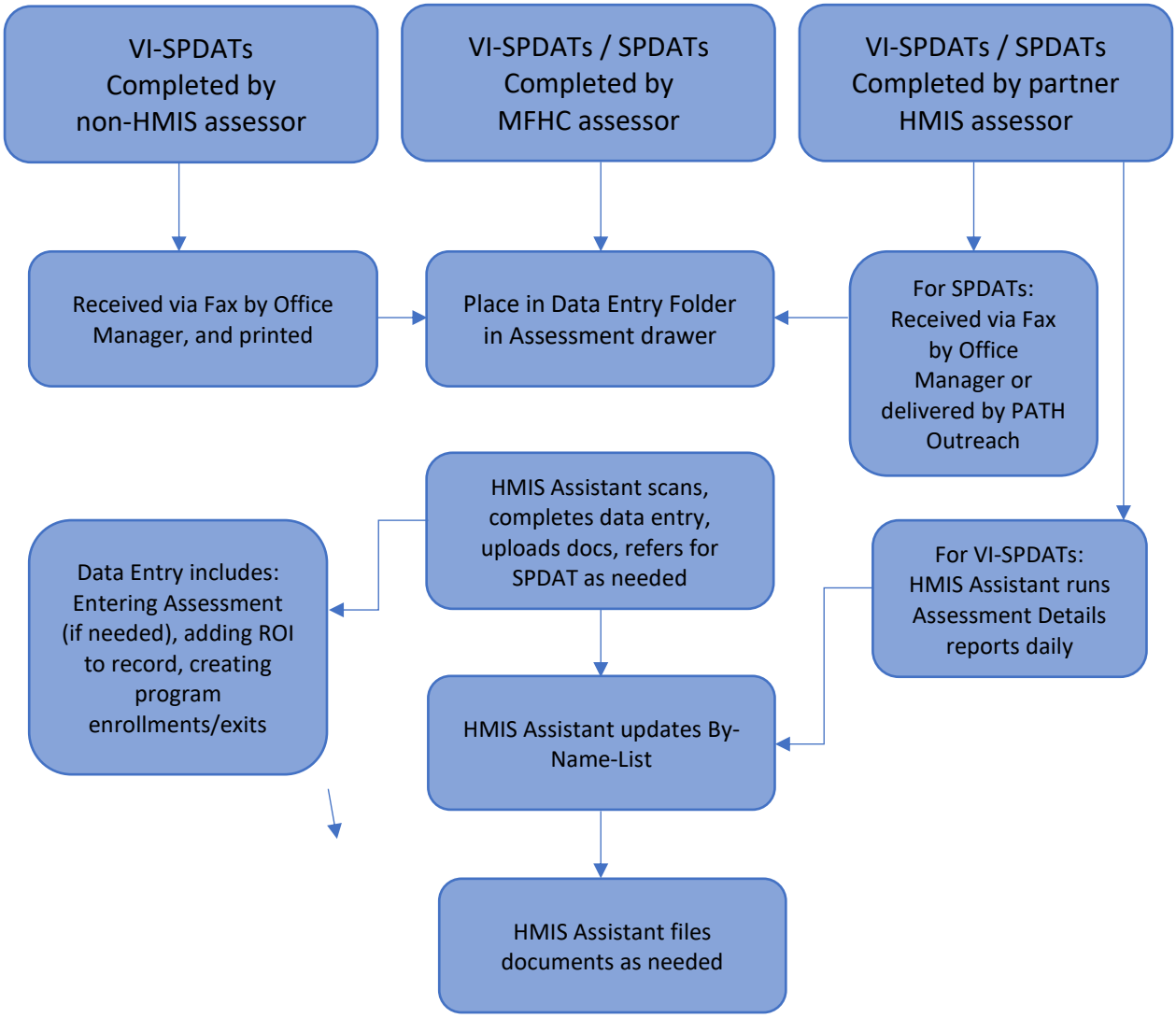
2.1.3. Timeline – A Housing Assessor will attempt to set up an appointment within five (5) business days of receiving a request for an assessment. Attempts will be made at least once each five business days for a total of 15 (fifteen) business days.

Reasons for denial of referral – Housing Assessors may decline the referral if:

- o the Assessor has been unable to make contact with the participant for 15 business days with at least one attempt in five day intervals;
- o The person misses two intake appointments within the fifteen (15) business days.

2.2. HMIS Workflow -The workflow below outlines the Coordinated Access steps in HMIS: *see chart below.*

HMIS WORKFLOW



2.3. Release of Information – All participants must sign a release of information prior to the assessment process.

2.4. Participant Photos – Photos can be taken at the time of assessment but are not required.

2.5. Timeline - The Housing Assessor notifies the participant of his/her eligibility to receive a second housing assessment (the SPDAT) if applicable, and that a referral will be made immediately if the Housing Assessor is not approved to do this assessment. Once a referral is made, Mid Florida Homeless Coalition has up to three business days to acknowledge receipt of the referral. Mid Florida Homeless Coalition must then attempt to make contact or deny the referral within seven (7) business days. Mid Florida Homeless Coalition can reject or deny the referral if the assigned staff member has been unable to contact the household after seven (7) business days. If a household makes contact after the seven (7) business days have expired, the staff member will assist the household in re-entering the system through the Coordinated Access System. All of this information is tracked in HMIS.

3. Housing Matching

3.1. MFHC HMIS Responsibilities - HMIS Staff at Mid Florida Homeless Coalition are responsible for the daily administration of the HMIS software and providing technical assistance and user training to participating agencies and end-users.

3.2. Housing Case Managers

3.2.1. Roles and Responsibilities - Housing Case Managers are staff from designated community agencies. The Housing Case Manager provides the participant with a housing plan, explaining both the participant and staff's role in the plan. Both the participant and staff sign the letter and it is maintained in the participant's chart. All Housing Assessors, Community Outreach Teams, and Case Managers operating as Housing Assessors carry the following responsibilities:

- Assisting participant in obtaining necessary documentation required for housing;
- Collecting and uploading necessary documentation, securing additional financial assistance if needed, providing transportation when allowable, accompaniment to potential housing options, etc.;
- Assisting participants in navigating any challenges related to the housing process; e.g., application and/or inspection process, etc.;
- Participating in case conferences;
- Responding to requests by the Coordinating Entity, as appropriate.

3.2.2. Training Requirements - Housing Assessors are trained by the Coordinating Entity. The training consists of the six (6) hour "Housing Navigator Orientation" in addition to HMIS training on the Coordinated Access workflow.

3.3. Timeline - Once the Coordinating Entity has made the referral to the Referring Agency, the Referring Agency attempts to make contact with the participant within three business days to schedule an intake appointment. This information is tracked in HMIS.

4. Housing Referral

4.1. When the Receiving Program indicates an opening for either Permanent Supportive Housing or Rapid Re-housing by emailing mfhcopeningdoors@gmail.com, the Coordinating Entity will acknowledge receipt of the request within one business day. The Coordinating Entity holds a conference call composed of members of the Coordinated Intake Committee on a weekly basis, and the potential referrals will be voted on at this time. There must be at least one member included on the conference call that is not an employee of the Coordinated Entity. There will be only one vote per agency. The Coordinated Entity will identify a minimum of three participants whenever applicable via the By-Name-List. The attendees of the conference call will then vote on the referral. The Coordinated Entity will then create a referral to the Receiving program with the opening.

4.1.1. Agency Case Managers attempt to make contact daily with the participant for seven (7) business days. This contact must be done at varying times and in varying ways. This can include, but is not limited to telephone calls, texts, emails, and going to the participant's last known location. All attempts are to be documented in HMIS.

4.1.2. If the participant cannot be contacted within that time frame, then the Agency Case Manager must request from the Coordinating Entity the next participant on the list.

4.1.3. Once the Agency Case Manager makes contact with the participant, the participant must decide by the end of the intake appointment whether to accept or decline program enrollment, if eligible.

4.1.4. If the participant accepts program enrollment, participant moves forward in the next steps toward move in.

4.1.5. If the participant declines program enrollment, or is exited due to non-compliance, then the Receiving Program must contact the Coordinated Entity so that the next participant on the By-Name-List can be contacted. The Receiving Program must also then send a referral to the Coordinated Entity so that contact may be made with the participant. The participant may be placed back on the By-Name-List at this time, pending decision of the Coordinated Entity. This may or may not be done by a Supervisor.

4.2 Receiving Program Responsibilities -Once a referral is made, the Receiving Program has up to three business days to acknowledge receipt of the referral. The Receiving Program must then enroll or deny the referral within seven (7) business days of contact. The Receiving Program can reject or deny the referral if the assigned Case Manager has been unable to contact the participant after seven (7) business days. If the participant contacts the Receiving Program after the seven (7) business days have expired, the Case Manager will inform them to contact the Coordinating Entity so that they can inform the participant of their current standing. All of this information is to be documented in HMIS.

4.2.1. Document Requirement Updates - Receiving Programs make eligibility determination decisions within one (1) business day of the intake interview (or when all required application materials are complete). The Receiving Program orally reviews the intake decision notification with the participant to ensure that the participant understands the decision, and applicable next steps, including the participant's right to appeal the decision. An intake decision notification includes at a minimum:

- ❖ first available move-in date, if applicable; and
- ❖ reason the participant cannot enter the program, including reason for rejection by participant or program
- ❖ instructions for appealing the decision

4.2.2. Reasons for denial - Receiving Programs may only decline participants found eligible for and referred by the Coordinated Entity under limited circumstances including:

- ❖ the participant missed two intake appointments within the seven (7) business days;
- ❖ the Receiving Program has been unable to make contact with the participant for seven (7) business days;
- ❖ the participant's household presents with a different number of people than referred by the Housing Assessor;
- ❖ based on their individual program policies and procedures, the Receiving Program has determined that the participant cannot be safely accommodated or cannot meet tenancy obligations with the supports provided by the program;
- ❖ the Receiving Program discovers nondisclosure or fraudulent information (including criminal and eviction histories);
- ❖ the Receiving Program is the recipient of acts of intimidation or violence, or threats of violence by the participant;
- ❖ the participant engages in criminal acts during the enrollment period.

Programs may not decline persons with psychiatric disabilities for refusal to participate in mental health services. The Receiving Program must update the referral outcome in HMIS for any decisions to accept or reject a participant. Reason for denial forms must be submitted to the participant on the same day as the decision was made, if possible, and the participating agency must notify the Coordinating Entity on the same day (see also 5.1).

4.2.3. Participant Choice - Participants may decline a referral because of program requirements that are inconsistent with their needs or preferences. There are no limitations on this decision. For example, participants may decline participation in programs requiring sobriety.

4.2.4. Participant Appeal - All participants have the right to appeal eligibility determinations issued by either the Coordinating Entity or any Receiving Program. Instructions for submitting an appeal are provided to participants at the time that an intake decision is made by the Receiving Program. The Coordinating Entity can assist participants in filing eligibility determination appeals, including but not limited to drafting a written appeal on behalf of the participant. All appeals of decisions by Receiving Programs should be made in writing and submitted to the Coordinating Entity.

4.3. Move-In - If the participant is accepted, the Receiving Program must document that acceptance in HMIS and arrange for move-in within 30 business days. If the participant does not move-in as scheduled or within three (3) business days of the original move-in date, due to participant choice, the Receiving Program must notify the Coordinating Entity and document it in HMIS. To the extent feasible, given available funding and as necessary, the

Receiving Program will provide the individual or family with move-in assistance. The receiving Program shall abide by the statutes set forth by HUD in working with housing and landlords. Specifically, statutes 982.306 & 982.401 shall be the guide in working with properties that fail inspection. These shall be applicable per property per family.

4.3.1. Housing Locator – Upon acceptance of the program by the participant, the Receiving Program must send a referral with a Housing Locator form within three business days. The Housing Locator will begin searching for housing to meet the needs of the participant if housing has not already been identified. The Housing Locator will contact the participant and the participant's case manager when potential housing is located. Housing Locator will meet the participant at potential housing and assist participant in completing all required paperwork.

4.4. PSH to PSH - under the CoC Program, Permanent Supportive Housing (PSH) projects may serve individuals and families from other PSH projects who originally met the eligibility requirements for PSH so long as the program participants were eligible for the original PSH (Section 423(f) of the McKinney-Vento Act, as amended by the HEARTH Act). This means that an individual or family may transfer from one PSH program to another under the CoC Program. This could occur under the following circumstances:

- ❖ If there were another PSH program that better met the services needs of the program participant;
- ❖ The program participant is evicted by the landlord or housing program and the participant is still eligible for case management services; or
- ❖ The current PSH program in which the individual or family is enrolled in has lost their funding.

4.4.1. PSH to PSH Referral - If any of the above scenarios apply, a staff member from the current PSH must notify the Coordinating Entity in writing via email to initiate the process of transferring the participant. The Coordinating Entity will verify that the request falls within the guidelines for the transfer as outlined in this manual. The Coordinating Entity will determine if a PSH unit is available, create the referral in HMIS, and notify the current PSH program. The current PSH program will then be responsible for assisting the program participant in completing the documentation necessary for the new PSH program. Transfer requests outside of the ones outlined in this manual will not be approved. If no PSH unit is available, then the current PSH program will have to continue to work with the program participant and the Coordinating Entity in securing alternative housing options. All information is to be documented in HMIS by the current Receiving Program.

4.5. Referrals to and from other systems not using HMIS - The Coordinated Access System appropriately addresses the needs of Veterans and individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking.

4.5.1. Domestic Violence (DV) - When a homeless or at-risk participant is identified by the Coordinated Access System to be identified as fleeing domestic violence, that participant is referred to the domestic violence hotline immediately. If the participant does not wish to seek DV specific services, the participant will have full access to the Coordinated Access System, in accordance with all protocols described in this manual. If the DV helpline determines that the participant seeking DV specific services is either not eligible for or cannot be accommodated by the DV specific system, the helpline will refer

the participant to an Assessment Hub for assessment and referral in accordance with all protocols described in this manual. All assessment information will be completed via paper documents, and will be retained by the CoC's DV Qualified/Privileged Assessor.

4.5.2. Veterans - When a homeless or at-risk individual is identified by the Coordinated Access System to be a Veteran, additional questions concerning service era, length of service, and discharge status will be asked. If it is believed that the Veteran may be eligible for VA services, the Veteran will be given the option of being referred to the VA. If the Veteran chooses that option, then that individual is referred to the VA immediately. The Housing Assessor should still complete the VI-SPDAT in HMIS and if applicable, refer the participant to Coordinating Entity for the SPDAT. Additionally, the Veteran should be referred to the local SSVF program for qualification of services as well. If the VA and SSVF determine that the individual seeking veteran specific services is not eligible for VA services, then the Veteran may be referred to a Receiving Program for assistance in alignment with the protocols in this manual.

5. Case Conferences

5.1. The Coordinating Entity will require a case conference to submit potential referrals for program openings as well as review and resolve rejection decisions by Receiving Programs. The purpose of the case conference will be to resolve barriers to the household receiving the indicated level of service.

- A case conference will be held on a weekly basis to discuss all potential referrals.
- A case conference will be held in all instances in which a household is declined by a Receiving Program.
- A case conferences will be held in all instances in which a household has declined more than two placements.
- Receiving Programs may also request a case conference, at their discretion, in other circumstances in which a household is insufficiently engaged in actions necessary to secure a permanent placement.
- A case conference will be held in all instances in which a household is facing program termination to review and determine next steps. The purpose of the case conference will be to discuss interventions used to date and resolve barriers to securing permanent housing including plans to have the household re-assessed for a more suitable housing program.

The Coordinating Entity will determine which parties will attend a case conference, including but not limited to the Housing Assessor, the Project Coordinator, the Receiving Program, the participant, and other contacts as determined necessary. The Coordinating Entity will make all logistical arrangements for the case conference, including but not limited to notifying all parties. In the case of a referral, at least one representative from an agency other than a MFHC employee must be on the call at all times.

VII. Fair Housing, Tenant Selection Plan, and Other Statutory and Regulatory Requirements

The Coordinating Entity takes all necessary steps to ensure that the Coordinated Access System is administered in accordance with the Fair Housing Act by promoting housing that is accessible to and usable by persons with disabilities. The Coordinated Access System complies with the non-discrimination requirements of the Fair Housing Act, which prohibits discrimination in all

housing transactions on the basis of race, national origin, sex, color, religion, disability status and familial status. This also includes protection from housing discrimination based on source of income. Additional protected classes under state law include sexual orientation (including gender identity), marital status, military discharge status, age (40+). Agencies cannot preference any protected class unless allowed by statute/regulation, or written waiver from their funding or regulatory body (i.e. U.S. Department of Housing and Urban Development).

All Authorized User Agencies who enter into an MOU for the Coordinated Access System agree to take full accountability for complying with Fair Housing and all other funding and program requirements. The MOU requires User Agencies to use the Coordinated Access System in a consistent manner with the statutes and regulations that govern their housing programs.

The Coordinating Entity will request from each Authorized User Agency their tenant selection plan and any funding contract that requires or allows a specific subpopulation of persons to be served. For instance, Housing Opportunities for Persons with AIDS (HOPWA) programs will show funding contract, a single-gender program must produce its HUD waiver. It is further recognized that the Fair Housing Act recognizes that a housing provider may seek to fulfill its "business necessity'' by narrowing focus on a subpopulation within the homeless population.

The Coordinated Access System may allow filtered searches for subpopulations while preventing discrimination against protected classes.

VIII. Evaluating and Updating Coordinated Access System Policies and Procedures

a. The implementation of the Coordinated Access System necessitates significant, community-wide change. To help ensure that the system will be effective and manageable for homeless and at-risk households and for the housing and service providers tasked with meeting their needs, particularly during the early stages of implementation, the Citrus, Hernando, Lake and Sumter Continuum of Care anticipates adjustments to the processes described in this manual. To determine those adjustments, the Coordinated Access System will be periodically evaluated, and there will be ongoing opportunities for stakeholder feedback, including but not limited to Referral and Receiving Program work groups convened and managed by the Coordinating Entity. Specifically, the Coordinating Entity is responsible for:
    1. Leading periodic evaluation efforts to ensure that the Coordinated Access System is functioning as intended; such evaluation efforts shall happen at least annually.
    2. Leading efforts to make periodic adjustments to the Coordinated Access System as determined necessary; such adjustments shall be made at least annually based on findings from evaluation efforts.
    3. Ensuring that evaluation and adjustment processes are informed by a broad and representative group of stakeholders.
    4. Ensuring that the Coordinated Access System is updated as necessary to maintain compliance with all state and federal statutory and regulatory requirements.

Evaluation efforts shall be informed by metrics established annually by the Coordinating Entity, in conjunction with the Governing Board and the Coordinated Access Committee. These metrics will be displayed on dashboards located on the Coordinating Entity's website and shall include indicators of the effectiveness of the functioning of the Coordinated Access System itself, such as:

- Wait times for initial contact;
- Extent to which expected timelines described in this manual are met;
- Number/Percentage of referrals that are accepted by receiving programs;
- Rate of missed appointments for scheduled assessments;
- Number/Percentage of persons declined by more than one (1) provider;
- Number/Percentages of Eligibility and Referral Decision appeals;
- # of program intakes not conducted through Coordinated Access System;
- Completeness of data on assessment and intake forms.

These metrics shall also include indicators of the impact of the Coordinated Access System on system-wide Continuum of Care outcomes, such as:

- Households referred have length of stays consistent with system guidelines;
- Program components meet outcome target;
- Reductions in long-term chronic homeless;
- Reduction in family homelessness;
- Reductions in returns to homelessness;
- Reduced rate of households becoming homeless for first time.

IX. Termination

Any Authorized User Agency may terminate their participation in the Coordinated Access System by giving written notice. Housing programs that are required to participate due to HUD guidelines will need HUD approval to terminate participation.

X. Appendices

A.	PR-VI-SPDAT Prevention/Re-Housing Prescreen Tool For Single Adults	i-vii
B.	PR-VI-SPDAT Prevention/Re- Housing Prescreen Tool For Families	i-ix
C.	VI-SPDAT Prescreen Triage Tool For Single Adults	i-xi
D.	VI-SPDAT Prescreen Triage Tool For Families	i-xiii
E.	TAY-VI-SPDAT Next Step Tool For Homeless Youth	i-xiii
F.	SPDAT Assessment Tool For Single Adults	i-xxvii
G.	F-SPDAT Assessment Tool For Families	i-xxxiii
H.	Y-SPDAT Assessment Tool For Single Youth	i-xxvii
I.	Intake Form	i-iii
J.	Coordinated Access User Agency MOU	I
K.	Release of Information	I
L.	Rights and Responsibilities	I
M.	Client Grievance	i-vi
N.	MFHC HIPPA Privacy Practices	i-iii
O.	Housing Locator Form	i-iii
P.	DV Cover Sheet	
Q.	Self-Certification of Homelessness	
R.	Case Manager Certification	
S.	FY 2019 Income Limits Documentation	
T.	FY 2019 Fair Market Rent Documentation System	
U.	982.306 PHA Disapproval of Owner	
V.	982.401 Housing Quality Standards	