



Milwaukee Continuum of Care

Coordinated Entry System

Manual

November 2017



Table of Contents

Purpose and Background	4
History – The Coordinated Entry Work Group	6
Initial Coordinated Entry System Recommendations (2013)	8
Coordinated Entry System - Key Design Decisions	9
Best Practice Standards	10
Lead Agency and Coordinating Agency Designation	12
Implementing Permanent Housing	13
Definition of Terms	15
Key IMPACT Job Descriptions	17
Program Coordinator Job Description	17
Coordinated Entry Mobile Screener	20
Coordinated Entry Intake Specialist	23
Coordinated Entry Facilitator	25
Coordinated Entry Emergency Housing Facilitator	28
Community Resource Specialist Job Description	30
Coordinated Entry Policies and Procedures	32
Governance Procedures	32
Coordinated Entry Assessment and Prioritization	35
The Role of Street Outreach	38
Prevention and Diversion	39
Shelter Referral Procedure	40
Coordinated Entry Policy and Procedure	43
Housing Referral Procedure	46
Domestic Violence Policy	48
Housing First	51
HMIS Data Entry, Usage, and Reporting	53
Non-Discrimination Policy	55
Grievance Policy and Procedure	56
Marketing of Coordinated Entry Process	58
Forms Used	59

Homeless History Tracking Form 59

Homeless Self-Certification Form..... 61

Single Permanent Supportive Housing Application 70

Client Grievance Form..... 76

Related ServicePoint Documents 77

MILWAUKEE CoC COORDINATED ENTRY HMIS GUIDE 77

Table of Contents 77

Purpose of Guide..... 78

Coordinated Entry Intake 78

 Establishing Homeless History 79

 Coordinated Entry Assessment 79

 1. The Interview Fields 80

 2. The Vulnerability Assessment 81

 3. The Chronic Homeless Determination Information questions 82

 4. Documentation Uploads and Tracking Fields..... 83

 Housing Prioritization List Referral 85

Coordinated Entry Follow-Up..... 90

 Updating Veteran Eligibility and Referral Status..... 90

 Updating the Chronic Homeless Information Questions 91

 Uploading and Noting further Documentation..... 92

 The CE Follow-up Sub-assessment..... 93

Coordinated Entry Placement/Discharge..... 94

 Closing a client’s Housing Prioritization List referral..... 94

Appendix A –Homeless History Tracking Form 99

Appendix B – Homeless Self-Certification – Due Diligence 103

References, Guides, and Regulations..... 114

Purpose and Background

Under the requirements of 24 CFR Part 578 Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH): Continuum of Care Program Final Regulations issued by the Department of Housing and Urban Development (HUD) in 2012, the Milwaukee Continuum of Care has established and continues to implement a coordinated assessment system. Coordinated assessment 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.

Coordinated Entry ensures that all people experiencing a housing crisis have fair and equitable access and are quickly identified, assessed for, and connected to housing and other services based on their strengths and needs. Coordinated Entry is a system that utilizes coordinated, comprehensive, and uniform assessment tools and practices to immediately respond to client needs for housing services across the community. It incorporates a system-wide, housing first approach, and coordinates assistance so that those with the most severe service needs are prioritized. Coordinated Entry informs the Continuum of Care by gathering data and providing gap analysis as well as Coordinated Entry performance outcomes to ensure system accountability and inform change.

The Milwaukee Continuum of Care Coordinated Entry System is designed to:

- ❖ Centralize program information, including offered services, eligibility requirements, and current capacity, for all Continuum of Care participant organizations at all levels of intervention: homelessness prevention, community-based case management, emergency shelter, transitional/interim housing, rapid re-housing, and permanent housing.
- ❖ 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;
- ❖ Maintain clarity, transparency, consistency and accountability for homeless clients, referral sources, and homeless service providers throughout the assessment and referral process;
- ❖ Ensure that people who have been homeless the longest and/or are the most vulnerable have priority access to scarce housing and supportive resources.
- ❖ Facilitate the continued evolution and coordination of all components of the homeless

service system toward the end of ending homelessness.

To achieve these objectives, *Coordinated Entry* includes:

- ❖ A **universally accessible “front door”** to the homeless service system that provides assessment, information, referral and intake for all persons seeking assistance.
- ❖ A **uniform and standard assessment process** to be used for all those who are homeless seeking housing assistance that will determine eligibility and priority, as well as procedures for making appropriate referrals to housing programs.
- ❖ **Data collection protocols** that establish provider data entry expectations, enable system-wide evaluation, and protect client anonymity as much as possible.
- ❖ **Uniform guidelines** among the providers concerning eligibility for services, priority populations, expected outcomes, and targets for length of stay.
- ❖ The **policies and procedure manual** contained herein, detailing the operations of *Coordinated Entry* and articulating the vision for further implementation.

To help ensure that the system will be effective and manageable for homeless persons and persons at risk for homelessness, as well as housing and service providers tasked with meeting their needs, a comprehensive group of stakeholders was and will continue to be involved in the design and implementation of *Coordinated Entry*.

Additionally, accurate data will drive decisions regarding allocation of resources, emerging needs, and provider engagement and accountability to a systems approach to ending homelessness. The Milwaukee Continuum of Care will rely on these feedback mechanisms to periodically update the policies and procedure described in this manual.

History – The Coordinated Entry Work Group

Milwaukee’s CoC (Continuum of Care) launched its Coordinated Entry Work Group in February of 2011 as part of its formal **Ten-Year Plan to End Homelessness** adopted by Milwaukee’s CoC and City and County governments in 2010. Chaired by Tim Baack, Senior Vice President of Strategic Development at Pathfinders and a long-standing elected member of Milwaukee CoC’s Steering Committee, the Work Group was comprised of representatives from across the homeless services system. Throughout the planning process, participants also included formerly homeless individuals and residents of Milwaukee concerned about homelessness and housing instability.

The Coordinated Entry Work Group included the following members at various points between February 2011-December 2015:

Chair:

Tim Baack –*Pathfinders*

Members:

Donna Rongholt Migan, Kristen Halula, Roni Fox, Tiana Jenkins & Tonyetta Ross - *Cathedral Center*

Helen King - *Center for Veterans’ Issues*

Rafael Acevedo & Birdie Boyd - *City of Milwaukee – Community Development Grants Administration*

Matt Raymond – *Community Advocates, Autumn West Safe Haven*

Sa Aire Salton, Madelene Amos, Maudwella Kirkendoll, Andi Elliott, Cheryl Teague & Latrice Hogan - *Community Advocates, Milwaukee Women’s Center and Family Support Center*

Nancy Weiland & Mary Ann Patti – *Community Advocates, Homeless Outreach Nursing Center*

Michael Bare - *Community Advocates, Public Policy Institute*

Pat Flannery - *Community Representative*

Stephanie Joski, Angela Atkins, Catina Harwell-Young, Demetrious Fitzpatrick, Claire Shanahan,

Andrew Musgrave, Rebecca Frank, & Christa Glowacki - *Guest House of Milwaukee*

Karen St. George - *Health Care for the Homeless*

Candice Hacker, Ken Schmidt, Erin Quandt, Patti Abbott & Wendy Weckler - *Hope House*

Bob Waite, Audra O’Connell, Stacey Polley, Chris Thao – *IMPACT, Inc.*

Adam Smith, Demetri Vincze & Nancy Monarrez – *Institute for Community Alliances*

Karl Schoendorf - *La Causa*

James Shautee & Rick Brunfield - *Living Proof*

Ann Bihrlé – *Mercy Housing*

Lisa Danahy, Carolina Soza, Christine Ullstrup & Jessica Perry – *Meta House*

Jessica Shriver, Jean Orlow, Eric Collins-Dyke – *Milwaukee County, Division of Housing*

Chad Stiles, Karen Dubis, Liam Looney & James Knapinski – *Milwaukee Police Department*

Kim Kampschroer & Claire Johnson - *Milwaukee Public Schools Homeless Education Program*

Carolyn Martin, Gwen Spears & Mamie Roberson – *My Home, Your Home Lissy's Place*

Jennifer Alfredson, Kris Dubois-Noe, Rebecca Frank, Precious Wilerson, Nateia Tolefree, Yvonne

Bell & Emily Palmer – *Outreach Community Health Center*

Adrienne Shrelcheck & Julie Bock – *Pathfinders*

Lin Fischer - *St. Vincent de Paul and Community Representative*

Nancy Szudzik, Debra Lewis, Tammy Graham, Dan Garcia, Amy Zeidler, Amanda Matuszaki &

Margo Florez -*Salvation Army*

Clairibel Gill – *SET Ministries*

Liz Marquardt – *Sojourner Family Peace Center*

Nicole Angresano, Irissol Arce, Jim Marks, & Shannon Reed - *United Way of Greater Milwaukee & Waukesha County*

Ben Hastil, Darlene Dyson & Lori Runge – *Walker's Point Youth & Family Center*

Jan Wilberg - *Wilberg Community Planning, Former CoC Consultant*

Initial Coordinated Entry System Recommendations (2013)

Before developing the framework for Milwaukee's Coordinated Entry system, Work Group members discussed and agreed upon the following key issues:

- Housing access in Milwaukee is a problem given the lack of a centralized or coordinated system.
- The current system of housing resources is fragmented and segmented, and would be improved with a coordinated/shared approach.
- Any new system should focus on the benefit of shifting screening to a central entity – freeing housing staff for more direct service.
- There exists strong interest in sharing the burden and responsibility of hard-to-serve clients.
- Coordinated Entry could gather better data and identify service gaps and emerging and/or unmet needs more quickly.
- Strong support exists for the transition from a *first come - first served* to a needs-based service access approach and philosophy.
- Concerns about funders' requirements/outcomes need to be addressed.
- Concerns about what will be expected of agencies will need to be articulated.
- Concerns about the interface with other systems (health care, behavioral health, foster care, corrections, basic needs resources, etc.) will need to be responded to and continued improvements in cross-system collaboration and cooperation need to be sustained.

Early in the Work Group's efforts, there was strong agreement on the following goal:

That every person experiencing a housing crisis will get their needs met in the most appropriate and effective manner.

Coordinated Entry System - Key Design Decisions

Members of the Coordinated Entry Work Group determined the following design elements of Milwaukee's Coordinated Entry System:

- Coordinated Entry should **not** be a physical place that people go to. After extensive discussion the Work Group determined that the negative aspects of a physical place outweighed the benefits. Coordinated Entry should be a phone service (such as IMPACT, Inc.) that can provide skilled screening/triage and an outreach team that can be dispatched to neutral locations to meet with individuals/families if necessary.
- The strong consensus of the Work Group is that Coordinated Entry should serve both families and single individuals (both youth and adults).
- Coordinated Entry (CE) will match referrals to agencies' criteria, making bed reservations that are contingent on agencies' approval with the expectation that agencies will honor appropriate referrals. Good, current information is central to this process relative to: adequate screening of the individual/family, agency admission criteria, and identification of individuals/families whose previous experience at an agency resulted in a bar to future admission. This approach is intended to reduce to nearly zero the occasions when an agency declines a referral through increased transparency and shared accountability.
- CE will implement screening and shelter diversion over the phone, using the CE Outreach Team to conduct face-to-face assessment when necessary.
- Participation will be required by the Continuum of Care (CoC) with funding sources backing up the requirement in their funding/program evaluation criteria. In order to accomplish this, the CoC needs to help organizations understand the value of participation in terms of cost savings and improved service to clients, and the CoC needs to obtain the support of United Way and state and local government funding sources.
- CE will include homeless prevention, shelter diversion, community case management, emergency shelter, transitional housing, and warm hand-off to other services that can support housing stability.
- CE should be established as a separate non-provider entity that can monitor the CE process, maintain good communication, organize participating agencies, identify and address implementation issues, and develop resources to improve the system.
- Governance of Coordinated Entry should be initially lodged with the Steering Committee of the Milwaukee Continuum of Care. The Steering Committee will then establish a separate governance vehicle representing a broader and more inclusive stakeholder group.

Best Practice Standards

Members of the Coordinated Entry Work Group conducted interviews with local providers and communities across the country regarding various models of Coordinated Entry being developed and implemented in order to identify emerging best practice standards and recommendations. Both local and national literature findings were also used in the development of Milwaukee's Coordinated Entry System.

Interviews were conducted with and information was obtained from the following sources:

- Hennepin County, Minnesota
- National Alliance to End Homelessness – Kim Walker
- Abt Associates – Matt White
- Philadelphia, PA – Kevin Breazeale
- Strategies to End Homelessness–Ohio - Kevin Finn
- Office to Prevent & End Homelessness–Virginia - Dean Klein
- WV Coalition to End Homelessness-West Virginia - Zachary Brown
- Cincinnati, Ohio
- Denver, Colorado
- Montgomery County, Ohio
- Milwaukee: CCI/IMPACT, Inc.
- Milwaukee: ANET System
- U.S. Department of Veterans Affairs: National Call Center
- Grand Rapids, Michigan

As a result of these efforts, key findings include:

- Coordinated Entry (CE) is now recognized as a “Best Practice” by HUD, NAEH, and numerous communities that have implemented a CE system.
- Collaboration at multiple levels - agencies, systems, and funders -is essential to Coordinated Entry's success.
- Strong HMIS capability and data-driven decision-making must be in place.
- The capacity to address problems associated with repeat shelter/housing system users is more effectively addressed through a Coordinated Entry System approach.
- Coordinated entry participation by agencies needs to be tied to funding.
- Coordinated Entry allows for expanded service and resource options: prevention services, emergency shelter, transitional and permanent supportive housing.
- Coordinated Entry has evidenced improved outcomes related to: quicker access, successful diversion, reduced shelter stays, reduced # homeless, recidivism, and chronic homelessness.

The literature reviewed by the Coordinated Entry Work Group as part of its system planning and development included the following:

- *Centralized Intake for Helping People Experiencing Homelessness: Overview, Community Profiles, and Resources*, HUD

- *One Way In: The Advantages of Introducing System-Wide Coordinated Entry for Homeless Families*, National Alliance to End Homelessness

- *Closing the Front Door: Creating a Successful Diversion Program for Homeless Families*, National Alliance to End Homelessness
- *At the Front Door: A System Improvement Review of Milwaukee’s Emergency Shelter System*, Wilberg Community Planning

- *Improving Access to Milwaukee’s Homeless Services*, Public Policy Institute/Community Advocates

- *2011 Point in Time Survey of Milwaukee’s Homeless Citizens – Data*

- *Profile of Milwaukee Shelter Consumers: 2010 Brief*

Lead Agency and Coordinating Agency Designation

As recommended by the Coordinated Entry Work Group, in March of 2013 the Milwaukee Continuum of Care's Steering Committee and Full Body approved United Way of Greater Milwaukee (now United Way of Greater Milwaukee and Waukesha County) as the Coordinated Entry System's Lead Agency and IMPACT, Inc. as its Coordinating Agency.

As Lead Agency, United Way of Greater Milwaukee met the following criteria as established by the Coordinated Entry Work Group:

- Independent and objective entity.
- Not a current housing or homeless service provider.
- Demonstrated capacity to build consensus.
- Has established and effective relationships with key community stakeholders.
- Member of the Milwaukee Continuum of Care (CoC).

In its role as Lead Agency, United Way has assumed responsibilities that include:

- Advocate for system improvement.
- Convene partners to review progress and convene Work Group meetings and tasks.
- Monitor process.
- Maintain effective communication and dialogue among partners.
- Facilitate HMIS data collection and utilization.
- Initiate resource development.
- Improve technology to support the system.

As the Coordinating Agency, IMPACT, Inc. has responsibilities that include:

- Provide System oversight and management through its full-time Program Coordinator.
- Provide through its Resource Specialists (nearly 7 FTE's by the end of 2014) standardized initial assessments that provide information on the needs of individuals and families seeking housing assistance through 2-1-1.
- Evaluate process.
- Maintain effective communication and dialogue among partners, providers, and consumers.
- Ensure HMIS data collection, utilization, and reporting

Implementing Permanent Housing

In July 2016, the Coordinated Entry Program Coordinator was given the task of implementing coordinated entry for permanent housing for all populations by the end of 2017. The Coordinated Entry Program Coordinator developed a Permanent Housing Workgroup to tackle this issue. The workgroup consisted of:

Emily Kenney- IMPACT (chair)
 Phil Connelly- Guest House
 Matt Raymond- Community Advocates
 Nancy Esteves- Institute for Community Alliances
 Wendy Weckler- Hope House
 Jean Orlow- Milwaukee County Housing Division
 Stephanie Nowak- IMPACT (intern)/Milwaukee County Housing Division (staff)
 Veronica Gartland- IMPACT (intern)

The group met biweekly from October 12, 2016-March 8, 2017 and drafted the Coordinated Entry Policy and Procedure, which was implemented by the Coordinated Entry Leadership Committee on April 1, 2017.

Additional workgroups were formed for sub-group policies, including The Role of Street Outreach, Domestic Violence, and the Youth Initiative.

Role of Street Outreach Workgroup Members

Emily Kenney- IMPACT (chair)
 Mary Ann Patti- Community Advocates
 Ashley Steinberg- Outreach Community Health Centers
 Eric Collins-Dyke- Milwaukee County Housing Division
 Adrienne Strehlcheck- Pathfinders

Domestic Violence Workgroup Members

Emily Kenney- IMPACT (chair)
 Madelene Amos- Community Advocates
 Maudwella Kirkedoll- Community Advocates
 Liz Marquadt- Sojourner Family Peace Center
 Adell Gray- Sojourner Family Peace Center
 Dolly – Sojourner Family Peace Center
 Veronica Gartland- IMPACT (intern)

Youth Initiative Workgroup Members

Emily Kenney- IMPACT (co-chair)
 Julie Bock- Pathfinders (co-chair)
 Joseph Stanley- Walker's Point Youth and Family Services
 Karie Lowe- Lad Lake
 Gracie Liebenstein- IMPACT (intern)
 Veronica Gartland- IMPACT (intern)

Veteran Registry Workgroup Members

Nancy Esteves- Institute for Community Alliances (chair)
 General Bob Crocrot- Center for Veteran's Issues
 Rachel Trainor- Center for Veteran's Issues
 Katrina Harris- Center for Veteran's Issues
 Berdie Cowser- Center for Veteran's Issues
 Barbara Gilbert- VA
 Norma Duckworth- VA
 Amy Mael- VA
 Regina Lipsey- IMPACT
 Ashley Steinberg- Outreach Community Health Centers

Chronic Initiative Workgroup Members

Eric Collins-Dyke- Milwaukee County Housing Division (chair)

Jean Orlow- Milwaukee County Housing Division

Luke Rosynek- Milwaukee County Housing Division

Nancy Esteves- Institute for Community Alliances

Zach Ehmann- Institute for Community Alliances

Claire Shanahan- City of Milwaukee

Emily Kenney- IMPACT

As of November 2017, the Youth Initiative Workgroup was meeting at least monthly as the process was being implemented. All other workgroups meet on an ad hoc basis when changes need to be made to the policies or procedures to be more effective.

Definition of Terms

Terms used throughout this manual are defined below.

Chronically Homeless (HUD definition):

An individual who:

- *Is homeless and lives in a place not meant for human habitation, a safe haven or in an emergency shelter; and*
- *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 in the last 3 years, where the combined occasions total a length of time of at least 12 months*
- *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.*
- *An individual who has been residing in an institutional care facility, including jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or*
- *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, developmental, 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; also includes:

Literally Homeless (HUD Homeless Definition – Category 1)

*Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:
Has a primary nighttime residence that is a public or private place not meant for human habitation;
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
Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human 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:
Residence will be lost within 14 days of the date of application for homeless assistance;
No subsequent residence has been identified; and
The individual or family lacks the resources or support networks needed to obtain other permanent housing.*

Homeless under other Federal Statutes (HUD Homeless Definition – Category 3)

*Unaccompanied youth under 25 years of age, or families with children and youth, who does not otherwise qualify as homeless under this definition, but who:
Are defined as homeless under the other listed federal statutes;*

Have not had a lease, ownership interest, or occupancy agreement in permanent housing at any time during the 60 days immediately preceding the date of application for homeless assistance.

Have experience persistent instability as measure by two moves or more during the 60-day period immediately preceding the date of applying for homeless assistance; and

Can be expected to continue in such status for an extended period of time due to special needs or barriers.

Fleeing domestic abuse or violence (HUD Homeless Definition – Category 4)

Any individual or family who:

Is fleeing, or is attempting to flee, domestic abuse;

Has no other residence; and

Lacks the resources or support networks to obtain other permanent housing.

Key IMPACT Job Descriptions

Program Coordinator Job Description

Position Title: Coordinated Entry Program Coordinator Homelessness Services **Revised:** 4/21/2016

Department: IMPACT 2-1-1

Reports to: Chief Operating Officer

Position Summary

The Coordinator will oversee IMPACT 2-1-1's activities related to Coordinated Entry Program in support of the goals and objectives set forth by the Milwaukee County Continuum of Care, United Way of Greater Milwaukee and Waukesha County and local agencies that serve the homeless and provide housing and support services.

The purpose of this program is to provide screening, diversion, intake and placement services for homeless individuals and families and provide oversight to the coordinated entry system. The Coordinator will oversee the use of rules and procedures for contacts with IMPACT 2-1-1 related to assisting individuals and families in accessing community and personal resources that will enable them to be successful in preventing or resolving homelessness.

The Coordinator will be well-versed in applicable HUD rules, laws and guidelines and any other state and local rules, laws and guidelines that are applicable to the provision of services to the homeless and those at risk of being homeless.

Principal Responsibilities

- Build and sustain strong working relationships and act as a liaison with Milwaukee County emergency shelters, Milwaukee County Continuum of Care members and other providers of services to the homeless and those at risk of homelessness.
- Assure the adherence to the processes and procedures detailed in the agreements between providers and IMPACT 2-1-1.
- Participate in meetings associated with the Milwaukee CoC, including the Coordinated Entry Workgroup, the Shelter Task Force, the Shelter Managers meeting and others as appropriate.
- Participate in trainings related to homelessness, HMIS and any other trainings associated with, shelter systems and housing and others as needed.
- Work with the Operations Center Manager to coordinate new and ongoing training within the guidelines of the Coordinated Entry system to all IMPACT 2-1-1 Community Resource Specialists (CRS).
- Work with the Operations Center Manager to assure that data entered into the Wisconsin

HMIS database by IMPACT 2-1-1 is accurate, up-to-date and entered according to the standards and practices required by the Milwaukee County Continuum of Care and all governing bodies.

- Provide periodic and “on-demand” reports as needed to funding partners, the Milwaukee County Continuum of Care, governing bodies and others as appropriate.
- Maintain up-to-date knowledge of changes and developments within the network of services within the Milwaukee County Continuum of Care and all other services related to assisting those who are homeless or at risk of being homeless.
- Understand AIRS Standards for Professional Information & Referral.
- Responsible for protecting client confidentiality and adhering to all state and federal laws and regulations regarding the protection to AODA and mental health information.
- Protects against unauthorized access, modifications, destruction, and disclosure as defined by IMPACT and relevant federal, state, and local laws.
- Provide quality professional services to internal and external customers with IMPACT 2-1-1. Implement IMPACT's philosophy of teamwork, customer service, and value added, in the call center and in the community.

Nothing in this job description restricts management's right to assign or reassign duties and responsibilities to this job at any time.

Background/Education

- Master’s degree in Social Work preferred, but similar Bachelor’s degree and strong background of applicable work experience.

Experience

- At least three years working within an emergency shelter system or other human service delivery system.
- Demonstrate proficiency with MS Office products, including WORD, EXCEL, OUTLOOK and POWERPOINT.
- Experience with direct supervision.
- Demonstrated experience in planning, organizing and working collaboratively within social service delivery systems.
- ServicePoint or current Wisconsin HMIS database proficiency

Abilities/Skills

- Exceptional customer service skills, both internal and external.
- Strong supervisory skills including the ability to provide feedback and develop direct reports
- Ability to work effectively in a team-oriented environment.
- Demonstrated strong interpersonal skills to build positive working relationships with outside agencies and organizations.

- Comfortable with public speaking.
- Exceptional verbal and written communication skills.
- Strong judgment, problem solving and decision making skills.
- Cultural competency skills to work effectively with diverse populations.
- Self-motivated and capable of growing system-wide approaches to achieving project goals.
- Demonstrated organization and time management skills.

Physical and Mental Demands:

While performing the duties of this job, the employee is regularly required to talk or hear. The employee frequently is required to use hands to finger, grasp, handle or touch objects. The employee is often required to stand, walk, sit, and reach above shoulders. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

Coordinated Entry Mobile Screener

Position Title: Mobile CE Screener/CRS 9/29/16

Department: IMPACT 2-1-1 Program

Reports to: IMPACT Coordinated Entry Coordinator

Nothing in this job description restricts management's right to assign or reassign duties and responsibilities to this job at anytime.

Position Summary

The Mobile CE Screener/ Community Resource Specialist(CRS) provides access to prevention/diversion resources through accessing the 2-1-1 database as well as conduct the standardized vulnerability assessment at locations throughout the city with the highest volume of homeless individuals most in need. This CRS will also have the capacity to be dispatched to meet the real-time needs of an individual experiencing a housing crisis.

The Mobile CE Screener/CRS will provide quality professional services to internal and external customers and implement IMPACT's philosophy of teamwork, customer service, and value added, in the call center and in the community.

Principle Responsibilities

1. Provide assessment, problem solving, information and referral, and crisis intervention when necessary in an empathetic and nonjudgmental manner.
2. Assist customers in developing an action plan within the scope of family, health, and social services that appropriately meets their needs.
3. Accurately document customer contacts in a computerized database and other means.
4. Provide advocacy for customers experiencing difficulties or lacking in abilities needed to make effective contacts with agencies, programs or groups.
5. Participate in ongoing IMPACT training and staff meetings.
6. Keep informed of and demonstrates knowledge of all special service programs.
7. Demonstrate the ability to effectively work in and adapt to ongoing necessary changes.
8. Ensure that IMPACT is compliant with applicable federal, state, and local laws ensuring client confidentiality.
9. Assure that data entered into the Wisconsin HMIS database by IMPACT 2-1-1 is accurate, up-to-date and entered according to the standards and practices required by the Milwaukee County Continuum of Care and all governing bodies.
10. Participate in trainings related to homelessness, HMIS and any other trainings associated with, shelter systems and housing and others as needed.
11. Assist with the analysis of the Coordinated Entry system as well as implementation of system changes, as needed.
12. Build and sustain strong working relationships and act as a liaison with Milwaukee County emergency shelters, Milwaukee County Continuum of Care members and other providers of services to the homeless and those at risk of homelessness, as needed.

Background / Experience

1. Bachelor's degree in Social Work or other human service studies preferred, but strong background of applicable work experience may substitute.
2. Experience as a fully trained IMPACT 2-1-1 Community Resource Specialist.
3. Demonstrate proficiency with MS Office products, including WORD, EXCEL, OUTLOOK and POWERPOINT as well as HMIS (ServicePoint)
4. AIRS Certified Information and Referral Specialist (CIRS) or willingness to become a CIRS.

Abilities and Skills

1. Possesses cultural competency skills to work effectively with diverse customers and staff.
2. Ability to respond effectively to a variety of callers' social service needs.
3. Exceptional customer service skills, both internal and external.
4. Demonstrated strong interpersonal skills to build positive working relationships with outside agencies and organizations.
5. Excellent problem solving skills.
6. Exceptional verbal and written communication skills.
7. Good judgment, problem solving and decision making skills.
8. Self-motivated.
9. Demonstrated organization and time management skills.
10. Ability to work effectively in a team-oriented environment.
11. Ability to adapt to and apply on-going program development changes.
12. Bilingual ability preferred.
13. Computer proficiency necessary.
14. Valid Wisconsin Driver's License required as well as a current automotive insurance policy
15. A reliable vehicle is required to provide timely response to screening sites

Responsibilities within the Scope of Providing Services to IMPACT Clients:

- Participate in a comprehensive initial training program.
- Provide assessment, problem solving, information and referral, and crisis intervention when necessary in an empathetic and nonjudgmental manner.
- Educate customers and assists customers in developing an action plan.
- Accurately document customer contacts in a computerized database and other means.
- Provide advocacy for customers experiencing difficulties or lacking in abilities needed to make effective contacts with agencies, programs or groups.
- Participate in ongoing training and staff meetings.
- Keeps informed of and demonstrates knowledge of all special service programs.
- Maintain call quality and quantity standards, i.e., 2-1-1 Call Map, length of calls, call per hour, and other set standards.

Standard IMPACT Requirements:

- Understand, promote and teach AIRS Standards for Professional Information & Referral.
- Responsible for protecting client confidentiality and adhering to all state and federal laws and regulations regarding the protection to AODA and mental health information.
- Protects against unauthorized access, modifications, destruction, and disclosure as defined by IMPACT and relevant federal, state, and local laws.

Physical and Mental Demands:

While performing the duties of this job, the employee is regularly required to talk or hear. The employee frequently is required to use hands to finger, grasp, handle or touch objects. The employee is often required to stand, walk, sit, and reach above shoulders. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

Coordinated Entry Intake Specialist

Reports to: IMPACT Coordinated Entry Coordinator

Nothing in this job description restricts management's right to assign or reassign duties and responsibilities to this job at anytime.

Position Summary

The CE Intake Specialist provides a comprehensive screening for access to Milwaukee County funded AODA treatment and facilitates access to prevention/diversion resources through accessing the 2-1-1 database as well as conduct the standardized vulnerability assessment for those who are seeking access to housing.

The CE Intake Specialist will provide quality professional services to internal and external customers and implement IMPACT's philosophy of teamwork, customer service, and value added, in the call center and in the community.

Principle Responsibilities

Provide assessment, problem solving, information and referral, and crisis intervention when necessary in an empathetic and nonjudgmental manner.

Assist customers in developing an action plan within the scope of family, health, and social services that appropriately meets their needs.

Accurately document customer contacts in a computerized database and other means.

Provide advocacy for customers experiencing difficulties or lacking in abilities needed to make effective contacts with agencies, programs or groups.

Effectively communicate with referral organizations.

Participate in ongoing IMPACT training and staff meetings.

Keep informed of and demonstrates knowledge of all special service programs.

Demonstrate the ability to effectively work in and adapt to ongoing necessary changes.

Ensure that IMPACT is compliant with applicable federal, state, and local laws ensuring client confidentiality.

Assure that data entered into the Wisconsin HMIS database by IMPACT 2-1-1 is accurate, up-to-date and entered according to the standards and practices required by the Milwaukee County Continuum of Care and all governing bodies.

Participate in trainings related to homelessness, HMIS and any other trainings associated with, shelter systems and housing and others as needed.

Assist with the analysis of the Coordinated Entry system as well as implementation of system changes, as needed.

Build and sustain strong working relationships and act as a liaison with Milwaukee County emergency shelters, Milwaukee County Continuum of Care members and other providers of services to the homeless and those at risk of homelessness, as needed.

Participate in monthly case review and closing of vouchers.

Background / Experience

Master's degree in Social Work or other human service studies.

Licensure as an LPC or LCSW preferred; ability to become licensed within 12 months of hire required.

Experience as a fully trained IMPACT 2-1-1 Community Resource Specialist preferred.

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Demonstrate proficiency with MS Office products, including WORD, EXCEL, OUTLOOK and POWERPOINT as well as HMIS (ServicePoint)

AIRS Certified Information and Referral Specialist (CIRS) or willingness to become a CIRS.

Abilities and Skills

Possesses cultural competency skills to work effectively with diverse customers and staff.

Ability to respond effectively to a variety of callers' social service needs.

Exceptional customer service skills, both internal and external.

Demonstrated strong interpersonal skills to build positive working relationships with outside agencies and organizations.

Excellent problem solving skills.

Exceptional verbal and written communication skills.

Good judgment, problem solving and decision making skills.

Self-motivated.

Demonstrated organization and time management skills.

Ability to work effectively in a team-oriented environment.

Ability to adapt to and apply on-going program development changes.

Bilingual ability preferred.

Computer proficiency necessary.

Responsibilities within the Scope of Providing Services to IMPACT Clients:

Participate in a comprehensive initial training program.

Provide assessment, problem solving, information and referral, and crisis intervention when necessary in an empathetic and nonjudgmental manner.

Educate customers and assists customers in developing an action plan.

Accurately document customer contacts in a computerized database and other means.

Provide advocacy for customers experiencing difficulties or lacking in abilities needed to make effective contacts with agencies, programs or groups.

Participate in ongoing training and staff meetings.

Keeps informed of and demonstrates knowledge of all special service programs.

Maintain call quality and quantity standards, i.e., 2-1-1 Call Map, length of calls, call per hour, and other set standards.

Standard IMPACT Requirements:

Understand, promote and teach AIRS Standards for Professional Information & Referral.

Responsible for protecting client confidentiality and adhering to all state and federal laws and regulations regarding the protection to AODA and mental health information.

Protects against unauthorized access, modifications, destruction, and disclosure as defined by IMPACT and relevant federal, state, and local laws.

Physical and Mental Demands:

While performing the duties of this job, the employee is regularly required to talk or hear. The employee frequently is required to use hands to finger, grasp, handle or touch objects. The employee is often required to stand, walk, sit, and reach above shoulders. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

Coordinated Entry Facilitator

Position Title: Facilitator – Access to Permanent Housing/CRS

Department: IMPACT 2-1-1 Program

Reports to: IMPACT Coordinated Entry Coordinator

Nothing in this job description restricts management's right to assign or reassign duties and responsibilities to this job at anytime.

Position Summary

This position will assist in the implementation of Coordinated Entry into permanent housing for individuals and families in the covered Milwaukee County Jurisdiction and provide access to prevention/diversion resources through accessing the 2-1-1 database as well as conduct the standardized vulnerability assessment.

The Facilitator – Access to Permanent Housing/CRS will provide quality professional services to internal and external customers and implement IMPACT's philosophy of teamwork, customer service, and value added, in the call center and in the community.

Principle Responsibilities

1. Participation in the development of standards that will inform the coordinated entry process including but not limited to:
 - Prioritization of eligible Category one homeless individuals and families residing in the Milwaukee County Jurisdiction
 - The process utilized for gathering and incorporating partner information
 - Alignment of available housing and participant needs
2. Vetting existing information with clients and partner organizations to ensure accuracy and eligibility
3. Facilitating regular staffing sessions with partners to determine priority, placement, and ancillary needs according to the guidelines set by the CoC.
4. Provide assessment, problem solving, information and referral, and crisis intervention when necessary in an empathetic and nonjudgmental manner.
5. Assist customers in developing an action plan within the scope of family, health, and social services that appropriately meets their needs.
6. Accurately document customer contacts in a computerized database and other means.
7. Provide advocacy for customers experiencing difficulties or lacking in abilities needed to make effective contacts with agencies, programs or groups.
8. Participate in ongoing IMPACT training and staff meetings.
9. Participate in scheduled CoC meetings.
10. Keep informed of and demonstrates knowledge of all special service programs.
11. Demonstrate the ability to effectively work in and adapt to ongoing necessary changes.
12. Ensure that IMPACT is compliant with applicable federal, state, and local laws ensuring client confidentiality.

13. Assure that data entered into the Wisconsin HMIS database by IMPACT 2-1-1 is accurate, up-to-date and entered according to the standards and practices required by the Milwaukee County Continuum of Care and all governing bodies.
14. Participate in trainings related to homelessness, HMIS and any other trainings associated with, shelter systems and housing and others as needed.
15. Assist with the analysis of the Coordinated Entry system as well as implementation of system changes, as needed.
16. Build and sustain strong working relationships and act as a liaison with Milwaukee County emergency shelters, Milwaukee County Continuum of Care members and other providers of services to the homeless and those at risk of homelessness, as needed.

Background / Experience

5. Bachelor's degree in Social Work or other human service studies with strong background of applicable work experience - Master's degree preferred.
6. Experience as a fully trained IMPACT 2-1-1 Community Resource Specialist.
7. Demonstrate proficiency with MS Office products, including WORD, EXCEL, OUTLOOK and POWERPOINT as well as HMIS (ServicePoint)
8. AIRS Certified Information and Referral Specialist (CIRS) or willingness to become a CIRS.

Abilities and Skills

16. Possesses cultural competency skills to work effectively with diverse customers and staff.
17. Ability to respond effectively to a variety of callers' social service needs.
18. Exceptional customer service skills, both internal and external.
19. Demonstrated strong interpersonal skills to build positive working relationships with outside agencies and organizations.
20. Excellent problem solving skills.
21. Exceptional verbal and written communication skills.
22. Good judgment, problem solving and decision making skills.
23. Self-motivated.
24. Demonstrated organization and time management skills.
25. Ability to work effectively in a team-oriented environment.
26. Ability to adapt to and apply on-going program development changes.
27. Bilingual ability preferred.

Responsibilities within the Scope of Providing Services to IMPACT Clients:

- Participate in a comprehensive initial training program.
- Provide advocacy for customers experiencing difficulties or lacking in abilities needed to make effective contacts with agencies, programs or groups.
- Participate in ongoing training and staff meetings.
- Keeps informed of and demonstrates knowledge of all special service programs.
- Maintain call quality and quantity standards, i.e., 2-1-1 Call Map, length of calls, call per hour, and other set standards.

Standard IMPACT Requirements:

- Understand, promote and teach AIRS Standards for Professional Information & Referral.
- Responsible for protecting client confidentiality and adhering to all state and federal laws and regulations regarding the protection to AODA and mental health information.
- Protects against unauthorized access, modifications, destruction, and disclosure as defined by IMPACT and relevant federal, state, and local laws.

Physical and Mental Demands:

While performing the duties of this job, the employee is regularly required to talk or hear. The employee frequently is required to use hands to finger, grasp, handle or touch objects. The employee is often required to stand, walk, sit, and reach above shoulders. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

Coordinated Entry Emergency Housing Facilitator

TITLE: Emergency Housing Facilitator

LAST UPDATED: 9/13/17

DEPARTMENT: 2-1-1

FSLA STATUS: Hourly

REPORTS TO: Director 2-1-1
In partnership with CE Program Director

WORK WEEK: Full-time
Monday –Friday 9:30 am – 5:30pm

Nothing in this position description restricts management’s right to assign or re-assign duties and responsibilities to this job at any time.

Position Summary

Provide quality professional services to internal and external customers with IMPACT 2-1-1. Implement IMPACT's philosophy of teamwork, customer service, and value added, in the call center and in the community.

This position coincides with regular duties as a Community Resource Specialist. When duties as the Emergency Housing Facilitator are fulfilled for a work shift or work day the facilitator will complete assignments and duties as a regular Community Resource Specialist.

Principal duties and responsibilities

- Prepare and facilitate a conference call every weekday morning with CoC partners.
 - a. Complete day to day bed and reporting needs for Coordinated Entry.
 - b. Contact all appropriate agencies with bed count via phone, email, or text.
- Update 2-1-1 and all community partners at end of shift:
 - a. Who was placed?
 - b. Who still needs to be placed and in what priority.
 - c. Any other information that is necessary to serve our partners and clients.
- Coordinate referrals from street outreach workers, community members, and self-referrals to emergency shelters and other emergency placement options based on vulnerability and need.
- Serve as the “go-to” consultant for emergency housing needs internally and externally.
- Obtain and maintain accurate bed counts for Coc Partners.
- Participate in trainings and meeting related to homelessness, HMIS and any other training or meetings with the placement of people and families into appropriate CoC agencies.
- Build and sustain strong working relationships and act as a liaison with Milwaukee County Coc agencies serving the homeless.
- In coordination with supervision, help to facilitate CE training to other IMPACT employees.
- Assure that data entered into the Wisconsin HMIS database by IMPACT 2-1-1 is accurate, up-to-date and entered according to the standards and practices required by the Milwaukee County Continuum of Care and all governing bodies. This includes being the primary backup of all ServicePoint data entry, correcting errors and entering on behalf of CRS and other agencies staff which do not have database access or request help with entry.
- Provide duties as a Community Resource Specialist when duties as the Facilitator are fulfilled for a work shift or work day.

Background / Education / Experience

- Experience as a fully trained IMPACT 2-1-1 Community Resource Specialist.
- Social services or human services work environment exposure
- Computer software expertise (Microsoft Word, Excel)
- Ability to learn and integrate other computer based programs
- AIRS Certified Information and Referral Specialist (CIRS) or willingness to become a CIRS.

Standard IMPACT Requirements:

- Understand, promote and teach AIRS Standards for Professional Information & Referral.
- Responsible for protecting client confidentiality and adhering to all state and federal laws and regulations regarding the protection to AODA and mental health information.
- Protects against unauthorized access, modifications, destruction, and disclosure as defined by IMPACT and relevant federal, state, and local laws.

Knowledge / Abilities / Skills

- Exceptional customer service skills and communication skills, both internal and external.
- Ability to work effectively in a team-oriented environment.
- Demonstrated strong interpersonal skills to build positive working relationships with outside agencies and organizations.
- Comfortable with public speaking.
- Excellent problem solving skills.
- Exceptional verbal and written communication skills.
- Good judgment, problem solving and decision making skills.
- Cultural competency skills to work effectively with diverse populations.
- Self-motivated and capable of growing and developing a new system-wide approach to achieving project goals.
- Demonstrated organization and time management skills.

Physical and Mental Demands

The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

While performing the duties of this job, the employee is **regularly required to:** work at a desk, conference table and work at a computer, both for extended periods of time; see for the purpose of reading or observing employees; communicate so that others can clearly understand normal conversation; hear and understand speech at normal levels.

The **employee frequently is required to:** walk and sit. The employee is **occasionally required to:** stand; lift and/or move up to 10 pounds unassisted; drive to locations to attend meetings.

I have had an opportunity to review the contents of this job description and understand the basic requirements of my position. I further understand that my performance will, at a minimum, be assessed based on its contents as well as the opportunity for my position to change as business needs warrant.

Community Resource Specialist Job Description

Position Title:	Community Resource Specialist	3/1/12
Department:	IMPACT 2-1-1 Program	
Reports to:	IMPACT 2-1-1 Program Call Center Operations Manager	

Nothing in this job description restricts management's right to assign or reassign duties and responsibilities to this job at any time.

Position Summary

As a member of the IMPACT 2-1-1 team, provide quality support to all of IMPACT and its' outside customers demonstrating IMPACT's philosophy of customer service, teamwork and value added. Answers IMPACT 2-1-1 information and referral line and its tie-in agency's incoming communications. Community Resource Specialists provide the following services: problem assessment, problem solving, information and referral, and assistance in the development of an action plan to customers within the scope of family, health, and social services that appropriately meets their needs.

Principle Responsibilities

1. Provides assessment, problem solving, information and referral, and crisis intervention when necessary in an empathetic and nonjudgmental manner.
2. Assists customers in developing an action plan.
3. Asks all customers permission to conduct a Customer Satisfaction Survey during the initial call.
4. Accurately documents customer contacts in a computerized database and other means.
5. Provides advocacy for customers experiencing difficulties or lacking in abilities needed to make effective contacts with agencies, programs or groups.
6. Participates in ongoing training and staff meetings.
7. Keeps informed of and demonstrates knowledge of all special service programs.
8. Ability to effectively work in and adapt to ongoing necessary changes.
9. Works varying work schedules.
10. Ensures that IMPACT is compliant with applicable federal, state, and local laws ensuring client confidentiality.

Background / Experience

1. Bachelor's degree or equivalent work experience.
2. AIRS Certified Information and Referral Specialist (CIRS) or willingness to become a CIRS.
3. A minimum of one-year customer service experience.
4. Social services-related experience preferred.

Abilities and Skills

1. Computer proficiency necessary.

2. Exceptional customer service skills, both internally and externally.
3. Able to work effectively in a team-oriented environment.
4. Exceptional verbal and written communication skills.
5. Good judgment, problem solving and decision making skills.
6. Bilingual ability preferred.
7. Possesses cultural competency skills to work effectively with diverse customers and staff.
8. Ability to respond effectively to a variety of callers' social service needs.
9. Ability to adapt to and apply on-going program development changes.

Physical and Mental Demands:

While performing the duties of this job, the employee is regularly required to talk or hear. The employee frequently is required to use hands to finger, grasp, handle or touch objects. The employee is often required to stand, walk, sit, and reach above shoulders. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

Coordinated Entry Policies and Procedures

Coordinated Entry Policy

Orig. Issue Date: 10/10/2016

Title: Governance Procedures

Date Last Reviewed: 06/12/2017

Governance Procedures

- **Reporting Structure**

Coordinated Entry is a process within the Milwaukee Continuum of Care (CoC). As such, it is responsible to the CoC through the following methods.

- **Reporting to the Continuum of Care Board of Directors**
The Coordinated Entry Program Coordinator will give at least a quarterly update on the program's process and goals to the Board of Directors. The Board of Directors may suggest feedback and additional steps to ensure that Coordinated Entry is working in the best interest of the CoC.
- **Coordinated Entry Lead Agency**
The Coordinated Entry Lead Agency is the United Way of Greater Milwaukee and Waukesha County (UWGMWC). UWGMWC will regularly attend Coordinated Entry and CoC meetings to hold the Coordinated Entry process accountable to the policies and procedures set forth through the CoC and Coordinated Entry Leadership Committee. As the Lead Agency, UWGMWC is also responsible for providing fiscal and other supports to ensure the success of Coordinated Entry.
- **Coordinated Entry Leadership Committee**
The Coordinated Entry Leadership Committee is responsible for the direction, implementation, compliance, funding, and overall function of the Coordinated Entry system. The Coordinated Entry Program Coordinator will give at least a monthly update on the program's process and goals, and will get approval for all policies and procedures for Coordinated Entry through the Coordinated Entry Leadership Committee. The Leadership Committee is co-chaired by the CoC Lead Agency and the Coordinated Entry Program Coordinator.
 - i.* To execute these functions, the Leadership Committee will do the following:
 - Determine implementation goals and chartering time-bound and/or project-defined work groups for Coordinated Entry system implementation and troubleshooting.
 - Propose new policies and procedures to be included in this manual.

- Ensure congruence between current policies and procedures laid out in this manual and the individual MOUs between Coordinated Entry participants.
- ii. The leadership committee has seven appointed members representing the following groups:
- United Way of Greater Milwaukee and Waukesha County
 - Coordinated Entry Program Coordinator at IMPACT
 - The City Of Milwaukee—Community Development Grants Administration
 - Shelter and Transitional Housing Task Force
 - Provider Advisory Committee
 - Milwaukee County Housing Division
 - Institute for Community Alliances
 - CoC Board of Directors
- ❖ Terms will be for 3 years. There is no limit to the number of terms an individual can serve.
 - ❖ Each seat is a standing seat and only individuals who take on the seat can vote, no person sitting in for the dedicated seat shall be allowed to vote.
 - ❖ Members must attend 75% of the meetings. After a member misses 6 meetings within one year, he/she will be replaced by a different representative from their group.
 - ❖ Quorum for voting must be four or more people present.
 - ❖ The leadership committee will nominate and vote on the following positions annually:
 - Chair, leads the meetings in concert with the Coordinated Entry Program Coordinator
 - Vice-Chair, assists the Chair and leads the meetings in the Chair’s absence
 - Secretary, responsible for recording meeting notes and distributing them
 - Client Rights Specialist, responsible for the role outlined in the Grievance Policy and Procedure
 - ❖ The leadership committee will ensure that the positions of the Grievance Hearing sub-committee are filled annual. This committee meets on an ad hoc basis when following the Grievance Policy and Procedure. It is comprised of:
 - a CoC Board Member
 - a case manager or street outreach worker
 - the Lead Agency
 - a peer
 - ❖ A Quality Assurance sub-committee will be comprised of the Coordinated Entry Program Coordinator, Institute for Community Alliances, and Milwaukee County, who will meet on an ad hoc basis to

review housing applications that are denied by a housing program to ensure that the Housing First policy is being adhered to.

- **Policy and Procedures Process**

1. A request for a new policy and/or procedure comes to the Coordinated Entry Leadership Committee from a member of the CoC, the CoC Board of Directors, the Leadership Committee itself, or one of the Lead Agencies.
2. The Coordinated Entry Program Coordinator will create a proposed draft policy/procedure to meet the concern. In this process, he/she may seek input from members of the CoC.
3. The draft proposal will be submitted to the Coordinated Entry Leadership Committee for initial approval.
4. The draft proposal, once approved by the Coordinated Entry Leadership Committee, will then be submitted to the CoC Board of Directors for final approval.
5. Once approved, the CoC Lead Agency will disseminate the information at Provider Advisory Committee and Full Body meetings. The Coordinated Entry Program Coordinator will be responsible for implementing the policy.

Coordinated Entry Policy

Orig. Issue Date: 02/06/2017

Program: Milwaukee Continuum of Care

Title: Coordinated Entry Assessment and Prioritization

Date Last Reviewed: 06/12/2017

Coordinated Entry Assessment and Prioritization**PURPOSE:**

According to HUD, each Continuum of Care (CoC) must utilize a standardized assessment across the CoC in order to create a single prioritization list of individuals experiencing homelessness (<https://www.hudexchange.info/resources/documents/Coordinated-Entry-Policy-Brief.pdf>). This policy addresses that mandate.

All Continuum of Care providers who encounter someone experiencing homelessness in Milwaukee County will complete the same standardized assessment, the VI-SPDAT, VI-FSPDAT, or TAY-VI depending on the population assessed through ServicePoint.

PROCEDURES:

- By April 1, 2017, all CE screeners, homeless outreach providers, and shelter staff who will be completing the client assessments, either in-person or via the 2-1-1 Call Center, will be trained in the use of the VI-SPDAT, VI-FSPDAT, and TAY-VI. Thereafter, any newly hired staff will complete this training within 60 days of their start date. Training can be accessed here: <http://www.orgcode.com/course/vi-spdatt-v2-training/>
- Recorded VI-SPDAT scores are valid for one year and should be reviewed, at a minimum, yearly to determine if changes are necessary. Data should be updated whenever there are any changes in client status. If necessary, a new VI-SPDAT may be completed more than annually.
- The VI-SPDAT, VI-FSPDAT, or TAY-VI are the tools used to create the prioritization lists for housing options within the Continuum of Care, therefore, anyone interested in services through the Continuum of Care should complete an assessment. However, if a client chooses not to complete the assessment, he/she can be added to the prioritization lists, but the VI score will not be taken into account.
- Any CoC provider is eligible to complete the VI-SPDAT, VI-FSPDAT, or TAY-VI. Groups outside of the CoC can direct their clients to call 2-1-1 for an assessment to be completed, or email coordinatedentry@impactinc.org to schedule a mobile screen.
- IMPACT will employ a Coordinated Entry Mobile Screener who will do inreach to places where people who are homeless tend to congregate in order to do assessments. Locations might include:
 - Meal sites
 - Public libraries
 - Day shelters
- In order to best reach special populations, paper assessments may be completed in places where the target population is likely to engage in services. The Coordinated Entry team will provide sufficient training for these assessments to be completed accurately, and will

complete the data entry necessary to follow the Coordinated Entry Policy and Procedure.

Possible locations include:

- The VA
- Diverse & Resilient
- LGBT Community Center
- Public Schools
- Hospitals
- All CoC providers working with clients in need of housing should complete an assessment as soon as possible, but should use professional judgment regarding the timing of the assessment so as to get the fullest, most honest answers.

TO ASSESS:

- 1) The assessment tool used is dependent on the person being assessed.
 - a. Single adults age 25 and older use the VI-SPDAT
 - b. Families use the VI-FSPDAT
 - c. Single adults age 18-24 use the TAY-VI
- 2) Explain the assessment tool in a brief introduction, an example is below:

The purpose of the VI-SPDAT is to assess your service needs. This assessment usually takes less than 7 minutes to complete. Any question can be skipped or refused. If you do not understand the question, let me know. It is important that you give accurate information; there's no right or wrong answer. This survey is in ServicePoint, which is our database, and it will be shared with housing providers only to get you into housing. What you provide remains confidential.

- 3) Complete the assessment in ServicePoint. Alternatively, complete the assessment on paper and put it into ServicePoint within 24 hours.

PRIORITIZATION LIST:

- To best utilize the lists, there are five referrals that can be made to the prioritization list based on client population and need.
 - 1) Choose which referral(s) need to be made.
 - a. Clients who are seeking emergency shelter should be referred to the Milwaukee CoC Emergency Shelter Prioritization List.
 - b. Single adults aged 25 and older seeking permanent housing options should be referred to the Milwaukee CoC Housing Priority List- Single Adults.
 - c. Families with heads of households 25 and older seeking permanent housing options should be referred to the Milwaukee CoC Housing Priority List- Families.
 - d. Single adults aged 18-24 seeking permanent housing options should be referred to the Milwaukee CoC Housing Priority List- Single Youth.
 - e. Families with heads of households aged 18-24 and seeking permanent housing options should be referred to the Milwaukee CoC Housing Priority List- Youth Families.
 - 2) Complete the referral according to the Cheat Sheet from Institute for Community Alliances.

- 3) As clients enter housing, the housing provider will enter a Service Transaction named “Permanent Supportive Housing” from within the referral, mark the referral as “Closed” and “Fully Met” which will take them off the prioritization list.
- 4) The Prioritization lists are prioritized as follows:
 - a. Housing Priority List by chronic status, then length of time homeless, then VI score through a Housing Priority List report run from ServicePoint.
 - b. Emergency Shelter Prioritization List by last outreach contact then by VI score through a daily report run from ServicePoint.
 - c. In the event that there are no chronically homeless clients in a particular category for housing, the prioritization will be of those who have the longest time of homelessness and then those with the highest service needs, which is also determined through the ServicePoint reports.

Coordinated Entry Policy

Orig. Issue Date: 02/27/2017

Program: Milwaukee Continuum of Care

No. 02

Title: The Role of Street Outreach**Date Last Reviewed:** 09/11/17

The Role of Street Outreach

Purpose:

Street Outreach is an integral piece to ending homelessness. It allows for finding those in need, building rapport, and working with people who may not choose to get housing assistance through the traditional system. The primary goal of Street Outreach is to find a housing solution for those who are homeless and sleeping outside or in places not meant for human habitation.

Procedure:

- All Street Outreach programs funded by the CoC, ESG, CDBG, SAMHSA, or City/County tax levy will have regularly scheduled outreach locations where people experiencing homelessness tend to congregate.
- At least once per week, Street Outreach programs will engage in an early morning shift where they look for people sleeping outside and in places not meant for human habitation.
- Street Outreach workers should be safe when engaging in these activities, ensuring that they go in pairs and don't go into dangerous situations without support (e.g. abandoned buildings).
- Street Outreach workers will quickly build rapport with clients to the point where they can complete the Coordinated Entry Assessment and the VI-SPDAT, VI-FSPDAT, or TAY-VI according to the Coordinated Entry Assessment Policy.
- Street Outreach workers will also get to know the clients' needs and desires as it relates to housing.
- The program supervisors of the Street Outreach teams will participate in weekly housing meetings with Coordinated Entry. At these weekly meetings, they will share what their team knows of the client.
 - ⊖ They will follow the Coordinated Entry Policy and Procedure and will completing housing applications with clients assigned to them via the weekly housing staffing in a timely manner.
- A representative of each Street Outreach team will participate in a conference call with 2-1-1 when they have a client who is seeking emergency shelter to give feedback on the best emergency housing option for them.
- Special attention should be paid to the incidence of mental health and substance use concerns, and options for alleviating these should be offered respecting client need and desire.
- Street Outreach programs will work with Coordinated Entry to avoid duplication of efforts and best attend to those in need, based on the housing prioritization list.

Coordinated Entry Policy

Orig. Issue Date: 10/09/2017

Program: All CoC-funded agencies

Title: Prevention and Diversion

Date Last Reviewed: 06/12/2017

Prevention and Diversion

Purpose: A necessary part of the Coordinated Entry process is giving people access first to mainstream resources to resolve their situation before utilizing limited HUD resources for those experiencing homelessness. This policy describes the actions taken to include prevention and diversion in the Coordinated Entry process.

Policy:

All programs should utilize prevention and diversion prior to bringing clients into the Coordinated Entry process.

- When a client calls 2-1-1, they will be evaluated first to determine if they are experiencing Category 1 or Category 2 homelessness.
- If they are experiencing Category 2 homelessness, they will be counseled and given resources for mainstream resources such as Emergency Assistance grants, legal resources, energy assistance, food help, employment training and resources, etc.
- Only if they are imminently going to be Category 1 homeless will an assessment for shelter be completed.
- When a client enters shelter or a Safe Haven, the shelter case manager will complete an assessment for diversion resources within the first 10 days of entering shelter. They will explore possible resources including subsidized housing through disabled or elderly housing, Section 8 or Housing Authorities, reconciling family/friend relationships to live with someone, going into a rooming house or rent without subsidy, etc. If none of those options are appropriate or feasible, they will complete the Coordinated Entry Assessment.
- When a client is encountered during street outreach, they will be evaluated for all possible resources including the Coordinated Entry process, subsidized housing through disabled or elderly housing, Section 8 or Housing Authorities, reconciling family/friend relationships to live with someone, going into a rooming house or rent without subsidy, etc. and will make referrals and follow up as appropriate.
 - The Coordinated Entry team, in collaboration with HUD and other partners, will keep spreadsheet of available housing units that are not within the CoC.
- Milwaukee County Housing Division will engage in prevention and diversion through their Community Intervention Specialist program.
- During weekly permanent Housing Placement meetings, a representative from Milwaukee County Housing Division will be present to inform the group of diversion options to divert people from the CoC resources as much as possible.

The Coordinated Entry team and the CoC Lead Agency will inform street outreach workers and case managers of resources outside of the Coordinated Entry process through announcements, trainings, and during weekly Housing Placement meetings.

All staff within the CoC will collaborate to share and brainstorm resources outside of CoC resources on a consistent basis, reserving CoC resources only for those who don't qualify for any other mainstream resources.

Coordinated Entry Policy

Orig. Issue Date: 10/25/2016

Revision: 3

Title: Shelter Referral Procedure

Date Last Reviewed: 09/11/2017

Shelter Referral Procedure

All emergency shelters funded through the Milwaukee CoC, with the exception of those serving youth and victims of domestic violence and Safe Havens, will take placements through the Coordinated Entry placement. We also recognize that emergency shelter may not be the appropriate placement for every person in need of an emergency option. For this reason, the Coordinated Entry Program Coordinator will work consistently to bring other emergency placement options to the table as participants as well, including programs such as (but not limited to) the Crisis Resource Centers, Safe Havens, youth-serving shelters, and domestic violence shelters.

Definition of Terms

- **IMPACT, Inc.**- the agency responsible for coordinating the Coordinated Entry process
- **2-1-1**- a program within IMPACT that provides information, assistance, and referral via phone to those seeking community resources
- **CE**- Coordinated Entry
- **CRS**- Community Resource Specialist- the staff member at 2-1-1 who answers the phone call and provides information, assistance, and referral
- **HMIS**- Homeless Management Information System- the database that tracks information regarding people seeking homeless service provision; it is called ServicePoint
- **CoC**- Continuum of Care- a collaborative body of homeless service provision agencies
- **Shelter**- an emergency shelter within the CoC participating in Coordinated Entry
- **Incident List**- a list within HMIS of clients who will need to be re-assessed before entering shelter due to issues during previous stays

Procedure

1. All service providers will follow the Assessment and Prioritization policy and procedure to put people in need of emergency housing on the Emergency Shelter Prioritization List.
2. All service providers involved in the Coordinated Entry process for emergency housing will provide a daily bed count, including when the count is zero, to IMPACT by emailing coordinatedentry@impactinc.org or calling 2-1-1 by 11:00pm, 10:00am, and 6:00pm each day.

10:00am bedcount

3. By 10:30am week each week day, the Emergency Housing Facilitator or a designee will text and email those involved in emergency housing, including, but not limited to, street outreach workers, emergency shelters, crisis options, and those serving special populations. All staff receiving the information must be members of the CoC. The information sent will include information for available beds and a time for a conference call.
4. By 10:30am each week day, IMPACT will run the Emergency Shelter Prioritization List.
5. By 11:00am each week day, IMPACT will convene a conference call for all those involved in emergency housing placement, including Street Outreach workers, emergency shelters, CRC, etc. IMPACT will host a placement staffing discussion based on the vulnerability of the clients in need, using the VI-SPDAT as a guide. Those who are sleeping in a place not meant for human habitation or are in imminent danger in a domestic violence situation when no DV beds are

available will be given priority over all others, following the Assessment and Prioritization and Domestic Violence policies and procedures.

During the call:

- a. IMPACT will review the available space for Coordinated Entry placements and those who are also involved will review their availability.
 - b. IMPACT will review the top people are the Emergency Shelter Prioritization List.
 - c. Street outreach workers and others working with people in need of emergency housing will briefly staff the situations of those most in need of emergency placement.
 - d. Shelters will staff any clients who came to them through street outreach during the night/early morning.
 - e. IMPACT will have final decision-making authority of which client is referred to which shelter program through the Coordinated Entry system.
6. The Emergency Housing Facilitator will match clients in need of a bed to appropriate shelter beds based on the conference call.
 - a. The CRS will complete a background check for each client.
 - b. The CRS will check and revise, as appropriate, the Client Profile portion in HMIS for each client.
 - c. The CRS will review each shelter matrix for eligibility requirements.
 7. The Emergency Housing Facilitator will refer to other resources as appropriate, for example, Crisis Resource Center or a DV shelter.
 8. The CRS will enter a Referral in HMIS by 3:00pm daily.
 - a. The CRS will choose the appropriate “Provider” and will add the VI-SPDAT Score.
 - b. The CRS will email the shelter to alert them of the referral and provide the telephone number for the client.
 - i. The email will include the client information, phone number, background check information, and VI-SPDAT score.
 9. *If the client is on the Incident List, the CRS will email the Shelter with the client information. The Shelter will set up a re-assessment appointment. The Shelter will then email the CRS back with the result of that appointment. If accepted, that client will go into to the next available bed at the Shelter. The CRS will complete the Referral in HMIS.*
 10. The Shelter will indicate the result of the referral in HMIS.
 - a. In “Referral Outcome,” the Shelter will choose the appropriate outcome.
 - i. “Accepted” indicates that the client is expected to come to the shelter.
 - ii. “Declined” indicates that the client declined shelter.
 - iii. “Canceled” indicates that the Shelter has deemed the client inappropriate to come to shelter.
 1. If the client is deemed inappropriate for shelter, the Shelter will call or email 2-1-1 to update the CRS. The CRS will make a note of this in the “Referral Needs Notes” section of the referral.
 2. The client will retain his/her position on the Emergency Shelter Prioritization Report for referral to another shelter.
 - b. The Shelter will choose the appropriate “Outcome of Need” from the following options:
 - i. Fully Met indicates that the client came into shelter.
 - ii. Not Met indicates that the client did not come into shelter.
 - c. The Shelter will choose the appropriate answer to “If Need is Not Met, Reason” from the following options:
 - i. Alcohol or Drug indicates that the client was intoxicated upon arrival to the shelter and was unable to stay.

- ii. Client Refused Services indicates that the client declined shelter. This should only be used if the “Referral Outcome” is “Declined.”
 - iii. Criminal Background indicates that the client is unable to enter shelter due to their criminal background.
 - iv. No Show indicates that the client was expected to come to shelter but did not show up. This should only be used if the “Referral Outcome” is “Accepted.”
 - v. Program Violations indicates that the client is ineligible for shelter due to past program violations.
 - vi. Violent Behavior indicates that the client is ineligible for shelter due to past or current violent behavior.
11. The CRS will close out the referral when the client has either stated that shelter is no longer needed or they have been accepted into shelter.
- a. In the referral, the CRS will mark the “Referral Outcome” appropriately, and will mark the Need as “Closed” and “Fully Met.”

6:00pm bedcount

12. Based on the conference call in the morning, the Emergency Housing Facilitator will leave the information of the next priority individuals and families with the 2nd shift 2-1-1 Lead. If there are any openings at the 6:00pm bedcount, the 2nd shift 2-1-1 CRSs will fill the slots according to the priority from the Emergency Housing Facilitator and, if needed, the Emergency Shelter Prioritization list. To do so, they will follow steps 6-11 above.

11:00pm bedcount

13. The CRS will email the bedcount for all shelters to ceoutreach@impactinc.org every evening. In order to provide safe shelter for the most vulnerable who are homeless, Street Outreach workers will place people into shelter on a first-come, first-served basis until the 10:00am bedcount.
- a. The Street Outreach workers will complete steps 6-11 above to make a placement.
 - b. Street Outreach workers will transport the client to the shelter right away.
 - c. Clients may be expected to wait in the shelter lobby. Street Outreach workers will provide food and other accommodations while the person is waiting.
 - d. Shelter staff will complete an assessment of the client as soon as possible during business hours so that the most suitable placement for them can be discussed at the conference call.

Weekends and Holidays

14. The Emergency Housing Facilitator will leave information about priority clients with the 2-1-1 Leads which will be utilized along with the Emergency Shelter Prioritization list to make the most appropriate placements, following steps 6-11 above, on holidays and weekends.

Coordinated Entry Policy

Orig. Issue Date: 02/27/2017

Program: Milwaukee Continuum of Care

No. 02

Title: Coordinated Entry Policy and Procedure**Date Last Reviewed:** 09/11/17

Coordinated Entry Policy and Procedure

Purpose:

The purpose of Coordinated Entry is to ensure fair and equitable access to homeless services to anyone experiencing homelessness in Milwaukee County. It creates a single prioritization list so that the Milwaukee Continuum of Care understands those in need and can place the most vulnerable into housing resources first.

Procedure:

- 1) All Street Outreach, Emergency Shelter staff, and Coordinated Entry Team members will refer people experiencing HUD Category 1 Homelessness to the Housing Prioritization Lists based on demographic (Singles ages 25 and over, Families with heads of households aged 25 and over, Singles 18-24 years old, and Families with heads of households ages 18-24) using the appropriate VI-SPDAT, VI-FSPDAT, or TAY-VI according to the Coordinated Entry Assessment and Prioritization Policy. They will also complete the Coordinated Entry Assessment within HMIS and upload a release of information and homeless history tracking form as soon as possible.
- 2) IMPACT 2-1-1 Coordinated Entry Screeners will assess for and place people into emergency shelters following the Coordinated Entry Assessment and Prioritization Policy and the Referral Policy.
- 3) Agencies and individuals outside of Street Outreach, Emergency Shelter, or IMPACT 2-1-1 will contact Coordinated Entry in one of the following ways: Call 2-1-1 for an assessment; Go to one of the Coordinated Entry Mobile Screener sites; Email CoordinatedEntry@impactinc.org to ask for a referral for an in-person screening. In addition, paper versions of the Coordinated Entry assessment will be available where people in special populations might engage in services, in a manner that is appropriate to that population, and they can be sent in to IMPACT for input into HMIS.
- 4) The Coordinated Entry Facilitator will maintain a spreadsheet of available permanent housing options including the program name, unit size, location, and other pertinent information. All Permanent Housing providers funded by CoC, CDBG, HOME, TBRA, or Milwaukee City/County tax levy dollars (with the exception of Section 8 or Housing Authorities) will report their anticipated openings with an approximate available date to the Coordinated Entry Facilitator by each Friday at 5:00pm. If an unanticipated opening occurs, the program will contact the Facilitator to provide updates.
- 5) The Coordinated Entry Facilitator will maintain the Housing Prioritization Lists by assuring accuracy of data populating the lists in preparation for at-least monthly housing placement case staffings.
 - a. On at least a monthly basis, the Coordinated Entry Facilitator will run the Housing Priority List report for each sub-type out of HMIS.
 - b. The Facilitator will go through each of the top 100 client files to ensure that there is a Housing

- Tracking form, homeless verifications, and, if needed, disability statements that match the information in the Coordinated Entry assessment.
- c. If there is not, the Facilitator will change the Coordinated Entry assessment to match the documentation in HMIS, will complete a Homeless History Tracking form and upload it into HMIS, and will notify the last point of contact of the change.
 - i. All documentation and verifications must be in line with the HUD policies on acceptable homeless documentation and, if applicable, the HUD chronic homeless policy and the Milwaukee CoC policy on documenting chronic homelessness.
 - d. If there is additional information uploaded into HMIS, the Coordinated Entry assessment can be changed accordingly.
 - e. If an outreach worker or case manager disagrees with a part of the Coordinated Entry assessment, they can complete a case conference with the Coordinated Entry Program Coordinator.
 - f. The next day, the Facilitator will then re-run the Housing Prioritization List report for each sub-type. From that list, the Client Status Update worksheet will be populated. This worksheet will be used for the weekly case staffings and will have people in the following categories: working on engagement, working on verifications, potentially eligible for housing, application in progress, application in review with the housing provider, application approved and looking for housing, housed.
 - g. Throughout the week, the Facilitator will update the Coordinated Entry Status on the Client Status Update worksheet and in the Coordinated Entry assessment in HMIS.
 - h. The previous month's Client Status Update worksheet will be compared to the vetted Housing Priority List for each subtype to have two points of reference for where each client is at in the process of housing each month.
- 6) At least monthly, a Housing Staffing will be held with stakeholders according to each homeless subtype that is a focus of the CoC (e.g., chronically homeless singles, homeless families, homeless veterans, homeless youth, homeless singles, etc.).
- a. The supervisors or a designee of each shelter, street outreach worker, or coordinated entry team member involved with that subpopulation will be present for the meetings.
 - b. The meetings will consist of making a housing plan and assigning a team to each client.
 - c. Subsequent meetings will include updates on progress made toward housing and problem-solving barrier reduction to getting people housed with the Housing First philosophy.
 - d. Teams are responsible for completing the housing application, collecting homeless verifications, verifying and completing the homeless history tracking form, and, if necessary, getting a medical statement to turn into the next Housing Placement meeting.
 - e. The Coordinated Entry Facilitator will host a discussion about housing fit and placement during the Housing Staffings for clients who have completed documentation.
 - f. The Coordinated Entry team will assist and support street outreach and emergency shelter teams by providing clinical support and additional assessments through the housing application and placement processes and throughout the client's time in a housing program.
 - g. The program supervisors are responsible for an update at each Housing Staffing for their target population until the client is housed. .

- 7) If a client declines housing, they will be offered housing at least every two weeks for six months before removing them from the Housing Priority List. The client can at any time be re-referred for housing if they change their mind.
- 8) Permanent Housing programs must follow the Housing First policy regarding acceptance of referrals, work done with the client while in the program, and discharging. The Continuum of Care endorses the Housing First paradigm for all of its programming.

Coordinated Entry Policy

Orig. Issue Date: 04/10/2017

Title: Housing Referral Procedure**Date Last Reviewed:** 04/10/2017

Housing Referral Procedure

After the Coordinated Entry Policy and Procedure has been followed, and a client is to be referred to a housing program, the following steps will take place. This policy defines how a referral is made and accepted, how a referral is rejected, and what happens in the case of a rejected referral.

Definitions

Contact Person- The main point person responsible for the client's referral into housing. This could be a street outreach worker or case manager.

Housing Placement Staffings- Weekly staffings with the Coordinated Entry team to discuss placement options and where referrals are made.

Coordinated Entry Facilitator- A member of the Coordinated Entry team whose main responsibilities are to facilitate the Housing Placement Staffings, maintain the Housing Priority List, and manage the housing openings.

Housing Programs- Any permanent housing programs (including Permanent Supportive Housing, Rapid Rehousing, and Tenant Based Rent Assistance) funded by HUD through CoC, ESG, or ETH funds.

Procedure

1. Follow the Coordinated Entry Policy and Procedure.
2. At the Housing Placement Staffings, once a client has been matched with an appropriate referral source, the Coordinated Entry Facilitator will give the Contact Person information about how to proceed with the referral.
3. Housing Programs have the ability to ask for additional paperwork in addition to the Contact Person packet (attached). They also can choose how to receive a referral, via phone call, email, or fax. This information must be communicated to the Coordinated Entry Facilitator any time there is a change.
4. The Contact Person will meet with their client as soon as possible to complete any additional paperwork, to take the client to see the unit and/or explain the program. The Contact Person will also connect the client with the Housing Program.
5. The Coordinated Entry Facilitator will create a referral to the Housing Program in HMIS.
6. The client, Contact Person, and Housing Program have five business days after the Housing Placement Staffing to decide whether or not the referral will be accepted. If the Housing Program will not accept a referral, they must provide a documented reason for refusal that does not contradict the Housing First policy.
7. Housing Programs must abide by the Housing First Policy when making their determinations on whether or not a client may enter a program.
8. The Contact Person must contact the Coordinated Entry Facilitator within five business days of the Housing Placement Staffing to give an update on the outcome of the referral.
9. If the client is denied or declines the referral, the Coordinated Entry Facilitator will update the referral in HMIS and the client will remain on the Housing Priority List until housed.
10. If the client needs more time to make a decision, or if the Contact Person is diligently looking for a client and can't locate them, they can ask the Coordinated Entry Facilitator for an extension. An extension of up to 15 days may be granted.

11. If the housing type is a housing voucher, the client has up to 60 days to find a unit and move in. The client's Contact Person and/or case manager should be heavily involved in helping to secure housing. If an extension is needed, it can be granted in a housing staffing meeting.
12. All efforts will be made to house people within 30 days.
13. The Contact Person, case manager, or a representative should continue to attend the housing staffings regularly until the client is housed. Once the client is housed, the Housing Program will update the referral and will close out the referral to the Housing Priority List. (See the Cheat Sheet, attached.)

Coordinated Entry Policy

Orig. Issue Date: 06/12/2017

Program: Emergency Shelter

No. 01

Title: Domestic Violence Policy

Date Last Reviewed:

Domestic Violence Policy

Purpose: Milwaukee's Continuum of Care recognizes that victims of dating violence, domestic violence, human trafficking, sexual assault, and stalking have unique and specific needs and must be treated with respect to their individual situations. As such, the following policy will be incorporated into our service delivery flow as Coordinated Entry is implemented:

Procedure:Training

Milwaukee's Sojourner Family Peace Center will provide annual training to CoC membership on the topic of domestic violence, date violence, sexual assault and stalking, to ensure that staff of member agencies remain sensitive to the specific needs of this population and are able to serve them effectively. Trainings will occur annually and will include availability of domestic violence professionals as consultants throughout the year, as well as access to domestic violence advocates who are embedded in all districts of Milwaukee's Police Department.

Identification and Assessment

As our primary provider of Coordinated Entry services for Milwaukee County, IMPACT, Inc. Community Resource Specialists (CRS) will assess for homelessness and housing crisis when clients call in for services. During this initial point of shelter assessment, IMPACT, Inc. CRS will ask callers if they are currently in a safe place, have fear for their safety or are attempting to flee a potentially violent situation. CRS will assess and document the current status of the domestic violence situation. If the client is deemed to be in immediate life-threatening danger, CRS will engage law enforcement. If not in immediate danger, CRS will warm transfer the client to Sojourner Family Peace Center or Milwaukee Women's Center for more intensive assessment, safety planning, and/or domestic violence shelter placement.

Sojourner Family Peace Center and Milwaukee Women's Center will do further assessment and provide community resources and, if appropriate, shelter. If no shelter space is available and the person is in need of a domestic violence shelter, Sojourner Family Peace Center and Milwaukee Women's Center will facilitate referrals to other DV shelters in the area. In the event that all those shelters are full, they will warm transfer the client back to 2-1-1 for a general shelter assessment.

At the time of warm transfer, CRS will instruct the caller to call 2-1-1 back if they are still in need of shelter after further assessment. In the event of a call back, CRS will conduct the shelter intake assessment and add the client's record to the Priority Index. Client discretion is honored at every level of intervention.

Prioritization

Callers who identify as persons attempting to flee or fleeing a dating violence, domestic

violence, human trafficking, sexual assault, and stalking situation are automatically deemed eligible for shelter placement and will be placed on the Emergency Shelter Prioritization List just below those who are verified as sleeping on the street. Shelter diversion and community case management opportunities will not be pursued to avoid further risk to safety.

Connection to the Housing Prioritization List and Emergency Shelter Prioritization List

Staff at Sojourner Family Peace Center and Milwaukee Women’s Center are encouraged to complete the VI-SPDAT, VI-FSPDAT, and TAY-VI with their clients as much as possible to ensure accurate information is used for the prioritization lists. The process will be this:

- 1) The staff will first ask the client if they have had an assessment done through 2-1-1 or street outreach.
- 2) If yes, the staff will ask if the client wishes to update the information, and if so, if they’d like to do so by calling 2-1-1 or with the staff.
- 3) The client can always call 2-1-1 to update their information.
- 4) Staff may also complete the VI-SPDAT, VI-FSPDAT, or TAY-VI on paper with the client and scan and email it to coordinatedentry@impactinc.org to be input into HMIS.
 - a. In this case, the staff will indicate on the form whether this client needs to be added to the shelter prioritization list, the housing prioritization list, or both.
- 5) Staff will also complete the Housing History Tracking form and email it to coordinatedentry@impactinc.org.
- 6) 2-1-1 CRSs will input the information into the HMIS Coordinated Entry Assessment within one business day.
- 7) Please refer to the confidentiality section of this policy for further information.

Supporting CoC Member Agencies

Sojourner Family Peace Center and Milwaukee Women’s Center will make their community-based services available for clients served by Milwaukee CoC member agencies if the CoC member agency requests it AND the client is interested in additional services. Because both Sojourner Family Peace Center and Milwaukee Women’s Center specialize in serving people in these sensitive situations, it is encouraged that CoC member agencies seek the support of these two agencies for support.

Confidentiality

While the confidentiality of all in the CoC is important, it is of utmost importance that those who are attempting to flee or fleeing a dating violence, domestic violence, human trafficking, sexual assault, and stalking situation have their identifying information as anonymous as possible. Therefore, when filling out the VI-SPDAT, VI-FSPDAT, or TAY-VI, staff at Sojourner Family Peace Center and Milwaukee Women’s Center may create an alias for the client that they will know identifies the client but leaves all identifying information out.

When a client is being considered for placement in shelter or housing, the general Coordinated Entry Policy and Procedure will be followed, and the staff at the DV agency will be contacted to communicate with the client.

When a client goes into a permanent housing program, the client file will be locked in HMIS

and all identifying information will be redacted from the HMIS and paper files so that the client may not be identified.

Coordinated Entry Policy

Orig. Issue Date: 02/27/2017

Program: Milwaukee Continuum of Care

No. 02

Title: Housing First

Date Last Reviewed: 09/11/2017

Housing First

Standard: All programs within the Continuum of Care will embody a housing first approach to working with clients.

Procedure:

All agency staff will be oriented to the Housing First philosophy as part of their initial orientation.

Low Barrier Entry into Programs

- 1) Coordinated Entry will make appropriate referrals to the program that best matches the client's needs and desires as expressed by the client.
- 2) Admission into a housing program should be based on client fit and client choice; programs may not decline to bring in a client due to mental health status or symptoms, alcohol or drug use, criminal history, credit history, housing history, employment status or history, immigration status, gender identity, sexual orientation, race, ethnicity, or any other such individual factors.
 - a. The Coordinated Entry team will offer additional assessment and community referrals, as well as support to clients and case managers upon entry.
 - b. Admission into a program should not take more than two weeks from receipt of the referral.
- 3) All efforts should be made to resolve barriers to entry on the part of landlords/housing providers, including, for example, paying double security deposits in a Rapid Rehousing program or working with clients to resolve legal histories that would traditionally make them ineligible for a project-based unit. This should be a joint effort between the client's Contact Person Team and the housing provider staff.

Providing Service Support to Maintain Housing

- 1) The housing provider is responsible for ensuring that sufficient case management and other wraparound services are offered to the client regularly for their success in housing.
- 2) Case managers must work closely with landlords and building owners. All efforts should be made not to remove a client from the housing program due to behavioral, substance use, mental health, or legal related issues.
- 3) If a client's housing is in jeopardy, the first recourse is for the client's case manager to offer more services more often to help resolve the issue, including the program manager for problem-solving help if needed.
- 4) If additional supports do not resolve the issue, the housing program must document a client meeting with the case manager, supervisor, landlord, and housing provider. The meeting should address what the issue is with the client, gain the client's perspective on it, and evidence of problem-solving efforts.

- 5) The Coordinated Entry Team will be available for trouble-shooting and will complete an assessment and service suggestions at any time at the request of a case manager or program manager.

Client Transfers and Discharges

- 1) According to HUD, “permanent supportive housing is meant to be permanent with no time limits and is intended to target disabled persons that are literally homeless that have not been successful at maintaining permanent housing on their own. A PSH recipient cannot determine when a program participant is "ready" to be transferred or exited from a program. If a program participant believes that they are ready and indicate that they would like to move on, recipients can work with the program participant to transition out of the project. In order to transfer or discharge a client from PSH to PSH, the case manager would need to demonstrate the client desire for the transfer, why they would be a good fit in a different program, and eligibility for the program prior to entering the PSH.”
- 2) To determine whether or not a client may transfer programs, the case manager will contact the Coordinated Entry Facilitator and will come to the next scheduled Housing First meeting. At that meeting, the case manager will be prepared with documentation regarding the reason for request of transfer/discharge, interventions that have been tried already, and the client’s needs and desires for housing and service provision.
- 3) All efforts will be made to prevent the client from returning to homelessness, including but not limited to switching to a more suitable permanent housing program through Rapid Rehousing or Permanent Supportive Housing programs.
- 4) In the event that a client must leave an apartment, all efforts will be made to have a mutual lease termination versus an eviction.
- 5) In the event that a client does return to homelessness, the Housing Program will contact the Coordinated Entry Program Coordinator and will make a referral in HMIS to the appropriate Housing Prioritization List.

Coordinated Entry Policy

Orig. Issue Date: 01/07/2017

Program: All CoC-funded agencies

Title: HMIS Data Entry, Usage, and Reporting **Date Last Reviewed:** 06/12/2017

HMIS Data Entry, Usage, and Reporting

PURPOSE: This policy will offer a structured guideline for the maintenance of appropriate timelines concerning the entry and usage of client data HMIS. Standardized, correct data entry is of utmost importance in order to provide a clear, systemic view of how Coordinated Entry is impacting utilization of CoC services and client needs.

PROCEDURES:Collecting Client Information

All CoC-funded agencies should review and revise, if necessary, the Client Profile in HMIS when they begin to work with a client. Street Outreach and Coordinated Entry staff (including 2-1-1 Community Resource Specialists) are not responsible for completing the sub assessments.

All Street Outreach, Emergency Shelter, Safe Haven, and Rapid Rehousing staff should pay special attention to the chronic homelessness section of the Client Profile and follow the CoC Chronic Verification Policy and Procedure to ensure that what is reported in the Client Profile can be supported by Service Transactions, program Entry/Exits, Outreach Contacts, and/or File Attachments. If there is no information in the Client Profile, the first staff to work with the client must fill it out.

All CoC-funded agencies should complete, review, and/or revise the appropriate VI-SPDAT, VI-FSPDAT, or TAY in the Assessments tab depending on the client demographic according to the Coordinated Entry Assessment Policy. Staff should also complete a referral to the appropriate Housing Prioritization List according to the Coordinated Entry Assessment Policy and the cheat sheet provided by Institute for Community Alliances.

Referrals to Housing Providers

Staff will have all monthly data regarding referrals and referral outcomes complete and accurate by the 5th of the following month. (For example, all referrals and referral outcomes that took place in the month of January will have complete and accurate HMIS entry by the 5th of February.)

Usage of HMIS Data

Coordinated Entry will utilize the information entered on the Client Profile and VI assessments via the referrals made to the Housing Prioritization Lists to create a single prioritization list for placement into CoC-wide housing options. The report includes client name, date of birth, number of days homeless, VI score, chronic status, veteran status, youth status, and family size.

Information regarding referrals made and referral outcomes will be combined with CoC program utilization data to analyze the effectiveness of Coordinated Entry.

Coordinated Entry Data Requests

All requests for Coordinated Entry data will go through the City of Milwaukee as the Lead Agency of the CoC. If the City deems it appropriate, the Coordinated Entry Program Coordinator will compile any data requested with, as needed, assistance from Institute for Community Alliances, and will deliver it to the City to distribute.

Coordinated Entry Policy

Orig. Issue Date: 06/12/2017

Program: Milwaukee Continuum of Care- Coordinated Entry

No. 01

Title: Non-Discrimination Policy**Date Last Reviewed:**

Non-Discrimination Policy

It is the policy of the Milwaukee Continuum of Care's Coordinated Entry system that no otherwise eligible applicant for services or service recipient shall be excluded from participation, be denied benefits or otherwise be subjected to discrimination in any manner on the basis of age, race, ethnic or cultural background, immigration status, gender, gender identity, sexual orientation, religious preferences, physical condition, developmental disability, mental health needs, arrest or conviction, military/veteran status or participation, previous history with our services or other homeless providers.

All clients within the Coordinated Entry system have the right to confidentiality, involvement in decision-making, and self-determination.

We adhere to civil rights laws to ensure equal opportunity for access to service delivery and treatment without regard to the above named characteristics.

The Coordinated Entry System will work with each person's individual situation to make our best effort to find a housing solution that will work for them.

Termination from one program service within the Milwaukee Continuum of Care does not preclude a client from eligibility from all programs, nor is termination considered indefinite.

All agencies that receive Milwaukee Continuum of Care funding must review and give each client the grievance document describing their rights and grievance policy. If a client believes that they have been discriminated against or their rights have been violated, they should contact the Coordinated Entry Program Coordinator and follow the Grievance Policy and Procedure.

Coordinated Entry Policy

Orig. Issue Date: 05/08/2017

Program: Milwaukee Continuum of Care- Coordinated Entry

No. 01

Title: Grievance Policy and Procedure**Date Last Reviewed:**

Grievance Policy and Procedure

Purpose:

This policy and procedure is written to describe the procedure for any client within the Coordinated Entry system who has a complaint regarding their experience. The hope is to resolve any incongruities between policy and practice in order to create a better system experience for all involved.

Policy:

Every CoC agency involved in Coordinated Entry is expected to act in accordance to the Coordinated Entry Policies in the Coordinated Entry Manual. Furthermore, each client within the system shall be treated with dignity and respect throughout the process. The Coordinated Entry system will respond quickly to resolve any client grievances in order to enrich the system through the procedure identified below.

Procedure:

- 1) All clients will receive an explanation of their rights, this grievance policy, and the grievance submission form on admission to a program verbally and in written form in a language that they understand.
- 2) Whenever possible, every effort must be made to resolve concerns directly with the party involved, via discussion, compromise and clarification of possible misunderstandings.
- 3) All CoC partner agencies are expected to provide clients with procedures for addressing grievances. When conflict resolution does not produce desired results or is not possible, clients will be directed to follow the agency's specific grievance procedures of the agency.
- 4) If there is no resolution found through the grievance procedure of the agency directly involved, the client may submit a complaint or concern to the Coordinated Entry Program Coordinator via telephone (414-256-4808). If needed, a case manager or street outreach worker will assist the client in making the complaint or concern known.
- 5) The Coordinated Entry Program Coordinator will respond to the client within 3 business days of the telephone contact to attempt to resolve the issue. The resolution will be documented and held with IMPACT, Inc., the agency that houses the Coordinated Entry Program Coordinator.
- 6) If there is no resolution through this process, the grievance will be forwarded by the Coordinated Entry Program Coordinator to the Coordinated Entry Client Rights Specialist.
 - a. The Coordinated Entry Client Rights Specialist is a voting member of the Coordinated Entry Leadership team designated by a majority vote of Coordinated Entry Leadership every January.
- 7) The Client Rights Specialist has 3 business days to respond to the client to attempt to resolve the complaint or concern. As needed s/he will bring the grievance forward to the Coordinated Entry Leadership team for feedback and decision-making.

- 8) If there is still no resolution, the client has the option to have a hearing with the Grievance Hearing sub-committee comprised of a CoC Board member, a case manager or street outreach worker, the Lead Agency, and a peer. This hearing will occur as soon as practicably possible for all sub-committee members involved after the client requests this step. Any action recommended at this hearing will be communicated to the client within one week of this meeting. This decision – via a majority vote – is final.

Client rights relating to grievance procedures:

- 1) Any grievance will remain confidential, shared only between client and necessary staff and documented in client files.
- 2) All agencies involved in Coordinated Entry will cooperate fully and offer assistance to clients in understanding and asserting their rights and issuing a grievance or complaint.
- 3) All clients may ask for representation or assistance with following the steps in the procedure.
- 4) Representation of clients may come from agency or partner agency staff or an outside resource, depending on the client's preference. Outside representation can be sought by the client independently or with staff assistance and will target community and public service entities as resources.
- 5) No person will receive punitive treatment as a result of filing a grievance.

Coordinated Entry Policy

Orig. Issue Date: 06/12/2017

Program: Coordinated Entry

No. 01

Title: Marketing of Coordinated Entry Process**Date Last Reviewed:**

Marketing of Coordinated Entry Process

PURPOSE: It is of utmost importance that community members be well-informed of the Coordinated Entry process as it is the entry point for all who are experiencing homelessness. This policy outlines how communication regarding Coordinated Entry will be disseminated.

PROCEDURES:

- The Coordinated Entry provider agency (IMPACT) is responsible for creating messaging regarding Coordinated Entry.
- Any messaging should be approved by Coordinated Entry Leadership.
- At minimum, the following will be created and then reviewed and updated as needed on an annual basis:
 - Posters/flyers with basic information for accessing Coordinated Entry that are available to any agency in the Milwaukee community
 - A handout with basic information for accessing Coordinated Entry that is available for agencies to pass out to individuals in the Milwaukee community
 - A “Coordinated Entry in a Nutshell” bullet-pointed list of talking points for partner agencies to use
 - A basic PowerPoint presentation regarding Coordinated Entry that the Coordinated Entry Program Coordinator or appropriate designee can use to present and answer questions at community agencies and programs
 - A webpage dedicated to Coordinated Entry information
- While materials and presentation requests are available to everyone, there will be a concerted effort to give updated information to key stakeholders and partners annually to ensure accurate information community-wide. Examples of these groups include, but are not limited to:
 - Homeless services providers
 - County agencies (Behavioral Health Division, Division of Disability Services, etc.)
 - Aging and Disability Resource Centers
 - Libraries
 - Public transportation
 - Faith-based groups, especially those with a focused homeless outreach
 - Volunteer groups with a focus on homeless outreach
 - Veteran-serving organizations
 - Youth-serving organizations
 - Schools
 - Hospitals
- In the event of a media request, IMPACT will work with the CoC Lead Agency to craft a response that is consistent with the messaging voiced in the Coordinated Entry materials.
- It is encouraged that Coordinated Entry Leadership create a communications plan annually that includes press releases, outreach to different media groups, and social media as appropriate to further promote a community-wide message regarding Coordinated Entry

Forms Used

Homeless History Tracking Form

In order to best document the homeless/housing interview completed with a client, the following form was created. This document, along with letters for 3rd- party verifications /self-certification, are submitted with the housing referral.

Milwaukee CoC Coordinated Entry Homeless History Tracking Form

This form is meant to comprehensively present a client's homeless history going back 3 years from the effective date and to further establish current and needed documentation for verifying chronic homeless status.

Client Name: _____
 WISP ID: _____
 Interviewing Staff: _____
 Date of Interview: _____

Date Uploaded Into WISP: _____

# Episodes:	
# Total Reported Months:	
# Documented Months:	
# Months requiring documentation ¹ :	

Record Type	Start Date	End Date	New Countable Months ²	Whereabouts (Description)	Documentation Source (obtained or anticipated)	Documentation Obtained?	Documentation Notes ³
<input type="checkbox"/> Homeless Break <input type="checkbox"/> NHNB ⁴		Current			<input type="checkbox"/> HMIS ES / SH record <input type="checkbox"/> HMIS Outreach record <input type="checkbox"/> 3 rd Party Letter <input type="checkbox"/> Self-Certification <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> Pending <input type="checkbox"/> N/A – break <input type="checkbox"/> N/A – month ready counted alr	
<input type="checkbox"/> Homeless Break <input type="checkbox"/> NHNB					<input type="checkbox"/> HMIS ES / SH record <input type="checkbox"/> HMIS Outreach record <input type="checkbox"/> 3 rd Party Letter <input type="checkbox"/> Self-Certification <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> Pending <input type="checkbox"/> N/A – break <input type="checkbox"/> N/A – month ready counted alr	
<input type="checkbox"/> Homeless Break <input type="checkbox"/> NHNB					<input type="checkbox"/> HMIS ES / SH record <input type="checkbox"/> HMIS Outreach record <input type="checkbox"/> 3 rd Party Letter <input type="checkbox"/> Self-Certification <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> Pending <input type="checkbox"/> N/A – break <input type="checkbox"/> N/A – month ready counted	

Homeless Self-Certification Form

Milwaukee Continuum of Care

HOMELESS SELF-CERTIFICATION – DUE DILIGENCE

Applicant Printed Name: _____

All pages in the Homeless Self-Certification-Due Diligence document must be fully completed in order to be reviewed by the Milwaukee Continuum of Care supportive housing program. Self-certification is only considered valid under exceptional circumstances, in which all potential sources of third party certification have been considered and ruled out. Completion of the due diligence form certifies that the Coordinated Entry liaison completed due diligence to obtain third party homeless certification for the above named individual or household, who experienced literal homelessness during the specified time frame on page 7.

Due Diligence Procedure:

Step 1) Determine if applicant has any records of homelessness covering the entire date range above in HMIS. If there are records of homelessness in HMIS **STOP, and attach time-stamped HMIS record of any outreach contacts, entry/exits into emergency shelter, and file attachments in HMIS indicating episodes of homelessness into the Coordinated Entry packet.** Time-stamped records can be obtained by print screen(s) of HMIS record(s) being copied and pasted into a blank document, as the print screen will indicate the date an HMIS record was obtained in the lower right-hand corner.

Step 2) If no record of homelessness for the above timeframe exists in HMIS, indicate information obtained regarding applicant’s homeless history through the following interview report, documenting interviews with the client on a minimum of 3 different dates from pages 1 to 3.

Step 3) The three interviews should provide the Coordinated Entry Liaison with at least three potential sources of third party homeless certification. The Coordinated Entry Liaison must record contact and follow up contacts with potential sources on pages 4 to 5.

Step 4) If the interviews and contacts do not lead to acquiring third party homeless certification, the Coordinated Entry Liaison should complete the narrative on page 6 explaining why the applicant’s self-certification is necessary to complete a record of chronic homelessness. The narrative must document how the applicant meets HUD’s criteria for applicability of self-certification, explaining how the applicant’s case is (1) rare, (2) extreme, (3) a severe living situation. Completion of steps 1 through 4 permits the Coordinated Entry Liaison to complete the Homeless Self-Certification Applicant Living Situation section on pages 6 and 7.

Step 5) The Coordinated Entry Liaison must upload the completed 7 or 8 page packet into client’s HMIS record as an attachment. Page 8 is only applicable for applications self-certifying an emergency shelter, drop in Center, or Safe Haven stay, and/or if additional comments are submitted.

Date of Applicant Interview (1 of 3): ___/___/_____

Homeless history information for self-certification period, reported by applicant on the above interview date:

Milwaukee Continuum of Care

HOMELESS SELF-CERTIFICATION – DUE DILIGENCE

Applicant Printed Name: _____

Date of Applicant Interview (2 of 3): ___/___/_____

Homeless history information for self-certification period, reported by applicant on the above interview date:

**Milwaukee Continuum of Care
HOMELESS SELF-CERTIFICATION – DUE DILIGENCE**

Applicant Printed Name: _____

Date of Applicant Interview (3 of 3): ___/___/_____

Homeless history information for self-certification period, reported by applicant on the above interview date:

**Milwaukee Continuum of Care
HOMELESS SELF-CERTIFICATION – DUE DILIGENCE**

Applicant Printed Name: _____

Please provide information below regarding contacts made to obtain third party homeless history record from a minimum of three potential sources. Sources of homeless history can include local businesses, police departments, day shelters, social service organizations, faith-based organizations, private street outreach groups, and meal sites that the client is in regular contact with. If there is no response from the third party, or no document submitted to the liaison from the third party after a reasonable waiting period for response, follow up contacts should be made to the third party that could provide third party homeless certification on 2 additional occasions. Third party homeless certification should be added to the Coordinated Entry packet along with this completed document.

Third Party Contact (1 of 3)

1) Date of Contact with Third Party: ___/___/___

Type of Contact (phone call, faxed release, voicemail, e-mail, etc.): _____

Name of Third Party Contact Person or Name of Organization Contacted: _____

Date third party homeless certification record received by liaison, if applicable: ___/___/___

2) Date of Follow up Contact with Third Party: ___/___/___

Type of Contact (phone call, faxed release, voicemail, e-mail, etc.): _____

Name of Third Party Contact Person or Name of Organization Contacted: _____

Date third party homeless certification record received by liaison, if applicable: ___/___/___

3) Date of 2nd Follow up Contact with Third Party: ___/___/___

Type of Contact (phone call, faxed release, voicemail, e-mail, etc.): _____

Name of Third Party Contact Person or Name of Organization Contacted: _____

Date third party homeless certification record received by liaison, if applicable: ___/___/___

**Milwaukee Continuum of Care
HOMELESS SELF-CERTIFICATION – DUE DILIGENCE**

Applicant Printed Name: _____

Third Party Contact (2 of 3)

1) Date of Contact with Third Party: ___/___/____

Type of Contact (phone call, faxed release, voicemail, e-mail, etc.): _____

Name of Third Party Contact Person or Name of Organization Contacted: _____

Date third party homeless certification record received by liaison, if applicable: ___/___/____

2) Date of 1st Follow up Contact with Third Party: ___/___/____

Type of Contact (phone call, faxed release, voicemail, e-mail, etc.): _____

Name of Third Party Contact Person or Name of Organization Contacted: _____

Date third party homeless certification record received by liaison, if applicable: ___/___/____

3) Date of 2nd Follow up Contact with Third Party: ___/___/____

Type of Contact (phone call, faxed release, voicemail, e-mail, etc.): _____

Name of Third Party Contact Person or Name of Organization Contacted: _____

Date third party homeless certification record received by liaison, if applicable: ___/___/____

Third Party Contact (3 of 3)

1) Date of Contact with Third Party: ___/___/____

Type of Contact (phone call, faxed release, voicemail, e-mail, etc.): _____

Name of Third Party Contact Person or Name of Organization Contacted: _____

Date third party homeless certification record received by liaison, if applicable: ___/___/____

2) Date of 1st Follow up Contact with Third Party: ___/___/____

Type of Contact (phone call, faxed release, voicemail, e-mail, etc.): _____

Name of Third Party Contact Person or Name of Organization Contacted: _____

Date third party homeless certification record received by liaison, if applicable: ___/___/____

3) Date of 2nd Follow up Contact with Third Party: ___/___/____

Type of Contact (phone call, faxed release, voicemail, e-mail, etc.): _____

Name of Third Party Contact Person or Name of Organization Contacted: _____

Date third party homeless certification record received by liaison, if applicable: ___/___/____

**Milwaukee Continuum of Care
HOMELESS SELF-CERTIFICATION – APPLICANT LIVING SITUATION**

Applicant Printed Name: _____

Applicant Signature: _____ Date: _____

Dates of homelessness self-certified from ___/___/_____ to ___/___/_____

Household without dependent children (complete one form for each adult in the household)

Household with dependent children (complete one form for household)

Total number of persons in the household: _____

List household members currently living with adult head of household in the following table:

Name of Household Member	Age of Household Member	Relationship to Head of Household

Authorized agencies must be recognized by Milwaukee Continuum of Care (CoC) as an agency that has a program designed to serve as liaison to Coordinated Entry for persons living in emergency shelter, on the street, or other places not meant for human habitation.

This is to certify that the above named individual or household experienced literal homelessness during the time frame based on the check mark, other indicated information, and signature indicating self-report of homeless history.

Check only one box indicating living situation and complete only that section on this page or page 8

Living Situation: Place not meant for human habitation (e.g., cars, parks, abandoned buildings, streets/sidewalks)

The person(s) named above is/are, or was/were living in (or, if currently in hospital or other institution, was living in immediately prior to hospital/institution admission) a public or private place not designed for, or ordinarily used as a regular sleeping accommodation for human beings, including but not limited to a car, park, abandoned building, bus station, airport, or camp ground.
Full description of current or past living situation:

Authorized Agency Representative Printed Name: _____ Date: _____

Authorized Agency Representative Signature: _____ Date: _____

Milwaukee Continuum of Care

Release of Information

RELEASE OF CONFIDENTIAL INFORMATION TO SECURE NECESSARY SERVICES

The Coordinated Entry Program is part of a network of services through the Milwaukee Continuum of Care with the purpose of working with you to solve your housing situation. By signing this release, you agree that IMPACT, Inc. may freely exchange information with other providers within the Continuum (including shelters, housing, prevention, outreach, transitional, and permanent housing programs) about your family makeup, history, medical/mental health/substance abuse information and the results of your criminal background check in order to provide you with the appropriate referrals and coordination of services. You also understand that you may request to know what information was shared.

Part of the Coordinated Entry System includes a housing staffing where information about your particular situation, including your needs and desires as they relate to housing, will be discussed for the purpose of finding the best fit for you. All agencies involved will abide by a strict confidentiality policy meaning that they will not discuss you or your information outside of the staffing, except for the purposes related to housing.

The agencies involved in the Coordinated Entry System are:

The Milwaukee Continuum of Care, Milwaukee County Housing Division, Milwaukee County Behavioral Health Division, Guest House, Cathedral Center, Salvation Army, Hope House, Community Advocates, Mercy Housing, Friends of Housing, Heartland Alliance, SET Ministries, Pathfinders, Walker’s Point, La Causa, United Way of Greater Milwaukee and Waukesha Counties, Institute for Community Alliances, IMPACT, Inc., Center for Veterans Issues, Whole Health Clinic Group, and Cardinal Capital.

Please note if you grant permission for your information to be shared, that agreement will be in effect for the duration of your participation in the program unless you revoke it in writing. You may end your agreement in writing and your personal and service information will no longer be shared from that date going forward. If you do not give permission for this agency to release your information, no other agency in the network will have access to it.

Maintaining the privacy and the safety of those using our services is very important. Your record will only be shared if you give permission. You cannot be denied services that you would otherwise qualify for if you choose not to share information. However, even if you choose not to share your information with other agencies, federal and state regulations may require limited data collection for funding purposes. If you have questions or to revoke this release, contact the Coordinated Entry Program Coordinator at 414-256-4808.

I have read the above, or it has been read and explained to me. I have asked any questions I have and understand the implications of signing below. I understand that this release is in addition to the HMIS release of information. I agree to release my information to the Coordinated Entry System for the purposes of solving my housing situation.

(optional) Furthermore, I authorize that my information be released to and from with the following agencies, not mentioned above:

Client Signature

Date

Witness

Date

Single Permanent Supportive Housing Application



MILWAUKEE

Continuum of Care

COORDINATED ENTRY

SUPPORTIVE HOUSING REFERRAL

REFERRED FOR: Permanent Supportive Housing Rapid Rehousing

CE Approved Referral to (provider):

PLEASE PRINT

Date of Referral _____

Applicant Name

Last

First

Middle Initial

Current Location _____ Telephone _____

Social Security #. _____ Date of Birth: _____

Additional Household Members (Adult and/or Children). Attach an additional sheet if more space is needed.

<u>Name</u>	<u>Age</u>	<u>Relationship to Applicant</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Homeless Status Detail: Provide a brief description of applicant's homelessness, current including location and start date. Attach required documentation.

Chronic Homeless Status: Has the applicant resided on the street, in an emergency shelter, and/or safe haven for at least 12 months:

Continuously for the last 12 months? Yes No / On at least 4 separate occasions in the last 3 years? Yes No Attach documentation of all homeless episodes and a Homeless History Tracking form.

Disabling Condition: Has the applicant been diagnosed with one 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 / chronic physical illness or disability? Yes No

Specify Disabling Condition(s)

Has condition been verified by a Licensed Medical Physician, Psychiatrist, Psychologist, APNP, PA, LCSW or LPC? Yes No Attach completed Medical Statement

Gender: Female Male

- Transgender female-male
- Transgender male-female
- Does not identify as female, male or transgender

Race: American Indian or Alaska Native

- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Other: _____
- Secondary Race (if any) _____

Ethnicity: Hispanic/Latino Non-Hispanic/Non-Latino

U.S. Military Veteran? Yes No

If yes..... Does veteran have DD Form 214? Yes No

Does veteran receive veteran's benefits? Yes No

Domestic Violence Victim/Survivor? Yes No

If yes, when..... within last 3 months 3-6 mos. ago

6-12 mos. ago more than 1 year

If yes, is applicant currently fleeing? Yes No

Formerly Ward of Child Welfare/Foster System Agency?

Yes No Age left Foster Care System? _____

Pregnant? Yes No Due Date? _____

Zip Code of Last Permanent Address?

CHRONIC HOMELESS DETERMINATION:

Date current homeless episode began:

Number of times staying on the street, in shelter or safe haven in the last 3 years? _____

Number of months staying on the street, in shelter or safe haven in the last 3 years? _____

- Mental Health _____ Yes No
- Physical _____ Yes No
- HIV / AIDS _____ Yes No
- Other _____

Current Location:

- Place not meant for human habitation
- Emergency shelter Safe Haven Interim Housing
- Foster care home/group home
- Hospital / other non-psychiatric medical facility
- Jail, prison, juvenile detention facility
- Psychiatric hospital or other psychiatric facility
- Substance abuse treatment facility or detox facility
- Permanent Housing for Formerly Homeless
- Transitional housing for homeless persons
- Living with relatives Living with friends
- Rental with no subsidy Rental other subsidy

No Disability

Co-occurring disorders? Yes No

Disability Determination? Yes No

Other:

Length of Stay in Current Location?

- 1 night or less 2-6 nights
- 1 week or more; less than 1 month 1 month or more; less than 90 days
- 90 days or more; less than 1 year
- 1 year or more
- Doesn't know Refused

DISABILITIES INFORMATION

Primary Disability: Receiving Start Date
 Treatment

- Alcohol Abuse _____ Yes No
- Both Alcohol & Drug Abuse _____ Yes No
- Chronic Health Condition _____ Yes No
- Developmental _____ Yes No
- Drug Abuse _____ Yes No

Type of Health Insurance:

- Medicaid
- Medicare
- State Children’s Health Insurance program
- VA Medical Services
- Employer– Provided Health Insurance
- Health Insurance through COBRA
- Private Pay Health Insurance
- State Health Insurance for Adults
- Indian Health Services Program
- Other: _____
- None

NON-CASH BENEFIT INFORMATION

Non-Cash Benefit from any source Yes No

Type of Non-Case Benefit:

- Supplemental Nutrition Assistance Program (Food Stamps)
- Special Supplemental Nutrition Program for WIC
- TANF Child Care Services
- TANF Transportation Services
- Other TANF Funded Services
- Sec. 8, Public Housing, or ~~oth~~ ongoing rent assistance
- Temporary rent assistance
- Other: _____
- None

Applicant Name: _____

MONTHLY INCOME INFORMATION

Income from any source Yes No

Average Monthly Income \$ _____

<u>Type of Income</u>	<u>Monthly Amount</u>
<input type="checkbox"/> Alimony or Other Spousal Support	\$ _____
<input type="checkbox"/> Child Support	\$ _____
<input type="checkbox"/> Earned Income	\$ _____
<input type="checkbox"/> Pension or Retirement from job	\$ _____
<input type="checkbox"/> Private Disability Insurance	\$ _____
<input type="checkbox"/> Retirement Income from Social Security	\$ _____
<input type="checkbox"/> SSDI	\$ _____
<input type="checkbox"/> SSI	\$ _____
<input type="checkbox"/> TANF	\$ _____

<u>Type of Income</u>	<u>Monthly Amount</u>
<input type="checkbox"/> Unemployment Insurance	\$ _____
<input type="checkbox"/> VA NonService Connected Disability Pension	\$ _____
<input type="checkbox"/> VA Service Connected Disability Compensation	\$ _____
<input type="checkbox"/> Worker’s Compensation	\$ _____
<input type="checkbox"/> Other _____	\$ _____
<input type="checkbox"/> _____	\$ _____
<input type="checkbox"/> _____	\$ _____
<input type="checkbox"/> No Financial Resources	

SUPPORTIVE SERVICES / CASE MANAGEMENT

Assigned Case Manager: _____ Agency

Phone: _____ Email: _____

Housing Provider Use Only

COORDINATED ENTRY SUPPORTIVE HOUSING REFERRAL CHECKLIST

APPLICANT NAME:

HOMELESS STATUS: Not Chronic

Chronic: 1 year continuously or at least 4 episodes in the last 3 years; at least 12 months

HOMELESS EPISODES: List all of the applicant’s homeless episodes in the past 3 years. List episodes in chronological order starting with the most recent. Each episode must have corresponding documentation attached to the referral.

Start Date	End Date	Describe Location	Documentation Source	Attached?
				<input type="checkbox"/> Yes
				<input type="checkbox"/> Yes
				<input type="checkbox"/> Yes
				<input type="checkbox"/> Yes
				<input type="checkbox"/> Yes
				<input type="checkbox"/> Yes
				<input type="checkbox"/> Yes
				<input type="checkbox"/> Yes

ATTACHMENTS

Coordinated Entry Homeless History Tracking Form & Supporting Documentation

Disabling Condition? No Yes If yes, Medical Statement

If yes, Disability Documentation: Written statement from eligible professional / SSA Disability Benefit Letter

The following documents are not required at submission of referral to Coordinated Entry, but may be required by housing provider for final approval.

Birth Certificate or Documentation of application for a birth certificate

Immigration Status: If applicant was born outside of the United States (or outlying territories or US possessions), documentation of eligible Immigration status is required for referrals to Milwaukee County

One of the following forms is required to verify immigration status: N560 N561 N550 N570

Social Security Card Picture ID

Referral prepared by: _____

Date:

Reviewed by: _____

Date

Client Grievance Form

GRIEVANCE SUBMISSION FORM

If you feel your right have not been upheld, first follow the grievance policy of the agency you work with. If that doesn't resolve the issue, you may make a grievance to Coordinated Entry. You can file a grievance by filling out this form or walking into our Resource Center at 1918 N 6th Street, Monday-Friday, from 8am-noon. You can turn this form in by emailing it to ekenney@impactinc.org or faxing it to Attn: Emily Kenney at 414-302-1021. You can also turn it in at the Resource Center.

Grievant/Client Information

Name _____ Date _____ WISP ID# _____

Phone (____) ____-____ Where is it easiest to find you during the day? _____

Date, Time, and Place of Occurrence

Details of Occurrence (identify people involved if possible)

Proposed Resolution

By signing, you indicate you have read and understand the CoC Grievance Policy and Procedure.

This form will be kept with IMPACT, Inc., the agency that houses the Coordinated Entry Program Coordinator. Any grievance will remain confidential, shared only between client and necessary staff. You should expect a response within 3 business days of receipt of this form.

Client name (print) _____

(sign) _____ Date _____

Received by (print) _____

(sign) _____ Date _____

Related ServicePoint Documents

MILWAUKEE CoC COORDINATED ENTRY HMIS GUIDE

Prepared for the Milwaukee CoC by the Institute for Community Alliances

Table of Contents

If you wish to access a particular section directly from the table of contents you can do so by holding down the Ctrl key and clicking on the heading of the section you wish to review.

Milwaukee CoC Coordinated Entry HMIS Guide	77
Table of Contents	77
Purpose of Guide	78
Coordinated Entry Intake	78
Establishing Homeless History	79
Coordinated Entry Assessment	79
1. The Interview Fields	80
2. The Vulnerability Assessment	81
3. The Chronic Homeless Determination Information questions	82
4. Documentation Uploads and Tracking Fields	83
Housing Prioritization List Referral	85
Coordinated Entry Follow-Up	90
Updating Veteran Eligibility and Referral Status	90
Updating the Chronic Homeless Information Questions	91
Uploading and Noting further Documentation	92
The CE Follow-up Sub-assessment	93
Coordinated Entry Placement/Discharge	94
Closing a client's Housing Prioritization List referral	94
Appendix A –Homeless History Tracking Form	99
Appendix B – Homeless Self-Certification – Due Diligence	103

Purpose of Guide

This guide lays out the Wisconsin Service Point (WISP) HMIS workflow for the Milwaukee CoC Coordinated Entry (CE) system. It does so from the point of view of providers of homeless services and divides the workflow into three distinct stages: Intake, Update, and Placement/Discharge.

WISP is the primary recordkeeping, data sharing, and auditing tool for the Coordinated Entry system, and adherence to the protocols outlined herein is critical for the appropriate identification, prioritization, and housing placement of persons experiencing homelessness in Milwaukee County.

It is also recommended that Emergency Shelter, Street Outreach, Safe Haven, and CE-specific staff review the [How to Document Length of Time Homeless Guide](#) referenced throughout this guide for more information regarding HUD's definition of Chronic Homelessness, the Chronic Homeless Determination Information (3.917) questions, conducting a Homeless History interview, and uploading relevant 3rd-Party or Self-Reported homeless verification documentation.

For more information on the roles of CE-specific staff and the data auditing process, see the companion guide: *IMPACT Coordinated Entry Staff HMIS Guide*. For more information on the Coordinated Entry system as a whole, see the *Milwaukee CoC Coordinated Entry Policies & Procedures Manual*.

Coordinated Entry Intake

Coordinated Entry Intake has three components that must *ALL* be completed for successful identification and prioritization. Per the Milwaukee CoC Coordinated Entry Policies & Procedures Manual, Intake must be completed within 7 days of Entry for Emergency Shelters and Safe Havens and as soon as possible for Street Outreach programs. Ideally, all components would be completed in the order that they appear in this guide; however, it is possible that some steps may be completed prior to others.¹

With the exception of the referral to the Housing Prioritization List and document upload, data entry at this stage occurs entirely within a client's Entry record and should reflect a client's situation at their point of entry into your program.

¹ For example: If a client either is incapable or refuses to cooperate in the construction of a Homeless History, staff can refer a client to the Housing Prioritization List to ensure that they are tracked and request additional support from CE Staff.

Establishing Homeless History

Per HUD prioritization guidelines, the Milwaukee CoC prioritizes clients for housing first by Chronic Homeless status and second by total length of time homeless in the past three years. For this reason, the CE System utilizes a standard documentation tool—the Homeless History Tracking Form (HHTF hereafter, see [Appendix A](#))—and accompanying interviewing procedure to establish a homeless history that conforms to the [HUD Final Rule on Chronic Homelessness](#). Additionally, this process also ensures that both client self-reported homelessness and documented homelessness are taken into account, and the HHTF can be used to guide documentation-gathering efforts.

The steps are detailed in brief below; however, more detailed instructions are found on the [How to Document Length of Time Homeless Guide](#).

- 1) Prior to interviewing a client, staff should review a client’s Service Point record to begin to complete the Homeless History Tracking Form (HHTF).
 - a. All days over a 3-year period must be accounted, and staff should leave a gap of at least one line per unaccounted month (or period within one month greater than 7 days).
 - b. Acceptable forms of documentation of homelessness include Shelter Stay records, Safe Haven Entry/Exits, Outreach Contacts, and 3rd-party verification letters.
 - c. Entry/Exit records for Transitional Housing, Rapid Re-housing and Permanent Supportive Housing (if actually housed) can also be used to establish HUD-defined breaks in homelessness.
- 2) Using the partial HHTF as a starting point, interview the client to fill in the gaps in their Homeless History.
- 3) Once completed, calculate the total number of reported episodes and months homeless, documented months homeless, and required documentation for chronic status if the total number of reported months/episodes suggests that a client may meet the Chronic Homeless definition.
- 4) Upload the completed HHTF onto the CE Assessment using the Documentation process detailed below.

Coordinated Entry Assessment

The Coordinated Entry Assessment is the central HMIS hub for the Coordinated Entry system. It is used as a tool for coordinated case management beginning at the point of initial intake and continues to serve as the repository for all relevant client information until the point a client is housed.

For the purpose of Intake, the Coordinated Entry (CE) Assessment can clicking the corresponding “tile” in the Assessments section of the Entry:

Entry Assessment

Select an Assessment

Milwaukee City-County CoC

VI-SPDAT 2.0

Coordinated Entry Assessment - Milwaukee CoC

WI UDE Entry Assessment SO ES SH

The CE Assessment has 4 sub-components that comprise the bulk of Intake data entry:

1. The Interview Fields

The Interview Fields are the collection of fields at the top of the CE Assessment that include the following:

- A) Information about the staff conducting CE intake and confirmation that the client has signed the CE release of information:

Coordinated Entry Assessment - Milwaukee CoC

Complete this assessment for singles or the head of household, then make a referral to the appropriate CoC housing priority list.

Interviewer's Information

Interviewer's Name	Nancy G
Agency's Full Name	ICA G
Today's Date (date of interview)	07 / 30 / 2017 🔄 🗑️ G

Client ROI Signed

Has the client consented to participate?	Yes G
--	--

- B) Client demographics, household size, contact information², and pertinent “special considerations” that would affect housing placement:

² NOTE: Can be Street Outreach worker or Case Manager as well.

Client Demographic Information

Enter the client's First Name, Last Name, Alias or Street Name, SSN, Date of Birth and Veteran Status on the Client Profile Tab

Gender	Female
Number in Household	3
Primary Language Spoken	English

Client Contact Information

On a regular day, where is it easiest to find you and what time of day is easiest to do so?	10th & St. Paul
Is there a phone number and/or email where someone can get in touch with you or leave you a message?	Nancy.esteves@jhsvkjdbv

Special Housing Considerations	wheelchair accessible service animal Southside location
---------------------------------------	---

- C) Veteran status information—meant to track eligibility, referral, and documentation status for client’s identified as Veterans:

Veteran Information (answer for Veterans only):

Is Veteran eligible for VA medical services?	Yes
Is Veteran Eligible for VASH?	No (HUD)
Date of VASH Referral	/ /
Is Veteran eligible for SSVF services?	Yes (HUD)
Date of SSVF Referral	12 / 01 / 2017
Is Veteran refusing federal VA services?	Yes (HUD)

Veteran Information		
DD 214 Form on File?	Year entered military service *	Year separated from military service
Yes	01/01/1990	12/31/2008
Showing 1-1 of 1		

2. The Vulnerability Assessment


The Vulnerability Assessment may actually be completed prior to the point of entry into the Coordinated Entry system for Permanent Housing through contact with 211. However, staff conducting CE Intake should always review existing Vulnerability Assessments with clients to ensure that they accurately reflect the client’s current situation. Scores from the Assessment are factored into the prioritization of clients on the Housing Prioritization List and expire after one year.

There are three versions of the Vulnerability Assessment, each for a different sub-population. Choose the one that best fits your client at the point of Assessment and create the assessment by clicking “Add” at the bottom of the appropriate table.

- ❖ **VI-SPDAT:** A single person 25 years old and over
- ❖ **VI-FSPDAT:** More than one person in a household that includes minor children.
- ❖ **TAY VI-SPDAT:** A single person 24 years old and under

Vulnerability Assessments

SINGLES

VI-SPDAT v2.0							
	Start Date *	PRE-SURVEY	A. HISTORY OF HOUSING AND HOMELESSNESS	B. RISKS	C. SOCIALIZATION & DAILY FUNCTIONS	D. WELLNESS	GRAND TOTAL
	11/01/2016	0	1	4	3	5	13
<input type="button" value="Add"/>		Showing 1-1 of 1					

NOTE: Existing assessments can be updated by clicking the pencil icon on the left of the record row.

3. The Chronic Homeless Determination Information questions

The Chronic Homeless Determination Information questions are a set of HUD-specified data fields in HMIS that reflect a client’s living situation prior to project entry and, by extension, identify clients that may be experiencing chronic homelessness in our community:

Chronic Homeless Determination Information

For this Section - Only include time on Street, in an Emergency Shelter, or Safe Haven

Residence Prior to Project Entry	Place not meant for habitation (HUD)
Length of Stay in Previous Place	One year or longer (HUD) G
Approximate date homelessness started:	11 / 01 / 2017    G
Regardless of where they stayed last night - Number of times the client has been on the Streets, in Emergency Shelter, or Safe Haven in the past three years including today	Four or more times (HUD) G
Total number of months homeless on the Street, in Emergency Shelter or Safe Haven in the past three years	More than 12 months (HUD) G
If more than 12 Months homeless on the street, in emergency shelter, or safe haven, Enter Total Number of Months in Past 3 Years	18 G

It is critical that staff understand the logic of each field. Refer to the [How to Document Length of Time Homeless Guide](#) for a more detailed breakdown.

NOTE: Data entered at intake must be corroborated by the Homeless History Tracking Form. If entered data does not correspond to the HHTF at the time of file review in the Coordinated Entry staffing process, CE staff are authorized to overwrite these fields with either the correct data per the HHTF or, if no HHTF is present, existing Service Point documentation. CE staff will notify the last point of contact of any changes made to allow for staff confirmation or appeal.

4. Documentation Uploads and Tracking Fields

All homelessness verification documentation, including the Homeless History Tracking Form, 3rd party verification letters, and the Self-Certification with Due Diligence Form (see [Appendix B](#)), must be uploaded into Service Point.



To upload documentation, staff must exit the Entry record and instead access the Coordinated Entry Assessment directly through the Assessments tab and must click the “binder clip” icon near the top right corner of the assessment:

Client Information | Service Transactions

Summary | Client Profile | Households | ROI | Entry / Exit | Case Managers | Case Plans | Measurements | Activities | **Assessments**

Select an Assessment

Coordinated Entry Assessment - Milwaukee CoC [Submit]





Coordinated Entry Assessment - Milwaukee CoC  

When a file is uploaded, a description must be added that follows a standard naming convention:

[Document Type_date range reported]

For example: *Client Self-Certification_3-1-2016 to 6-15-2016*




Following upload, any Service Point user can access documents either by clicking the “binder clip” icon on the Coordinated Entry Assessment or through the File Attachments sub-assessment, found

File Attachments								
		Date Added ▼	Name	Description	Type	Provider	Added From	
			10/12/2015	PHC-jeans.jpg	Homeless Verification Letter 1-1-2016 to 2-3-2016	jpg	Institute for Community Alliances - Wisconsin	Client Profile 
Add New File Attachment			Showing 1-1 of 1					

near the bottom of the Client Profile tab:

Finally, staff must complete the “Homelessness Verification Documents Attached” section:

Homelessness Verification Documents Attached

Homeless History Tracking Form	<input type="checkbox"/>	Yes	
All 3rd party documentation needed for chronic homeless determination	<input type="checkbox"/>	Yes	
Client Self-Certification of Homelessness w/ Due Diligence	<input type="checkbox"/>	Yes	
Explanation if documentation not attached	<input type="checkbox"/>	Autumn West has it	

NOTE: Housing Applications, disability documentation, and government issued identity documents

should NOT be uploaded into Service Point; however, document procurement should still be tracked using the “Documents on File” fields:

Documents on File (Do NOT Upload)

Income Verification	No	G
Disability Verification	No	G
Birth Certificate	No	G
Housing Application	Yes	G
Location of Documents	IMPACT has documents on file	

Housing Prioritization List Referral

Clients are prioritized for housing placements on the basis of their place on the Housing Prioritization List (HPL). To get on the HPL, a client must have a Referral created for the appropriate provider:



- Before creating a Referral, check to see if one already exists! Go to *Service Transactions* > Click on “Entire Service History” and then navigate to the Referrals tab.
 - ❖ Open Referrals will have a BLANK response under the Referral Outcome column with a Need Status of “Identified” and a Need Outcome of “Service Pending”:

Client Information | **Service Transactions**

Needs | Services | **Referrals** | Shelter Stays | Entire Service History


Previous Referrals

Select Dates: Start Date: End Date: More Search

	Need Date	Referred Date	Referred To	Referral Outcome	Need Type	Need Status	Need Outcome
 	11/01/2016	11/01/2016	Milwaukee CoC Housing Priority List - Families		Supportive Housing Placement/Referral	Identified	Service Pending

Add Referral Showing 1-1 of 1

- ❖ Closed Referrals will say either “Accepted,” “Cancelled,” or “Declined” and will have the Need Status “Closed”:

Client Information			Service Transactions				
Needs	Services	Referrals	Shelter Stays	Entire Service History			
Previous Referrals							
Select Dates		Start Date	End Date		More	Search	
-Select- v		/ /	/ /				
	Need Date	Referred Date	Referred To	Referral Outcome	Need Type	Need Status	Need Outcome
	11/01/2016	11/01/2016	Milwaukee CoC Housing Priority List - Families	Accepted	Supportive Housing Placement/Referral	Closed	Fully Met

- If the client has an OPEN Referral to the appropriate Housing Prioritization List (Single or Family), **no further action is needed.**
- If there is NO Referral or all Referrals are CLOSED, **a new Referral must be created following the steps below.** Do NOT edit already-closed Referrals.
- ADD NEEDS:** Select ONLY the Head of Household.

▼ Add Needs

▼ Household Members

~~To include Household members for this Service Transaction, click the box beside each name. Only members from the SAME Household may be selected.~~

- (202670) Couple with Child(ren)
- (651466) Testing, Totally
- (674177) Test, Just A
- (651472) Testing, Not Really

- NEEDS Assignment:** Regardless of housing intervention anticipated, “Supportive Housing Placement/Referral” will be the selected Service Code. Once you highlight the Service Code, hit **“Add Terms.”**

Needs Assignment

Service Code Quicklist

- Case/Care Management (PH-1000)
- Emergency Shelter (BH-1800)
- Family Permanent Supportive Housing (BH-8400.2000)
- Homeless Motel Vouchers (BH-1800.8500-300)
- Homeless Permanent Supportive Housing (BH-8400.3000)
- Rent Payment Assistance (BH-3800.7000)
- Supportive Housing Placement/Referral (BH-8500)**

6. **Referral Provider Quick list:** You will have the option to select either a Singles or Family Provider.

Singles: Provider = *Milwaukee CoC Housing Priority List – Singles OR Milwaukee CoC Housing Priority List – Youth Singles*

Referral Provider Quicklist

Provider: Milwaukee CoC Housing Priority List - Singles (10061)



Families: *Milwaukee CoC Housing Priority List – Families OR Milwaukee CoC Housing Priority List – Youth Families*

Referral Provider Quicklist

Provider: Milwaukee CoC Housing Priority List - Families (10063)

Once you have selected the provider from the dropdown box, hit **“Add Provider.”**




7. **Selected Providers:** If selected correctly, the provider will show up in this section.

Selected Providers					
	Provider ▲	Type	Phone	Location	Last Updated
	 Milwaukee CoC Housing Priority List - Families	Level 2	Unknown	Unknown	11/10/2016
Showing 1-1 of 1					

8. **Referral Data:** The Needs Referral Date MUST be the actual date you met with client to discuss housing with the understanding that they will be placed on a prioritization list. This date is typically the SAME date you complete the VI-SPDAT, VI-FSPDAT or the TAY VI-SPDAT and/or the Housing History Tracking Form.

Need Referral Date: Date of Referral
 Referral Ranking: Blank

Referral Data




Needs Referral Date *	11 / 01 / 2016    1 : 28 : 09 PM
Referral Ranking	-Select-

VI-SPDAT, VI-FSDAT or TAY VI-SPDAT Score: Hit Search button to pull in most recent VI score

VI-SPDAT Score	Please Select a VI-SPDAT Score	<input type="button" value="Search"/>	<input type="button" value="Clear"/>
TAY-VI-SPDAT Score	Please Select a VI-SPDAT Score	<input type="button" value="Search"/>	<input type="button" value="Clear"/>
VI-FSPDAT Score	Please Select a VI-FSPDAT Score	<input type="button" value="Search"/>	<input type="button" value="Clear"/>

Once you find the score, click on the green cross to pull in the score and associate with the referral.







Select VI-SPDAT Score

Household Members	VI-SPDAT v2.0	VI-SPDAT	TAY-VI-SPDAT v1.0																
<input checked="" type="checkbox"/> (651466) Testing, Totally Age: 51	<table border="1"> <thead> <tr> <th>Provider</th> <th>Start Date</th> <th>* PRE-SURVEY</th> <th>A. HISTORY OF HOUSING AND HOMELESSNESS</th> <th>B. RISKS</th> <th>C. SOCIALIZATION & DAILY FUNCTIONS</th> <th>D. WELLNESS</th> <th>GRAND TOTAL</th> </tr> </thead> <tbody> <tr> <td> Institute for Community Alliances - Wisconsin (2)</td> <td>11/01/2016</td> <td>0</td> <td>1</td> <td>4</td> <td>3</td> <td>5</td> <td>13</td> </tr> </tbody> </table>	Provider	Start Date	* PRE-SURVEY	A. HISTORY OF HOUSING AND HOMELESSNESS	B. RISKS	C. SOCIALIZATION & DAILY FUNCTIONS	D. WELLNESS	GRAND TOTAL	 Institute for Community Alliances - Wisconsin (2)	11/01/2016	0	1	4	3	5	13		
Provider	Start Date	* PRE-SURVEY	A. HISTORY OF HOUSING AND HOMELESSNESS	B. RISKS	C. SOCIALIZATION & DAILY FUNCTIONS	D. WELLNESS	GRAND TOTAL												
 Institute for Community Alliances - Wisconsin (2)	11/01/2016	0	1	4	3	5	13												

Showing 1-1 of 1

The actual Referral Data will look as follows:

Referral Data

Needs Referral Date *	11 / 01 / 2016    1 : 38 : 33 PM
Referral Ranking	-Select-
VI-SPDAT Score	13 Recorded using VI-SPDAT v2.0 on 11/01/2016 by Institute for Community Alliances - Wisconsin (2) <input type="button" value="Search"/> <input type="button" value="Clear"/>
VI-FSPDAT Score	Please Select a VI-FSPDAT Score <input type="button" value="Search"/> <input type="button" value="Clear"/>
Projected Follow Up Date	<input type="text"/> / <input type="text"/> / <input type="text"/>   
Follow Up User	Institute for Community Alliances - Wisconsin (2) <input type="button" value="Search"/> <input type="button" value="My Provider"/> <input type="button" value="Clear"/> -Select-

9. **Referrals:** Make sure the Head of Household is checked in the “Referrals” box.

Referrals		Send Summary
Referred-To Provider	Supportive Housing Placement/Referral	Referred Clients
Milwaukee CoC Housing Priority List - Families (10063)		(72036) Test, Test

10. **Date of Need:** Same as Referral Date

▼ **Need Data**

Date of Need * 11 / 01 / 2016 1 : 38 : 33 PM

11. **Need Status/Outcome:** The Need Status will always be **“Identified”** and the Outcome will be **“Service Pending.”**

▼ **Need Data**

Date of Need * 11 / 01 / 2016 12 : 00 : 00 PM

Selected Needs

Need	Amount if Financial	Need Status / Outcome / If Not Met, Reason	Notes
Supportive Housing Placement/Referral (BH-8500)		Identified Service Pending -Select-	

[Remove All Needs](#)

One completed hit **“Save ALL”**




12. Your client is now officially on the Housing Prioritization List.

Previous Referrals							
Select Dates	Start Date		End Date		More	Search	
-Select-	/	/	/	/			
Need Date	Referred Date	Referred To	Referral Outcome	Need Type	Need Status	Need Outcome	
11/01/2016	12/01/2016	Milwaukee CoC Housing Priority List - Families		Supportive Housing Placement/Referral	Identified	Service Pending	
Add Referral		Showing 1-1 of 1					

NOTE: If a client is added to Housing Prioritization List BEFORE a VI-SPDAT assessment is completed OR if an entirely NEW VI-SPDAT is completed following HPL Referral, it is the responsibility of the staff that completes the VI-SPDAT to attach the assessment to the existing referral:

1. Click the “Pencil” icon next to the Referral record in the Referrals tab under Service Transactions.
2. Scrolling down to the Referral Data section, search (again) for the New/Updated Assessment:

Referral Data [Send Summary](#)

Referred-To Provider	Milwaukee CoC Housing Priority List - Families (10063)		
Needs Referral Date *	12 / 18 / 2017	  	11 : 39 : 02 AM
Referral Ranking	-Select- ▾		
VI-SPDAT Score	Please Select a VI-SPDAT Score	<input type="button" value="Search"/>	<input type="button" value="Clear"/>
TAY-VI-SPDAT Score	Please Select a TAY-VI-SPDAT Score	<input type="button" value="Search"/>	<input type="button" value="Clear"/>
VI-FSPDAT Score	8 Recorded using VI-FSPDAT v2.0 on 01/13/2017 by IMPACT, Inc. (1237)		<input type="button" value="Search"/> <input type="button" value="Clear"/>

Once the selection has been made and the appropriate score appears, click “Save and Exit.”

Coordinated Entry Follow-Up

Following CE Intake, staff working with a client to obtain housing are responsible for updating the CE Assessment to reflect a client’s progress in the Coordinated Entry process. **For this purpose, the CE Assessment should ALWAYS be accessed through the Assessment tab and edited with back-date set to the effective date of the information entered:**

(651466) Testing, Totally Date: 12/01/2016 12:00:00 AM

Release of Information: Ends 10/01/2017 -Switch to Another Household Member- ▾

Client Information

Service Transactions

Summary

Client Profile

Households

ROI

Entry / Exit

Case Managers

Case Plans

Measurements

Activities

Assessments

Select an Assessment

Coordinated Entry Assessment - Milwaukee CoC ▾

NOTE: When in back-date mode, the ribbon near the top of your Service Point browser will turn yellow.

Updating Veteran Eligibility and Referral Status

The Milwaukee CoC Veterans Initiative has established a process of client eligibility verification with our local VA Medical Center and CVI Milwaukee’s SSVF program. ICA submits requests to the local HUD

VASH office for clients that appear on the Veterans Benchmarks report that have not already been screened for discharge status and VA-program eligibility.

Following eligibility screening, it is the responsibility of staff working with clients staffed at the Veterans Initiative Case Managers meeting to update the veteran-specific fields in the CE Assessment should they refer clients to Veteran-serving programs:

Veteran Information (answer for Veterans only):

Is Veteran eligible for VA medical services?	<input type="text" value="Yes"/>	G
Is Veteran Eligible for VASH?	<input type="text" value="No (HUD)"/>	G
Date of VASH Referral	<input type="text" value=""/> / <input type="text" value=""/> / <input type="text" value=""/>	G
Is Veteran eligible for SSVF services?	<input type="text" value="Yes (HUD)"/>	G
Date of SSVF Referral	<input type="text" value="12"/> / <input type="text" value="01"/> / <input type="text" value="2017"/>	G
Is Veteran refusing federal VA services?	<input type="text" value="Yes (HUD)"/>	G

Veteran Information		
DD 214 Form on File?	Year entered military service *	Year separated from military service
Yes	01/01/1990	12/31/2008
<input type="button" value="Add"/>		Showing 1-1 of 1

Updating the Chronic Homeless Information Questions

It is the responsibility of a client’s current case manager to update the Chronic Homeless Determination Information questions on the CE Assessment **on a monthly basis** in the following circumstances:

- A client is staying in a literally homeless situation (i.e., emergency Shelter, safe Haven, or place not meant for habitation) OR
- A client is currently staying in an institutional situation (e.g. hospital, detox, jail), has not stayed in that situation for more than 90 days, and was staying in a literally homeless situation immediately prior to entry into the institution.

Whereas information entered at CE Intake must reflect a client’s situation at their point of Entry into your program, **CE updates (beginning the first calendar month after intake) should reflect a client’s current living situation while in your program.**

For example, if a client entered Emergency Shelter on 9/05/2017 and reports three months of street homelessness during the Homeless History Interview, their original Chronic Homeless Determination

Information section would look like this:

Chronic Homeless Determination Information

For this Section - Only include time on Street, in an Emergency Shelter, or Safe Haven

Residence Prior to Project Entry	<input type="text" value="Place not meant for habitation (HUD)"/>
Length of Stay in Previous Place	<input type="text" value="90 days or more, but less than one year"/> G
Approximate date homelessness started:	<input type="text" value="06"/> / <input type="text" value="05"/> / <input type="text" value="2017"/> G
Regardless of where they stayed last night - Number of times the client has been on the Streets, in Emergency Shelter, or Safe Haven in the past three years including today	<input type="text" value="One time (HUD)"/> G
Total number of months homeless on the Street, in Emergency Shelter or Safe Haven in the past three years	<input type="text" value="4"/>
If more than 12 Months homeless on the street, in emergency shelter, or safe haven, Enter Total Number of Months in Past 3 Years	<input type="text" value=""/> G

However, after 1 month in Shelter, the case manager should update the fields to reflect the client’s current situation to look like this:

Chronic Homeless Determination Information

For this Section - Only include time on Street, in an Emergency Shelter, or Safe Haven

Residence Prior to Project Entry	<input type="text" value="Emergency shelter, including hotel or motel paid fo"/>
Length of Stay in Previous Place	<input type="text" value="One month or more, but less than 90 days"/> G
Approximate date homelessness started:	<input type="text" value="06"/> / <input type="text" value="05"/> / <input type="text" value="2017"/> G
Regardless of where they stayed last night - Number of times the client has been on the Streets, in Emergency Shelter, or Safe Haven in the past three years including today	<input type="text" value="One time (HUD)"/> G
Total number of months homeless on the Street, in Emergency Shelter or Safe Haven in the past three years	<input type="text" value="5"/>

Uploading and Noting further Documentation

Any homeless verification documentation procured after initial CE Intake should be uploaded into the client’s Service Point record through the CE Assessment:



As a reminder, any time documentation is procured (and uploaded), staff should update the appropriate documentation sections at the bottom of the CE Assessment:

Homelessness Verification Documents Attached

Homeless History Tracking Form	Yes	G
All 3rd party documentation needed for chronic homeless determination	Yes	G
Client Self-Certification of Homelessness w/ Due Diligence	Yes	G
Explanation if documentation not attached	Autumn West has it	

Documents on File (Do NOT Upload)

Income Verification	No	G
Disability Verification	No	G
Birth Certificate	No	G
Housing Application	Yes	G
Location of Documents	IMPACT has documents on file	

The CE Follow-up Sub-assessment

Near the bottom of the CE Assessment is the *Coordinated Entry Referral Follow Up* section:







Coordinated Entry Referral Follow Up

CE Staff Only:

Assigned to: Case Manager Name	<input type="text" value="James"/>
CE Status	<input type="text" value="-Select-"/>

Assigned Contact Person Only:

CE Referral Follow Up Information				
	Follow Up Date *	Date of Original Referral	Outcome of Follow Up *	Notes
 	07/06/2017	07/01/2017	Follow up completed, still needs housing, remains on list	Documented homeless history through Homeless History Tracking Form.
 	06/26/2017	06/01/2017	Unable to Contact Client	Attempted to contact by phone and through inreach at Rescue Mission.

Showing 1-2 of 2

Non-CE Staff should NOT edit the “CE Staff Only” fields; however, staff should create records in the CE Referral Follow Up Information sub-assessment to document client contact and provide more detailed information on client’s CE progress.

Coordinated Entry Placement/Discharge

Coordinated Entry Placement/Discharge requires the closure a client’s Housing Prioritization List referral. This should ONLY be done once a client has been actually housed.

- ❖ **If the client is housed by an HMIS-participating housing provider**, it is the responsibility of that housing provider to close the Housing Prioritization List referral. In this case the Referral Outcome is marked as “Accepted.”
- ❖ **If the client secures their own housing or is housed by a non-HMIS-participating housing provider**, it is the responsibility of the last provider working with the client prior to housing to close the Housing Prioritization List referral. In these cases, the Referral Outcome is marked as “Declined.”


In cases where a client requests to be removed from the Housing Prioritization List prior to housing or contact is lost for over 90 days, staff should notify coordinatedentry@impactinc.org. If confirmed, the Referral is closed by CE staff with the Referral Outcome “Cancelled.”

Closing a client’s Housing Prioritization List referral


1. Within the client’s Service Point record, go to Service Transactions > Entire Service History

Client Information | **Service Transactions**


Service Transaction Dashboard




Add Need




Add Service




Add Multiple Services



Add Referrals



View Shelter Stays



View Entire Service History

2. Then Click on the “Referrals” tab; click on the pencil next to the referral to the Prioritization List to edit.


Client Information | **Service Transactions**

Needs | Services | **Referrals** | Shelter Stays | Entire Service History

Previous Referrals

Select Dates Start Date End Date

-Select- [] / [] / [] [] / [] / [] More Search

	Need Date	Referred Date	Referred To	Referral Outcome	Need Type	Need Status	Need Outcome
	11/01/2016	11/01/2016	Milwaukee CoC Housing Priority List - Families		Supportive Housing Placement/Referral	Identified	Service Pending

3. Once inside the Referral record, scroll down to Referral Data section:

Referral Data

Referred-To Provider	Milwaukee CoC Housing Priority List - Families (10063)
Needs Referral Date *	11 / 01 / 2016 12 : 00 : 00 AM
Referral Ranking	-Select-
VI-SPDAT Score	Please Select a VI-SPDAT Score <input type="button" value="Search"/> <input type="button" value="Clear"/>
TAY-VI-SPDAT Score	Please Select a TAY-VI-SPDAT Score <input type="button" value="Search"/> <input type="button" value="Clear"/>
VI-FSPDAT Score	4 Recorded using VI-FSPDAT v2.0 on 07/01/2017 by Institute for Community Alliances - Wisconsin (2) <input type="button" value="S"/>
Referral Outcome	-Select-

4. Referral Outcome:

a. **Accepted** if placed in Housing

Referral Outcome	Accepted
------------------	----------

b. **Declined** -Client has other housing options and has declined assistance. **Reasons:**

- i. Client living with family/friends – permanent tenure
- ii. Client secured housing on their own
- iii. Client obtained Section 8 or site-based housing

Referral Outcome	Declined
If Canceled or Declined, Reason	Client obtained Section 8 or site-based housing

c. **Cancelled**—Used to denote administrative reasons for removal. **Reasons:**

- i. Unable to Contact Client [90+ days]
- ii. Client asked to be removed from list
- iii. Client declined housing offer³
- iv. Household Composition Change (Milwaukee CoC only)
- v. Death

Referral Outcome	Canceled
If Canceled or Declined, Reason	Unable to Contact Client

5. **Need Status:** ALWAYS *Closed*

6. **Outcome of Need:**

³ This only occurs with the permission of the CE Coordinator following 6 months of bi-weekly housing offers that have all been refused.

- a. *Fully Met* if Permanently Housed
- b. *Not Met* if NOT Permanently Housed. Choose appropriate **Reason**:
 - i. If Unable to Contact – “No Show”
 - ii. If entered Jail or Prison (expected duration >90 days) – “Ward of the Court”
 - iii. If Household composition changed and Referral needs to be recreated – “Other”
 - iv. If Deceased – “Physical Health”

Need Status *	Closed ▼
Outcome of Need	Fully Met ▼
If Need is Not Met, Reason	-Select- ▼


- 7. **If the Referral was ACCEPTED** (i.e., if the client was housed by an HMIS-participating provider), scroll down to Service Information section and click **“Provide Service”**:
- 8. The Service provided should be the same as the Need attached to the Referral: “Supportive Housing Placement/Referral.” The date should be the same as a client’s Housing Move-in date. Adding this service with that date reflects that a client has been successfully placed through C

Service Provider *	IMPACT, Inc. (1237)	Search	My Provider	Clear
Creating User	Zach Ehmann			
Start Date *	05 / 10 / 2017	23	12 ▼	: 00 ▼
End Date	05 / 10 / 2017	23	12 ▼	: 00 ▼
Service Type *	Make Service same as Need ←			Look Up
	Supportive Housing Placement/Referral (BH-8500) ▼			
Provider Specific Service	-Select- ▼			

ordinated Entry. Then click “Save and Continue.”

NOTE: Click the hypertext “Make Service same as Need to auto-populate the Need for the Service record.

- 9. FINAL STEP: Save & Exit. The Referral record should look similar to this:

Previous Referrals							
Select Dates		Start Date		End Date			
-Select-		/ /		/ /		More Search	
	Need Date	Referred Date	Referred To	Referral Outcome	Need Type	Need Status	Need Outcome
	11/01/2016	12/01/2016	Milwaukee CoC Housing Priority List - Families	Accepted	Supportive Housing Placement/Referral	Closed	Fully Met
Add Referral			Showing 1-1 of 1				

10. The client has now been removed from the Housing Prioritization List and is thereby discharged from CE through HMIS.

Appendix A –Homeless History Tracking Form

Date Uploaded
Into WISP:

# Episodes:	
# Total Reported Months:	
# Documented Months:	
# Months requiring documentation ⁷ :	

Record Type	Start Date	End Date	New Countable Months ⁴	Whereabouts (Description)	Documentation Source (obtained or anticipated)	Documentation Obtained?	Documentation Notes ⁵
<input type="checkbox"/> Homeless <input type="checkbox"/> Break <input type="checkbox"/> NHNB ⁶		Current			<input type="checkbox"/> HMIS ES / SH record <input type="checkbox"/> HMIS Outreach record <input type="checkbox"/> 3 rd Party Letter <input type="checkbox"/> Self-Certification <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> Pending <input type="checkbox"/> N/A – break <input type="checkbox"/> N/A – month already counted	
<input type="checkbox"/> Homeless <input type="checkbox"/> Break <input type="checkbox"/> NHNB					<input type="checkbox"/> HMIS ES / SH record <input type="checkbox"/> HMIS Outreach record <input type="checkbox"/> 3 rd Party Letter <input type="checkbox"/> Self-Certification <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> Pending <input type="checkbox"/> N/A – break <input type="checkbox"/> N/A – month already counted	
<input type="checkbox"/> Homeless <input type="checkbox"/> Break <input type="checkbox"/> NHNB					<input type="checkbox"/> HMIS ES / SH record <input type="checkbox"/> HMIS Outreach record <input type="checkbox"/> 3 rd Party Letter <input type="checkbox"/> Self-Certification <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> Pending <input type="checkbox"/> N/A – break <input type="checkbox"/> N/A – month already counted	

Client Name: _____

WISP ID: _____

⁴ If there is evidence of a break in homelessness within a month, days homeless must be counted instead of counting the entire month.

⁵ Consider including information such as the source or holder of documentation and anticipated reception date if pending.

⁶ “Not Homeless Not Break” – Refers to a short period (< 7 days for housed situations and < 90 days for institutional situations) that does NOT constitute a formal break in homelessness and may be included in a client’s length of time homeless IF they were homeless immediately prior to this period. This may also include a period of greater than 7 days **within an already-documented month** (i.e. only self-report is needed).

⁷ This number should account for the number of months that require documentation to prove chronic homelessness per the [HUD Final Rule definition](#).

Interviewing Staff: _____

Date of Interview: _____

Record Type	Start Date	End Date	New Countable Months	Whereabouts (Description)	Documentation Source (obtained or anticipated)	Documentation n Obtained?	Documentation Notes
<input type="checkbox"/> Homeless <input type="checkbox"/> Break <input type="checkbox"/> NHNB					<input type="checkbox"/> HMIS ES / SH record <input type="checkbox"/> HMIS Outreach record <input type="checkbox"/> 3 rd Party Letter <input type="checkbox"/> Self-Certification <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> Pending <input type="checkbox"/> N/A – break <input type="checkbox"/> N/A – month already counted	
<input type="checkbox"/> Homeless <input type="checkbox"/> Break <input type="checkbox"/> NHNB					<input type="checkbox"/> HMIS ES / SH record <input type="checkbox"/> HMIS Outreach record <input type="checkbox"/> 3 rd Party Letter <input type="checkbox"/> Self-Certification <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> Pending <input type="checkbox"/> N/A – break <input type="checkbox"/> N/A – month already counted	
<input type="checkbox"/> Homeless <input type="checkbox"/> Break <input type="checkbox"/> NHNB					<input type="checkbox"/> HMIS ES / SH record <input type="checkbox"/> HMIS Outreach record <input type="checkbox"/> 3 rd Party Letter <input type="checkbox"/> Self-Certification <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> Pending <input type="checkbox"/> N/A – break <input type="checkbox"/> N/A – month already counted	
<input type="checkbox"/> Homeless <input type="checkbox"/> Break <input type="checkbox"/> NHNB					<input type="checkbox"/> HMIS ES / SH record <input type="checkbox"/> HMIS Outreach record <input type="checkbox"/> 3 rd Party Letter <input type="checkbox"/> Self-Certification <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> Pending <input type="checkbox"/> N/A – break <input type="checkbox"/> N/A – month already counted	
<input type="checkbox"/> Homeless <input type="checkbox"/> Break <input type="checkbox"/> NHNB					<input type="checkbox"/> HMIS ES / SH record <input type="checkbox"/> HMIS Outreach record <input type="checkbox"/> 3 rd Party Letter <input type="checkbox"/> Self-Certification <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> Pending <input type="checkbox"/> N/A – break <input type="checkbox"/> N/A – month already counted	
<input type="checkbox"/> Homeless <input type="checkbox"/> Break <input type="checkbox"/> NHNB					<input type="checkbox"/> HMIS ES / SH record <input type="checkbox"/> HMIS Outreach record <input type="checkbox"/> 3 rd Party Letter <input type="checkbox"/> Self-Certification <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> Pending <input type="checkbox"/> N/A – break <input type="checkbox"/> N/A – month already counted	

Record Type	Start Date	End Date	New Countable Months	Whereabouts (Description)	Documentation Source (obtained or anticipated)	Documentation n Obtained?	Documentation Notes
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<input type="checkbox"/> Homeless <input type="checkbox"/> Break <input type="checkbox"/> NHNB					<input type="checkbox"/> HMIS ES / SH record <input type="checkbox"/> HMIS Outreach record <input type="checkbox"/> 3 rd Party Letter <input type="checkbox"/> Self-Certification <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> Pending <input type="checkbox"/> N/A – break <input type="checkbox"/> N/A – month already counted	
<input type="checkbox"/> Homeless <input type="checkbox"/> Break <input type="checkbox"/> NHNB					<input type="checkbox"/> HMIS ES / SH record <input type="checkbox"/> HMIS Outreach record <input type="checkbox"/> 3 rd Party Letter <input type="checkbox"/> Self-Certification <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> Pending <input type="checkbox"/> N/A – break <input type="checkbox"/> N/A – month already counted	
<input type="checkbox"/> Homeless <input type="checkbox"/> Break <input type="checkbox"/> NHNB					<input type="checkbox"/> HMIS ES / SH record <input type="checkbox"/> HMIS Outreach record <input type="checkbox"/> 3 rd Party Letter <input type="checkbox"/> Self-Certification <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> Pending <input type="checkbox"/> N/A – break <input type="checkbox"/> N/A – month already counted	
<input type="checkbox"/> Homeless <input type="checkbox"/> Break <input type="checkbox"/> NHNB					<input type="checkbox"/> HMIS ES / SH record <input type="checkbox"/> HMIS Outreach record <input type="checkbox"/> 3 rd Party Letter <input type="checkbox"/> Self-Certification <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> Pending <input type="checkbox"/> N/A – break <input type="checkbox"/> N/A – month already counted	
<input type="checkbox"/> Homeless <input type="checkbox"/> Break <input type="checkbox"/> NHNB					<input type="checkbox"/> HMIS ES / SH record <input type="checkbox"/> HMIS Outreach record <input type="checkbox"/> 3 rd Party Letter <input type="checkbox"/> Self-Certification <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> Pending <input type="checkbox"/> N/A – break <input type="checkbox"/> N/A – month already counted	

Record Type	Start Date	End Date	New Countable Months	Whereabouts (Description)	Documentation Source (obtained or anticipated)	Documentation n Obtained?	Documentation Notes
<input type="checkbox"/> Homeless <input type="checkbox"/> Break <input type="checkbox"/> NHNB					<input type="checkbox"/> HMIS ES / SH record <input type="checkbox"/> HMIS Outreach record <input type="checkbox"/> 3 rd Party Letter <input type="checkbox"/> Self-Certification <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> Pending <input type="checkbox"/> N/A – break <input type="checkbox"/> N/A – month already counted	
<input type="checkbox"/> Homeless <input type="checkbox"/> Break <input type="checkbox"/> NHNB					<input type="checkbox"/> HMIS ES / SH record <input type="checkbox"/> HMIS Outreach record <input type="checkbox"/> 3 rd Party Letter <input type="checkbox"/> Self-Certification <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> Pending <input type="checkbox"/> N/A – break <input type="checkbox"/> N/A – month already counted	
<input type="checkbox"/> Homeless <input type="checkbox"/> Break <input type="checkbox"/> NHNB					<input type="checkbox"/> HMIS ES / SH record <input type="checkbox"/> HMIS Outreach record <input type="checkbox"/> 3 rd Party Letter <input type="checkbox"/> Self-Certification <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> Pending <input type="checkbox"/> N/A – break <input type="checkbox"/> N/A – month already counted	
<input type="checkbox"/> Homeless <input type="checkbox"/> Break <input type="checkbox"/> NHNB					<input type="checkbox"/> HMIS ES / SH record <input type="checkbox"/> HMIS Outreach record <input type="checkbox"/> 3 rd Party Letter <input type="checkbox"/> Self-Certification <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> Pending <input type="checkbox"/> N/A – break <input type="checkbox"/> N/A – month already counted	
<input type="checkbox"/> Homeless <input type="checkbox"/> Break <input type="checkbox"/> NHNB					<input type="checkbox"/> HMIS ES / SH record <input type="checkbox"/> HMIS Outreach record <input type="checkbox"/> 3 rd Party Letter <input type="checkbox"/> Self-Certification <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> Pending <input type="checkbox"/> N/A – break <input type="checkbox"/> N/A – month already counted	
<input type="checkbox"/> Homeless <input type="checkbox"/> Break <input type="checkbox"/> NHNB					<input type="checkbox"/> HMIS ES / SH record <input type="checkbox"/> HMIS Outreach record <input type="checkbox"/> 3 rd Party Letter <input type="checkbox"/> Self-Certification <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> Pending <input type="checkbox"/> N/A – break <input type="checkbox"/> N/A – month already counted	

Appendix B – Homeless Self-Certification – Due Diligence Milwaukee Continuum of Care

HOMELESS SELF-CERTIFICATION – DUE DILIGENCE

Applicant Printed Name: _____

All pages in the Homeless Self-Certification-Due Diligence document must be fully completed in order to be reviewed by the Milwaukee Continuum of Care supportive housing program. Self-certification is only considered valid under exceptional circumstances, in which all potential sources of third party certification have been considered and ruled out. Completion of the due diligence form certifies that the Coordinated Entry liaison completed due diligence to obtain third party homeless certification for the above named individual or household, who experienced literal homelessness during the specified time frame on page 7.

Due Diligence Procedure:

Step 1) Determine if applicant has any records of homelessness covering the entire date range above in HMIS. If there are records of homelessness in HMIS **STOP, and attach time-stamped HMIS record of any outreach contacts, entry/exits into emergency shelter, and file attachments in HMIS indicating episodes of homelessness into the Coordinated Entry packet.** Time-stamped records can be obtained by print screen(s) of HMIS record(s) being copied and pasted into a blank document, as the print screen will indicate the date an HMIS record was obtained in the lower right-hand corner.

Step 2) If no record of homelessness for the above timeframe exists in HMIS, indicate information obtained regarding applicant's homeless history through the following interview report, documenting interviews with the client on a minimum of 3 different dates from pages 1 to 3.

Step 3) The three interviews should provide the Coordinated Entry Liaison with at least three potential sources of third party homeless certification. The Coordinated Entry Liaison must record contact and follow up contacts with potential sources on pages 4 to 5.

Step 4) If the interviews and contacts do not lead to acquiring third party homeless certification, the Coordinated Entry Liaison should complete the narrative on page 6 explaining why the applicant's self-certification is necessary to complete a record of chronic homelessness. The narrative must document how the applicant meets HUD's criteria for applicability of self-certification, explaining how the applicant's case is (1) rare, (2) extreme, (3) a severe living situation. Completion of steps 1 through 4 permits the Coordinated Entry Liaison to complete the Homeless Self-Certification Applicant Living Situation section on pages 6 and 7.

Step 5) The Coordinated Entry Liaison must upload the completed 7 or 8 page packet into client's HMIS record as an attachment. Page 8 is only applicable for applications self-certifying an emergency shelter, drop in Center, or Safe Haven stay, and/or if additional comments are submitted.

Date of Applicant Interview (2 of 3): __/__/_____

Homeless history information for self-certification period, reported by applicant on the above interview date:

Milwaukee Continuum of Care

HOMELESS SELF-CERTIFICATION – DUE DILIGENCE

Applicant Printed Name: _____

Date of Applicant Interview (3 of 3): __/__/____

Homeless history information for self-certification period, reported by applicant on the above interview date:

Milwaukee Continuum of Care

HOMELESS SELF-CERTIFICATION – DUE DILIGENCE

Applicant Printed Name: _____

Please provide information below regarding contacts made to obtain third party homeless history record from a minimum of three potential sources. Sources of homeless history can include local businesses, police departments, day shelters, social service organizations, faith-based organizations, private street outreach groups, and meal sites that the client is in regular contact with. If there is no response from the third party, or no document submitted to the liaison from the third party after a reasonable waiting period for response, follow up contacts should be made to the third party that could provide third party homeless certification on 2 additional occasions. Third party homeless certification should be added to the Coordinated Entry packet along with this completed document.

Third Party Contact (1 of 3)

1) Date of Contact with Third Party: ___/___/___

Type of Contact (phone call, faxed release, voicemail, e-mail, etc.): _____

Name of Third Party Contact Person or Name of Organization Contacted: _____

Date third party homeless certification record received by liaison, if applicable: ___/___/___

2) Date of Follow up Contact with Third Party: ___/___/___

Type of Contact (phone call, faxed release, voicemail, e-mail, etc.): _____

Name of Third Party Contact Person or Name of Organization Contacted: _____

Date third party homeless certification record received by liaison, if applicable: __/__/__

3) Date of 2nd Follow up Contact with Third Party: __/__/__

Type of Contact (phone call, faxed release, voicemail, e-mail, etc.): _____

Name of Third Party Contact Person or Name of Organization Contacted: _____

Date third party homeless certification record received by liaison, if applicable: __/__/__

Milwaukee Continuum of Care

HOMELESS SELF-CERTIFICATION – DUE DILIGENCE

Applicant Printed Name: _____

Third Party Contact (2 of 3)

1) Date of Contact with Third Party: __/__/__

Type of Contact (phone call, faxed release, voicemail, e-mail, etc.): _____

Name of Third Party Contact Person or Name of Organization Contacted: _____

Date third party homeless certification record received by liaison, if applicable: __/__/__

2) Date of 1st Follow up Contact with Third Party: __/__/__

Type of Contact (phone call, faxed release, voicemail, e-mail, etc.): _____

Name of Third Party Contact Person or Name of Organization Contacted: _____

Date third party homeless certification record received by liaison, if applicable: __/__/__

3) Date of 2nd Follow up Contact with Third Party: __/__/__

Type of Contact (phone call, faxed release, voicemail, e-mail, etc.): _____

Name of Third Party Contact Person or Name of Organization Contacted: _____

Date third party homeless certification record received by liaison, if applicable: __/__/__

Third Party Contact (3 of 3)

1) Date of Contact with Third Party: __/__/__

Type of Contact (phone call, faxed release, voicemail, e-mail, etc.): _____

Name of Third Party Contact Person or Name of Organization Contacted: _____

Date third party homeless certification record received by liaison, if applicable: __/__/__

2) Date of 1st Follow up Contact with Third Party: __/__/__

Type of Contact (phone call, faxed release, voicemail, e-mail, etc.): _____

Name of Third Party Contact Person or Name of Organization Contacted: _____

Date third party homeless certification record received by liaison, if applicable: __/__/__

3) Date of 2nd Follow up Contact with Third Party: __/__/__

Type of Contact (phone call, faxed release, voicemail, e-mail, etc.): _____

Name of Third Party Contact Person or Name of Organization Contacted: _____

Date third party homeless certification record received by liaison, if applicable: __/__/__

Milwaukee Continuum of Care

HOMELESS SELF-CERTIFICATION – DUE DILIGENCE

Applicant Printed Name: _____

Narrative – Use the space below to document how the applicant’s case warrants self-certification based on HUD’s criteria. Responses must explain how the applicant’s case is (1) rare, (2) extreme, and (3) a severe living situation.

Milwaukee Continuum of Care

HOMELESS SELF-CERTIFICATION – APPLICANT LIVING SITUATION

Applicant Printed Name: _____

Applicant Signature: _____ Date: _____

Dates of homelessness self-certified from ___/___/_____ to ___/___/_____

- Household without dependent children (complete one form for each adult in the household)
- Household with dependent children (complete one form for household)

Total number of persons in the household: _____

List household members currently living with adult head of household in the following table:

Name of Household Member	Age of Household Member	Relationship to Head of Household

Authorized agencies must be recognized by Milwaukee Continuum of Care (CoC) as an agency that has a program designed to serve as liaison to Coordinated Entry for persons living in emergency shelter, on the street, or other places not meant for human habitation.

This is to certify that the above named individual or household experienced literal homelessness during the time frame based on the check mark, other indicated information, and signature indicating self-report of homeless history.

Check only one box indicating living situation and complete only that section on this page or page 8

Living Situation: Place not meant for human habitation (e.g., cars, parks, abandoned buildings, streets/sidewalks)

The person(s) named above is/are, or was/were living in (or, if currently in hospital or other institution, was living in immediately prior to hospital/institution admission) a public or private place not designed for, or ordinarily used as a regular sleeping accommodation for human beings, including but not limited to a car, park, abandoned building, bus station, airport, or camp ground.

Full description of current or past living situation:

Authorized Agency Representative Printed Name: _____ Date: _____

Authorized Agency Representative Signature: _____ Date: _____

Milwaukee Continuum of Care

HOMELESS SELF-CERTIFICATION – APPLICANT LIVING SITUATION

Applicant Printed Name: _____

Living Situation: Emergency shelter, drop-in center, Safe Haven

The person(s) named above is/are or was/were living in (or, if currently in hospital or other institution, was living in immediately prior to hospital/institution admission) a supervised publicly or privately operated shelter, drop in center or Safe Haven as follows:

Program Name: _____

Program City, State: _____

Authorized Agency Representative Printed Name: _____ Date: _____

Authorized Agency Representative Signature: _____ Date: _____

OPTIONAL - Use this space to provide additional comments:

References, Guides, and Regulations

Helpful Links for Learning about Coordinated Entry and Homeless Service Delivery Systems

HUD Notice CPD-17-01: Notice Establishing Additional Requirements or a Continuum of Care Centralized or Coordinated Assessment System (Establishing Requirements for CoCs): <https://www.hudexchange.info/resources/documents/Notice-CPD-17-01-Establishing-Additional-Requirements-or-a-Continuum-of-Care-Centralized-or-Coordinated-Assessment-System.pdf>

HUD Coordinated Entry Core Elements Guidebook: <https://endhomelessness.org/resource/coordinated-entry-toolkit-core-elements/>

United States Interagency Council on Homelessness “Crisis Response”: <https://www.usich.gov/solutions/crisis-response>

National Alliance to End Homelessness Coordinated Entry Toolkit: Core Elements (Coordinated Entry resources and documents created by other communities): <https://endhomelessness.org/resource/coordinated-entry-toolkit-core-elements/>

Several resources and FAQs for addressing special populations in Coordinated Entry can be found at <https://www.hudexchange.info>, <https://endhomelessness.org>, and <https://www.usich.gov>