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INTRODUCTION TO THE COORDINATED ASSESSMENT AND REFERRAL SYSTEM-CARS (COORDINATED ENTRY)

WHAT IS CARS?

The Coordinated Assessment and Referral System, also known as Coordinated entry, is a consistent, community wide process to match people experiencing homelessness to community resources that are the best fit for their situation. In a community using coordinated entry, homeless individuals and families complete a standard triage assessment survey that identifies the best type of intervention for that household. Participating programs accept referrals from the system, reducing the need for people to travel distances seeking assistance at every provider separately. When participating programs do not have enough space to accept all referrals from the system, people are prioritized for services based on need. In the Monterey/San Benito Counties Continuum of Care (CoC), the system is referred to as the Coordinated Assessment and Referral System (CARS).

BENEFITS OF COORDINATED ENTRY

A coordinated entry system can:

- Use existing resources more effectively by connecting people to the housing/service program that is the best fit for their situation.
- Reduce the need for people to call around to multiple programs and fill out multiple applications to join waitlists. Coordinated entry assesses people for all participating housing/service programs at the same time.
- Provide clear communication about what housing is available and when it is available.
- Leverage technology to improve system effectiveness.
- Improve information about homelessness and program and system performance. This information will help us to advocate for more resources to provide housing and services for homeless people and to better direct existing resources.
- Strengthen systems change efforts and improve CoC-wide collaboration.

**HUD Requirements and Policies**

Under the interim rule for the U.S. Department of Housing and Urban Development’s (HUD) CoC program, each CoC must establish and operate a centralized or coordinated assessment system (24 CFR 578.7(a)(8)). HUD defines a centralized or coordinated assessment system, often referred to as a “coordinated entry” system, as “a centralized or coordinated process designed to coordinate program participant intake assessment and provision of referrals. A centralized or coordinated assessment system covers the geographic area, is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool” (24 CFR 578.3).

**Project Overview and Vision**

**Project Overview**

All homeless individuals and families entering the CARS system complete a standard triage assessment survey that considers the household’s situation and identifies the best type of housing intervention to address their situation. The standard triage assessment survey used is the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT). The VI-SPDAT is integrated into the Homeless Outreach Mobile Engagement (HOME) app for people who are homeless, and conducted at CARS partner agencies, including shelters, service centers, transitional housing programs, permanent housing programs, and outreach programs, or wherever people who are homeless first encounter our system of care.

Homeless housing programs, including permanent supportive housing, rapid rehousing, and transitional housing, fill available spaces in their programs from a master list of eligible households generated from the HOME app. To ensure the most needy are housed first, the master list is prioritized based on VI-SPDAT scores, length of time homeless, severity of need, and local population priorities. This coordination improves the targeting of housing...
resources CoC-wide, and reduces the need for people to travel distances seeking assistance at every provider separately. HMIS data are integrated with HOME app data in a data warehouse.

CARS uses a decentralized “any door” system of access, so that persons in need can contact the system at any one of multiple participating programs in different geographic locations. CARS coordinated entry is inclusive and known to street outreach teams, homeless service providers, institutions (hospitals and jails), public service institutions (health departments, county clinics, human services), faith based organizations, emergency and crisis support groups (including domestic violence groups), and intake systems such as 211. These groups and institutions either serve as access points or have the ability to make referrals to access points.

**LOCAL VISION FOR COORDINATED ENTRY**

All individuals and families experiencing or at risk of homelessness in Monterey and San Benito counties will have a fair, standardized, automated, and easily accessible process for timely access to the most appropriate housing intervention and services given their needs, in a client centered, culturally competent setting that supports client choice and dignity.

**TARGET POPULATION**

CARS serves all families and individuals who are homeless or at risk of homelessness as defined under the federal HEARTH Act and its implementing regulations.

**GEOGRAPHIC COVERAGE**

CARS covers the entire CoC area, which includes all of Monterey and San Benito counties.

**GOVERNANCE AND PARTNER ROLES**

**GOVERNANCE STRUCTURE**

The Monterey/San Benito Counties CoC governs CARS. As referred to above, the CoC is ultimately responsible for compliance with HUD requirements under the CoC Interim Rule that include:
• Establishing and operating a centralized or coordinated assessment system.
• Meeting the HUD coordinated entry requirements described above, in the CoC Interim Rule, in any other HUD Notice, and in the CoC Notice of Funding Available (NOFA).
• Developing a specific policy for how the coordinated entry system will address the needs of persons fleeing domestic violence, but who are seeking assistance from non-victim service programs.
• Establishing and following written standards for CoC assistance.
• Coordinating with ESG recipients in establishing the centralized or coordinated assessment system and CoC written standards.

The Homelessness Prevention and Rapid Rehousing Program (HPRP) Committee of the CoC has significant responsibilities that include:

• Meeting monthly to help plan, implement, and operate CARS.
• Serving as a forum for CoC member, provider, and community participation and feedback in planning, implementing, and operating CARS, and in identifying needs and solutions related to the project.
• Developing specific, program, policy, and technology options and solutions for recommendation to and approval by the CoC.
• Coordinating with the staff of the CARS Lead Agency.
• Coordinating with the CoC’s HMIS and CARS technology provider.
• Reviewing system performance data and evaluating the efficiency of CARS.
• Other tasks as needed.

Agency Roles & Responsibilities

Lead Agency – Coalition of Homeless Service Providers

Due to its proven leadership on homelessness, high profile, and access to resources and expertise, the Coalition of Homeless Service Providers (Coalition) has been selected by the CoC as the CARS lead agency. Thus, the Coalition is responsible for day-to-day administration of CARS, including but not limited to:
• Hiring and training staff to support CARS.
• Managing and overseeing contractors working on components of CARS.
• Working to ensure resources are available for the project.
• Gathering (with provider input) and keeping up to date information regarding shelter and housing bed/unit availability.
• Expanding HMIS capacity to fully incorporate all components of CARS.
• Ensuring a technology solution so that providers that are not currently participating in HMIS can use the system and conduct assessments.
• Implementing and administering the CARS master list.
• Providing training across the homeless service provider network to enact systems change to incorporate CARS.
• Developing and updating CARS policies and procedures.
• Managing the client eligibility and acceptance determination appeals process.
• Participating in case conferences requested to resolve housing placement issues or concerns.
• Preparing materials for and facilitating CoC and HPRP Committee meetings related to CARS.
• Creating and widely disseminating materials regarding CARS and how to access its services.
• Providing reports on the progress of CARS to elected officials and public, and serving as a point of contact for media and public requests for information.

**PARTNER AGENCIES**

All programs that receive CoC, ESG, SSVF, or targeted VA funding are required by their funding sources to participate in CARS. All other programs serving persons who are or are at risk of experiencing homelessness are encouraged and welcome to join CARS. Agencies with programs that are not required by their funder to participate in the CES will sign a Memorandum of Understanding (See Attachment D) agreeing to participate in CARS. In general, partner agencies are responsible for:
• Ensuring that clients seeking assistance have prompt access to screening and assessment in a safe and welcoming environment.
• Carrying out screening and assessment of clients, responding to their immediate needs, using CARS tools and technology, supporting referral of clients per CARS protocols, accepting client referrals per CARS protocols.
• Attending CARS trainings.
• Following CARS policies and procedures.
• For receiving agency – accepting and promptly acting on client referrals through CARS.
• Participating in case conferences requested to resolve housing placement issues or concerns.
• Abide by client eligibility and acceptance determination decision.
• Complying with fair housing legal requirements in all housing transactions and tenant selection plans and procedures.

**OVERVIEW OF SYSTEM MODEL AND PROCESS WORK FLOW**

**ANY DOOR MODEL**

Because of the diversity and geographic size of the Monterey and San Benito Counties CoC, CARS uses a decentralized “any door” system of access. This benefits persons in need because they can contact the system at any one of multiple participating programs in different geographic locations. The principles of this approach are:

• A client can receive integrated services through any of the participating programs.
• Clients gain equal access to information and advice about the housing assistance for which they are eligible in order to assist them in making informed choices.
• Participating providers have a responsibility to respond to the range of client needs pertaining to homelessness and housing, and act as the primary contact for clients who apply for assistance unless or until another provider assumes that role.
• Participating providers will guide the client in applying for assistance or accessing services from another provider regardless of whether the original provider delivers
the specific housing services required by a presenting client.

- Participating providers will work collaboratively to achieve responsive and streamlined access services and cooperate to use available resources to achieve the best possible housing outcomes for clients, particularly for those with high, complex or urgent needs.

**Importance of a CoC-Wide View**

It is very important participating programs and staff take a CoC-wide view when they assess and serve clients in need. When serving clients, the key question becomes not whether this household is eligible for our program, but “What housing and service assistance options are best for this household among the various options available in the CoC?”

**Process Work Flow**

The following is an illustration of the overall coordinated entry workflow:
ACCESS

ACCESS POINTS
To ensure easy access to assistance, CARS provides access to assessments, housing, and services from multiple, convenient locations throughout the Monterey and San Benito counties. The homeless person in need may initiate a request for housing by walking into or calling any participating program or through contact with a street outreach program.

The minimum requirements for a program to participate as a physical access point are:

- Have user access to the HOME App.
- Have at least one staff person trained and authorized both to use of the HOME app and to conduct the VI-SPDAT assessment; this may include a community volunteer who is trained and authorized by the Coalition, and is connected to a CARS participating agency.
- Sign a CARS participation agreement.
- Agree to follow CARS policies and procedures, community guidelines for conducting assessments and communicating about coordinated entry.
- Agree to provide additional referrals to other community services, as appropriate, to people completing the assessment.

Additional information can be found at the Coalition of Homeless Service Provider’s website: http://www.chspmontereycounty.org/coordinated-entry/.

ASSESSMENT

STANDARDIZED ASSESSMENT TOOL – VI SPDAT
As mentioned above, CARS uses the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) as the standard assessment tool. The VI-SPDAT is built into the HOME app, facilitating participation in CARS by programs that do not use HMIS.

The VI-SPDAT is completed in the HOME app with all individuals and families who are
homeless under HUD’s definition of homelessness. The assessment can be conducted by any qualified agency or program participating in CARS.

**Training and Authorization of Users**

As mentioned above, the VI-SPDAT can only be conducted by agency staff (or volunteers who are connected to the agency) who have successfully completed training and been authorized by the Coalition as the CARS lead agency. Trainings are coordinated by CoC staff and include but are not limited to training on:

- Using the HOME app
- Completing the VI-SPDAT (conducted by OrgCode or a certified local trainer)
- Communicating with clients about coordinated entry and answering their questions.

**Pre-Screening**

As a first step, the individual or family should be asked basic pre-screening questions to determine if they need homelessness assistance, whether they have already received the VI-SPDAT, and whether they are a member of special population requiring specialized assistance.

If the individual or family is not homeless, the assessment process should not be continued. Rather, they should be provided or directed to other more appropriate services, e.g., prevention services if they are at risk of homelessness.

If the individual or family does need homelessness assistance, staff should check the HOME app to see if they have already received the VI-SPDAT in the past year. If not, or if it seems their situation has changed significantly since the last time, the assessment can proceed.

If the individual or family is: fleeing domestic violence (DV) situations or otherwise meets the criteria of category (4) of the definition of Homelessness\(^1\); an unaccompanied youth

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\(^1\)See Attachment A, Definitions, for a detailed definition of Category 4 of the “Homeless” definition.
under 18 years of age; or a veteran of active duty in the U.S. Armed Forces, then the procedures under Unique Procedures for Special Populations below should be followed.

**COMMUNICATION**

The assessment should be conducted in a setting that promotes safety, privacy, and confidentiality. Staff conducting the assessment should follow community guidelines below for explaining the assessment process and benefits. Key points that may be covered include:

- That the assessment takes about 10 minutes and most responses are “yes” or “no,” or just one word.
- That the collected information will be entered into the HOME app, which will help ensure that they will only need to complete the assessment once, that they will go onto the master list, and that they will not have to go around to different agencies getting on separate waiting lists.
- That if they have an existing case manager helping them apply for housing, they should continue working with that case manager.
- That the assessment will help result in a recommended housing intervention.
- That due to limited housing availability, it is unlikely that the recommended intervention will be available immediately, and it is important provide up-to-date contact information for when the intervention does become available, and to immediately call Coalition staff at 831-883-3080 to inform staff of any contact information changes.
- That the assessment is voluntary, but that completing it will make it easier to provide the assistance needed and will allow them to be placed on the master list for referrals.
- That the assessment will be conducted and entered into the HOME app only if a Release of Information (ROI) is signed.

**RELEASE OF INFORMATION AND DATA SHARING**
A standard HIPAA-compliant ROI covers the assessment and VI-SPDAT. The ROI authorizes the agency to conduct the assessment and VI-SPDAT, enter the information into the HOME app, and share the individual or family’s information with other participating agencies to facilitate connecting the individual or family with housing and services. The ROI must be signed before any information can be collected and entered into the HOME App.

**Conducting the Assessment**

If the ROI has been signed the assessment can be conducted. The assessment usually is entered directly into the HOME app, may be completed on paper where possible and more comfortable for the client, or may only be completed on paper in the case of a victim service provider. If completed on paper, the VI-SPDAT score must be entered into the HOME app within 24 hours of the assessment, with appropriate de-identification for persons served by a victim service provider. (See Unique Procedures for Special Populations below for more information about special assessment procedures for person fleeing DV.)

An extensive body of evidence from peer-reviewed studies and government documents supports the VI-SPDAT and its questions. Any changes to the wording (unless authorized) or the order of the questions could make the assessment less valid. Thus, the assessment process should adhere to the following rules:

- Clients may be asked to answer the questions as accurately as possible.
- The order of questions should not be changed.
- All questions should be asked, including all linked questions.
- The wording used should not be changed (unless authorized).
- The information gathered and entered should only be through client self-report (not through staff opinion or guesses or third-party information).

**Conducting Additional or Follow Up Assessments**

As long as individuals/families remain homeless, they should complete the VI-SPDAT annually to capture changes in their circumstances. In addition, individuals/families may complete a new assessment whenever they experience a significant change in their circumstances.
MATCHING AND PRIORITIZATION

THE MASTER LIST – CLIENT LIST AND HOUSING PROGRAM INVENTORY

The Coalition of Homeless Services Providers and Community Technology Alliance (CTA) jointly maintain a “master list” in the Home app that includes:

- A sortable list of clients prioritized by VI-SPDAT score and local population/subpopulation factors in the Prioritization Matrix (attached).
- An inventory and basic eligibility information for each participating housing program, including transitional housing, rapid rehousing, and permanent supportive housing.
- A listing of beds/units that are currently availability or expected to become available.

HOUSING PROGRAM ELIGIBILITY DETAILS AND BED/UNIT AVAILABILITY

Participating agencies that use HMIS enter their basic program inventory and eligibility information into HMIS. This information is exported to the HOME app for use in the coordinated entry process. Participating agencies that do not use HMIS enter their basic program inventory and eligibility information directly into the Home app. All programs use the Home app to update their current bed/unit availability and expected availability. The eligibility criteria are used, along with the local eligibility limits (attached), to ensure that only eligible clients for a particular program or unit are referred to that program or unit.

As detailed further below, each participating agency’s authorized staff person must use the Home app to update the master list any time that program beds/units become, or are expected to become, vacant and available. RRH programs indicate whether funding is or will be available for financial assistance, along with funding source (e.g., SSVF). Participating agencies must also keep CoC staff apprised of beds/units that are currently or expected to become available.
In general, participating agencies must work consistently with Coalition and CTA staff to make sure their inventory, eligibility, and bed/unit availability information is always up-to-date.

**Matching to Program Type**

The VI-SPDAT score and master list are used by CoC staff to sort all individuals and families assessed by housing intervention type. This improves cost efficiency and program effectiveness system-wide. Those with high acuity scores are matched to permanent supportive housing, medium acuity scores to transitional housing, low-medium acuity scores to RRH, and low acuity scores to other appropriate interventions. For further details, see Attachment B, Local Housing Eligibility and Prioritization.

**Prioritization Within the Program Types**

The master list is used to generate a prioritized list of individuals and families, within each program type, based upon an overall score that combines VI-SPDAT score, local population/subpopulation priorities, and, in the case of PSH, the level of chronicity and service need. For further information, see Attachment B.

**Fair Housing and Other Statutory Requirements**

CARS takes steps to ensure that client prioritization, matching, and referral to housing opportunities do not violate the non-discrimination requirements of the federal Fair Housing Act, which prohibits discrimination in housing transactions on the basis of race, national origin, sex, color, religion, disability status, and familial status, and do not violate California fair housing law which further prohibits discrimination in housing transactions on the basis of sexual orientation, gender identity, gender expression, marital status, medical condition, ancestry, source of income, age, genetic information, and arbitrary discrimination.

The master list allows filtered searches for subpopulations, priority, and eligibility, while preventing discrimination against protected classes.


**REFERRAL**

**MATCHES FOR SPECIFIC HOUSING OPPORTUNITIES**

When a PSH or TH bed/unit or RRH financial assistance becomes available, the master list will be sorted by both priority score AND eligibility criteria to identify the highest priority individual or family who is also eligible for the particular housing opportunity. This means that a person with a higher overall priority score will not be the one referred if he/she is not otherwise eligible for the housing. For example, a high scoring individual will not be referred family housing, and only Veterans will be referred to a program targeting Veterans.

**STANDARD REFERRAL STEPS/RESPONSIBILITIES**

*Referral* to a receiving program does not signify *admission* to that program. Rather, the receiving program will carry out its own intake process, including but not limited to an application, verification process, and admission decision.

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Timeliness Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>When a bed/unit will be available, CoC staff start the process of locating the highest ranking appropriate client.</td>
<td>Immediately upon availability; bed/unit availability will be updated weekly in HOME</td>
</tr>
<tr>
<td>Step 2</td>
<td>CoC staff attempt to make contact with the client; for efficiency CoC staff may chose to contact up to the 3 highest ranking appropriate clients per unit.</td>
<td>3 business days</td>
</tr>
<tr>
<td>Step 3</td>
<td>If contact is not made, CoC staff move on to the next highest-ranking appropriate client.</td>
<td>3 business days</td>
</tr>
<tr>
<td>Step 4</td>
<td>Once contacted, the client decides whether or not to accept referral.</td>
<td>Immediately</td>
</tr>
<tr>
<td>Step 5</td>
<td>If the referral is declined, CoC staff move on to the next highest-ranking appropriate client. Absent extenuating circumstances, a client declining 2 referrals will be removed from the master list and placed on a separate list; CoC staff may later reassign the client to the master list.</td>
<td>Immediately</td>
</tr>
<tr>
<td>Step 6</td>
<td>If the referral is accepted, CoC staff record the referral within the master list and follow up with receiving program as needed.</td>
<td>Immediately</td>
</tr>
</tbody>
</table>
 RECEIVING PROGRAM STEPS

<table>
<thead>
<tr>
<th>Step</th>
<th>Timeliness Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>Once the referral is made, the receiving program attempts to contact the client to schedule an appointment. 3 business days</td>
</tr>
<tr>
<td>Step 2</td>
<td>Once the client is contacted, the receiving program schedules the appointment. 3 business days</td>
</tr>
<tr>
<td>Step 3</td>
<td>If the client misses the appointment, the receiving program attempts to schedule a 2nd appointment. Absent extenuating circumstances, a client missing 2 appointments will removed from the master list and placed on a separate list; CoC staff may later reassign the client to the master list. 3 business days</td>
</tr>
<tr>
<td>Step 4</td>
<td>Absent extenuating circumstances, the client has 3 business days after the intake interview to provide any missing application materials. 3 business days</td>
</tr>
<tr>
<td>Step 5</td>
<td>The receiving program provides the client with a written eligibility/acceptance determination (see below). 3 business days or when application materials complete</td>
</tr>
<tr>
<td>Step 6</td>
<td>If the client is accepted, the receiving program works with the client to arrange move in. 30 calendar days latest</td>
</tr>
<tr>
<td>Step 7</td>
<td>The receiving program records program entry in HMIS (or uses the master list to refer back to the CoC if the client rejected). Immediately</td>
</tr>
</tbody>
</table>

EXTENUATING CIRCUMSTANCES

A key goal of the process is to balance the need for process efficiency with the goal of ensuring that clients, who often face considerable challenges, have every opportunity to access and succeed in housing. Thus, clients who decline more than one referral, who miss two or more appointments, or who are late in providing application materials can be excused if there are extenuating circumstances. A report will detail the date, status, and history (including reasons for declining) of each referral.

“Extenuating circumstances,” means circumstances outside of the client’s control preventing the client from accepting the referral, attending an appointment, or providing documentation timely. This is a case-by-case determination. Examples of extenuating circumstance include:
• Verifiable medical problem or lack of funds preventing accepting of a housing referral
• Verifiable Illness or lack of transportation means preventing attendance at appointment
• Required documentation not available in time from the source preventing timely provision of application materials.

Extenuating circumstances do not include matters within a client's control. For example, they do not include a client’s choice or preference for location of housing, unless for example a different location is needed for accessibility reasons or safety from domestic violence, or for example a particular program is required for recovery from military sexual violence.

A determination of extenuating circumstances requires the client to provide documentation of the extenuating circumstance where possible or legally allowable, and to communicate regularly regarding steps to move forward in the process.

POLICIES REGARDING DENIAL OF CARS REFERRALS

EXPECTATION THAT RECEIVING PROGRAM WILL ACCEPT REFERRALS
To ensure system efficiency and the best possible client service, receiving programs are generally expected to accept every referral received from CARS.

DECLINING OF REFERRALS FROM CARS
Notwithstanding the above expectation, receiving programs may decline an individual or family referred through CARS if any of the following exceptions are demonstrated:

• There is no appropriate vacancy available
• Household presents with more or fewer people than the unit is designed for in line with housing standards
• The individual or family is not eligible under funding source or local eligibility requirements for the program in question (see the Local Eligibility Limits by Housing Program Type)
• For recovery-based housing programs only: if an individual indicates unwillingness to comply with sober program requirements
• The program provides documentation that it lacks the resources needed to effectively or safely serve and support the individual or family in question
• For transitional housing programs only: if the client has already graduated from a transitional housing program within the previous two years
• Client misses two or more intake appointments within a 48-hour period of time
• Clients may decline a referral because of program requirements that are inconsistent with their needs or preferences. There are no limitations on this decision
• The program provides documentation that it is contractually required to serve only clients referred from a sole source or separate process (e.g., processes for County Behavior Health, CalWORKS Housing Support, or SSVF)
• There is a conflict of interest as defined in writing by the receiving agency, e.g., where the client is related to a staff or Board member of the receiving agency.

RECEIVING PROGRAM ACCOUNTABILITY FOR TURNING DOWN REFERRALS

If a receiving program shows a pattern of declining otherwise acceptable referrals, it will be subject to accountability measures. A “pattern” is defined as two or more instances of declining an otherwise acceptable referral within a period of 60 calendar days. A second violation occurs when there is another instance of declining an otherwise acceptable referral within 12 months from the first violation. Additional violations occur when there are any other instances of declining an otherwise acceptable referral within 12 months from the second violation.

Accountability measures for receiving programs showing violations of this policy will be in progressive tiers as follows:

• Tier 1 (one pattern violation): Agency must participate in a conference with CoC Coordinator to determine reasons and plan to resolve the problem.
• **Tier 2** (second pattern violation in 12 months): Agency is required to develop and implement a written Performance Improvement Plan (PIP), which may include staff re-training; the PIP must be approved by the CoC Coordinator.

• **Tier 3** (any additional pattern of violations in an additional 12 months or evidence of failure to implement the PIP): Lower score in CoC and/or other funding competitions, and potential CoC grant reallocation.

**Receiving Program Follow Up Responsibilities**

• Take reasonable steps to notify the client verbally and with a letter of the decision and reasons within one business day after completion of the client’s application and program decision. Where no mailing address can be determined, the letter should be left at the program front desk.

• The decision letter must:
  o Use a decision letter format provided by CoC staff with space for the agency to provide additional information regarding the decision.
  o Be put on agency letterhead, be dated, and be signed by an authorized staff member.
  o Give the first available move-in date (if the client is accepted).
  o Include a brief statement of reasons for the denial, must include a statement that the client has a right to an appeal process, must include instructions for appealing the decision (if the client is rejected).
  o Comply with the HIPAA privacy rule or any other applicable confidentiality requirements.

• Copy any acceptance or rejection letter to CoC staff at the same time it is provided to the client.

• Communicate timely with CoC staff so that all steps can be taken to reassign the client.

• Participate in any case conference, if requested by CoC staff, to assist in finding a more appropriate referral.

• Accept client if appeals process overturns denial decision (see appeals process below).
ADDITIONAL RECEIVING PROGRAM RESPONSIBILITIES

- Keep CoC staff apprised of any beds/units that are currently vacant, or that they know will become vacant, along with relevant programmatic/eligibility details.
- Update the master list promptly and regularly regarding current and upcoming bed/unit availability. RRH programs will indicate whether funding is or will be available for financial assistance, along with funding source (e.g., SSVF).
- Check email and the master list daily to see if any referrals have been made to the program, if the program has beds/units that are currently or expected to become available.
- Ensure that HMIS records are complete, accurate, and timely.

CLIENT APPEALS PROCESS

Clients referred by or through CARS have a right to appeal adverse program admissions decisions by receiving programs. The appeals process is as follows:

NOTICE OF DENIAL TO APPLICANT

- The above-referenced decision letter will serve as effective written notice of a decision to deny program admission.

SCHEDULING A HEARING

- The client must make a request for a hearing in writing and delivered to CoC staff in person, via mail, or via e-mail. CoC staff must receive the request within 10 business days after the date of the written notice to deny program admission.
- CoC staff must schedule and send written notice to the client and receiving program director of the hearing within 10 business days after the date of the client’s request. The notice to the receiving program director must include a copy of the client’s request.

HEARING PROCEDURES

- The CoC Coordinator, or his or her designee, will conduct hearings. In all cases, the
hearing must be conducted by a person other than one who participated in or approved the denial decision, or a subordinate of this person.

- The client must be given the opportunity to provide written or oral objections to the denial decision, and the receiving program must be given the opportunity to provide written or oral justifications for the denial decision.
- If the client fails to appear for the hearing, the denial decision will be upheld.

**Appeal Decision**

- CoC Coordinator, or his or her designee, will be responsible for making the final decision on whether or not program admission should be granted or denied.
- In making the decision, the following factors should be evaluated:
  - Were the grounds for denial stated factually in the notice of decision to the client?
  - Were the grounds for the denial decision valid? If there was no basis for the decision in applicable law, regulations, or CARS policies and procedures, then the decision to deny will be overturned.
  - Was there sufficient evidence supporting the grounds for denial? If the evidence proves there were valid grounds for denial, and law or CoC policy requires denial, then the decision to deny will be upheld.
- The CoC Coordinator, or his or her designee, will provide written notice within 10 business days of the hearing to the client and receiving program director of the final decision, including a statement of the reasons for the decision.

**Accessibility**

- The appeals process will comply with applicable law on disability, language, and literacy access.
- Accommodations must be offered as required by the law at any and all stages of the appeals process on the basis or disability, language, or literacy.
- Examples of accommodations include but are not limited to: reading of the denial notice to the client, language translation of materials, use of a translation line or service, and provision of assistive listening services.
UNIQUE PROCEDURES FOR SPECIAL POPULATIONS

DOMESTIC VIOLENCE

Victim and non-victim housing/service agencies must prioritize safety and equitable access to housing/services for persons fleeing or attempting to flee domestic violence, dating violence, sexual assault, stalking, or human trafficking (DV), while ensuring that client choice is upheld. Therefore, the screening process includes the following “yes” or “no” questions:

1. “Are you currently residing in, or trying to leave, an intimate partner who threatens you or makes you fearful?” (If yes, ask the following question):
2. “Do you want services that are specifically geared to domestic violence survivors OR do you need a confidential location to stay?”

If the client answers “yes” to both questions, the client must be offered assistance to contact the appropriate domestic violence assistance provider as follows:

- **If in San Benito County:**
  Emmaus House 24-Hour Emergency Hotline at **877-778-7978**
- **If In Monterey County:**
  YWCA Domestic Violence (DV) Crisis Line at **831-372-6300** or **831-757-1001**.

If the screening indicates the client may have been sexually assaulted or abused, the client must be offered assistance to contact the appropriate sexual violence provider as follows:

- **If in San Benito County**
  Community Solutions Crisis Hotline at **877-363-7238**
- **If in Monterey County**
  Monterey County Rape Crisis Center at **831-375-4357** or **831-424-4357**.

In addition, any agency serving as an access point must coordinate with the appropriate victim services provider around safety planning and must participate in any trainings provided on how to carry out appropriate safety planning and how to ensure trauma-
informed, culturally appropriate services.

Whether or not the client wishes to be connected to DV services, the client must be offered equitable access to the full housing/services system available through CARS, in accordance with all protocols described in this manual. In such cases, the assessment can be conducted by paper or using an “anonymous” client assessment if possible and desired by the client.

To help ensure equitable access while emphasizing safety, victim service providers\(^2\) may elect or not elect to administer the CARS assessment process (including prescreening and the VI-SPDAT) for clients seeking other housing/services available through CARS. However, the victim service provider should have a standardized policy governing when and how they elect to use the CARS assessment process, and it should have a process for referring the client to another agency that does administer the VI-SPDAT. The prescreening and VI-SPDAT may only be administered on paper, and in no circumstances can client identifying information be entered into the master list or HMIS. Rather, the VI-SPDAT score and a unique identifier must be provided to CoC staff, and the victim service agency must destroy any paper copies of the VI-SPDAT and pre-screening form.

**Veterans**

The screening process will include following “yes” or “no” questions:

1. Have you served on active duty in the Armed Forces of the United States? (If yes, ask the following question):
2. Do you want Veteran-specific services?

If the client indicates, “yes” to both questions, the Veteran must be referred to the appropriate VA Center for appropriate assessment and services.

If the client does not wish to seek Veteran-specific housing/services, the client will have

\(^2\) A ‘victim service provider” is a private nonprofit organization whose **primary** mission is to provide services to victims of domestic violence, dating violence, sexual assault, or stalking. See Attachment A, Definitions, for further information.
access to housing/services system available through CARS, in accordance with all protocols described in this manual. In such cases the client must be fully informed that the decision not to seek Veteran-specific housing/services may significantly limit his/her chances of receiving timely housing/services and that HUD rules limit access to CoC-funded housing if VA-funded or other Veteran-eligible housing is available to that Veteran.

**UNACCOMPANIED YOUTH UNDER 18**

The screening process will include following “yes” or “no” question:

**Are you under the age of 18?**

If the client answers “yes,” the client must referred to and offered assistance to contact Community Human Services Safe Place for appropriate assessment and services as follows:

- Community Human Services Safe Place at **831-373-4421**.

**ADMINISTRATION REQUIREMENTS FOR COORDINATED ENTRY SYSTEM**

**INITIATION OF PROGRAM PARTICIPATION**

As mentioned earlier, all programs that receive CoC, ESG, SSVF, or targeted VA funding are required by their funding sources to participate in CARS. All other programs serving persons who are experiencing homelessness are strongly encouraged and welcome to join CARS.

In order to initiate program participation in CARS, please contact the Coalition at:

**(831) 883-3080**

Agencies will work with Coalition staff on the following steps:

- Obtaining and signing the Memorandum of Understanding (See Attachment D) agreeing to participate in and comply with all the requirements of CARS (including the CARS policies and procedures and any other community guidelines developed by the CoC relating to CARS).
• Obtaining user access to the HOME App.
• Having at least one staff person trained and authorized both to use of the HOME app and to conduct the VI-SPDAT assessment; this may include a community volunteer who is trained and authorized by the Coalition, and is connected to a CARS participating agency.

Once the above steps are completed, program participation in CARS can begin.

**Termination of Program Participation**

A participating program or agency may terminate participation in CARS by giving written notice to the Coalition. Due to the importance of community-wide use of coordinated entry, the CoC expects that the participating agency will communicate with Coalition staff to try to resolve any issues and barriers to its participation prior to giving written notice.

Programs and agencies are hereby warned that termination of participation in CARS may also result in the loss of funding from funding sources that require their participation in coordinated entry.

**Outreach and Advertising**

The CoC will develop a strategy for affirmative marketing of CARS and its waitlist to private and public agencies, including those in the CoC, VA, social service agencies, and local government agencies. The purpose of this outreach is to educate agencies about and provide information on the role of CARS and how these agencies’ homeless clients can access CARS.

In addition, the CoC will develop a strategy for affirmative marketing CARS and its waitlist directly to unsheltered homeless people throughout the CoC geography. This outreach may be conducted in coordination with street outreach programs, the biennial unsheltered point-in-time count, and other public and private agencies that regularly contact unsheltered homeless people. The purpose of this outreach is to ensure that unsheltered persons are prioritized for assistance in the same manner as any other person assessed through CARS.
PROGRAM EVALUATION

The implementation of CARS creates significant opportunities for system-wide improvements to the Monterey and San Benito counties homeless assistance system. To help ensure that CARS achieves the maximum possible efficiency, effectiveness, and usefulness both for homeless persons and the programs that serve them, the CoC expects adjustments to the CARS processes, policies, and procedures, especially in the early stages. To inform these adjustments, CARS is periodically evaluated and opportunities for stakeholder feedback are provided through the HPRP Committee and other meetings staffed by the Coalition.

In particular, the CoC, HPRP Committee, and Coalition staff work to ensure that:

- An evaluation effort and report on findings occurs at least annually
- Adjustments are periodically made to CARS based upon evaluation findings
- Evaluations benefit from a broad and inclusive stakeholder group.

Evaluation efforts are informed by metrics reviewed established periodically by the HPRP Committee and full CoC. These metrics include indicators that illuminate the effectiveness of CARS itself, such as:

- Wait times for initial contact
- Extent to which timelines and referral timeliness goals are achieved
- Rates of referral acceptance by receiving programs
- Rate of missed appointments for assessments or for housing provider interviews
- Number/percentage of persons declined by more than one provider
- Rate of program admissions not conducted through CARS
- Accuracy and completeness of data on assessment forms.

The metrics also include indicators of CARS impact on CoC system-wide outcomes, such as:

- Reduced client length of stay in emergency shelters
- Reduced waiting lists for all program types
- Program components meet outcome targets for housing stability and increased income
- Reduced chronic homelessness, family homelessness, and youth homelessness
- Reduced homelessness recidivism
- Reduced rate of first-time homelessness.

**ATTACHMENTS**

A. Definitions

B. Local Housing Eligibility and Prioritization Matrix

C. Local Eligibility Limits by Housing Program Type and Population Matrix

D. Participant Agency MOU
ATTACHMENT A: DEFINITIONS

Access Point – Locations where people can complete the standardized assessment to participate in coordinated entry. Access points often include emergency shelters and drop-in service centers.

At Risk of Homelessness – An individual or family who has income below 30% of area median family income for the area, as defined by HUD, and who does not have sufficient resources or support networks immediately available to prevent them from moving into an emergency shelter or other place described in the “homeless” definition (See Exhibit A and Exhibit B), and meets one if the following definitions defined under 24 CFR 578.3 (CoC program) or 24 CFR 576.2 (ESG program). This may also include a child or youth who qualifies as homeless under other Federal programs.

Chronic Homelessness – HUD’s definition of chronically homeless means an individual or family who:

- Chronically Homeless Individual (CHI): For HUD CoC Grants requiring that applicants be chronically homeless, under HUD’s definition, “chronic homelessness” means an individual who lives either in a place not meant for human habitation, safe haven, or in an emergency shelter immediately before entering the institutional care facility.

- In order to meet the CHI definition, the individual also must have been living as described above continuously for 12 months, or on at least four separate occasions in the last three years, where the combined occasions total a length of time of at least 12 months. Each period separating the occasions must include at least 7 nights of living in a situation other than a place not meant for human habitation, in an emergency shelter, or in a safe haven.

Continuum of Care (CoC) - The Monterey and San Benito Counties Continuum of Care carries out the responsibilities required under HUD regulations, set forth at 24 CFR 578 – Continuum of Care Program. The CoC is comprised of a broad group of stakeholders
dedicated to ending and preventing homelessness in Monterey and San Benito Counties. The over-arching CoC responsibility is to ensure community-wide implementation of efforts to end homelessness and ensuring programmatic and systemic effectiveness of the local continuum of care program.

Emergency Shelter – Any facility, the primary purpose of which is to provide a temporary shelter for the homeless in general or for specific populations of the homeless and which does not require occupants to sign leases or occupancy agreements.

Emergency Solutions Grant (ESG) – ESG is a grant program of the U.S. Department of Housing and Urban Development (HUD) that funds emergency assistance for people who are homeless or at-risk of homelessness. ESG grantees are required to participate in Coordinated Entry.

Homeless Outreach Mobile Engagement (HOME) App – The HOME app is a cross-platform app, compatible with both Windows and IOS systems. Whether as a stand-alone or integrated into the coordinated entry system, HOME is based on open source technology for easy adoption and customization. HOME is preloaded with the VI-SPDATs, Point in Time and basic demographic fields. Additional data elements can be added. A chat feature allows staff to be in contact with one another. HOME comes with a web-based portal, allowing an administrator to manage users, add or edit assessments, review and export data to a data warehouse or reporting platform.

Homeless – HUD’s definition of homelessness (24 CFR 578.3) has four categories:

- **Category 1** – Literally homeless individuals/families
- **Category 2** – Individuals/families who will imminently lose their primary nighttime residence with no subsequent residence, resources, or support networks.
- **Category 3** – Unaccompanied youth or families with children/youth who meet the homeless definition under another federal statute.
- **Category 4** – Individuals/families fleeing or attempting to flee domestic violence.
Detailed definition of Category 4: Any individual or family who: (i) Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, human trafficking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual’s or family’s primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence; (ii) Has no other residence; and (iii) Lacks the resources or support networks, e.g., family, friends, and faith-based or other social networks, to obtain other permanent housing.

**Homeless Management Information System (HMIS)** – a local information technology system used to collect data on the provision of housing and services to homeless individual/families.

**Homelessness Prevention** – A program targeted to individuals and families at risk of homelessness. Specifically, this includes those that meet the criteria under the “at risk of homelessness” definition at 576.2, as well as those who meet the criteria in Category 2, 3, and 4 of the “homeless definition and have an annual income below 30% of family median income for the area.

**Housing First** – An approach to quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment or service participation requirements. Supportive services are offered to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to permanent housing entry.

**Housing Interventions** – Housing programs and subsidies, including transitional housing, rapid re-housing, and permanent supportive housing programs, as well as permanent housing subsidy programs (e.g. Housing Choice Vouchers).

**Housing and Urban Development (HUD)** – The United States Department of Housing and Urban Development.

**Literally Homeless** – Category 1 of HUD’s definition of homelessness. Literally homeless means an individual or family who lacks a fixed, regular, and adequate nighttime residence,
meaning the individual or family has a primary nighttime residence that is a public or private place not meant for human habitation, the individual or family is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including hotels and motels paid for by charitable organizations or federal, state, or local government programs), or the individual is existing 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.

**Master List** – A prioritized list in the HOME app of people who have completed the assessment survey and are in need of permanent housing. The list can be sorted by basic eligibility criteria and is prioritized so that individuals and families with the greatest need are housed first.

**Permanent Supportive Housing (PSH)** – a type of permanent housing designed for chronically homeless and other highly vulnerable individuals and families who need long-term support to stay housed. Permanent supportive housing provides housing linked with case management and other supportive services. Permanent supportive housing has no time limitation, providing support for as long as needed and desired by the resident.

**Rapid Rehousing (RRH)** – a type of permanent housing program that provides short-term financial assistance and support to quickly re-house homeless households in their own independent housing. The goal is to quickly move households out of homelessness and back into permanent housing, providing the lightest level of service necessary to assist the household.

**Release of Information (ROI)** – The consent form that individuals/households complete and sign to grant consent for their personal information to be entered into the HOME app and used for coordinated entry.

**Transitional Housing** – Temporary housing with services to facilitate movement of homeless individuals and families to permanent housing within 24 months

**Victim Service Provider** – A private nonprofit organization whose primary mission is to provide services to victims of domestic violence, dating violence, sexual assault, or stalking.
This term includes rape crisis centers, battered women’s shelters, domestic violence transitional housing programs, and other programs.

**Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT)** – a pre-screening tool designed by OrgCode Consulting, Inc. and Community Solutions that can be conducted to quickly determine whether a client has high, moderate, or low acuity.
## Attachment B: Local Housing Eligibility and Prioritization Matrix

### Monterey County Coordinated Assessment & Referral System

#### Housing Eligibility and Prioritization Matrix

**Program Applicability:**
- CoC, ESG, HUD VASH, VA-funded homeless programs – Must participate per federal requirements
- All other homeless programs – Strongly encouraged to participate through participation MOU

<table>
<thead>
<tr>
<th>Program Type</th>
<th>Client Eligibility Screening Criteria</th>
<th>Prioritization/Population Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent Supportive Housing</td>
<td>• Literal homelessness (Cat. 1) and fleeing domestic violence (Cat. 4)</td>
<td>Prioritization:</td>
</tr>
<tr>
<td></td>
<td>• Verifiable disability</td>
<td>✓ Chronicity of homelessness and highest service needs</td>
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<td></td>
<td>• Other limits may apply if CoC funded (e.g., from streets or shelters)</td>
<td>✓ VI-SPDAT scores of (with highest scores prioritized)</td>
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<td></td>
<td>• Additional eligibility and prioritization requirements may apply based on other funder requirements</td>
<td>• 8 or higher for individuals</td>
</tr>
<tr>
<td></td>
<td>• Local client background limitations:</td>
<td>• 9 or higher for families</td>
</tr>
<tr>
<td></td>
<td>o See attached CoC Local Standards on Client Background Limitations by Program Type</td>
<td>✓ Non-chronic homeless households with disabilities and most severe service needs</td>
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<td></td>
<td></td>
<td>✓ VI-SPDAT scores of (with highest scores prioritized)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 8 or higher for individuals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 9 or higher for families</td>
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<td></td>
<td>Populations/Subpopulations</td>
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<td></td>
<td></td>
<td>✓ Local population/subpopulation priority points (points can be aggregated)</td>
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<tr>
<td></td>
<td></td>
<td>• 2 points: youth/young adults, ages 18-24</td>
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<tr>
<td></td>
<td></td>
<td>• 1 point: families with children</td>
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<td></td>
<td></td>
<td>• 2 points: veterans</td>
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<td></td>
<td></td>
<td>• 3 points: medically frail (includes individuals with more complex medical needs who may require more intensive or longer duration services, for example: cancer, strokes, heart diseases,</td>
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</tbody>
</table>
Goal is Housing First – screen in rather than screen out where possible

cirrhosis, tuberculosis, paraplegia, persons who need assistance with daily living, etc.

<table>
<thead>
<tr>
<th>PROGRAM TYPE</th>
<th>CLIENT ELIGIBILITY SCREENING CRITERIA</th>
<th>PRIORITIZATION/POPULATION FACTORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transitional Housing (Shared and Non-shared Units)</td>
<td>• Literal homelessness (Cat. 1), at imminent risk (Cat. 2), and fleeing domestic violence (Cat. 4) • Additional eligibility and prioritization requirements may apply based on other funder requirements • Local client background limitations: o See attached CoC Local Standards on Client Background Limitations by Program Type</td>
<td><strong>Prioritization:</strong> Only households within a targeted population will be eligible for transitional housing, and will be prioritized in the following order: ✓ <strong>Vulnerability</strong> • VI-SPDAT scores of (with highest scores prioritized) • 6 - 7 for individuals • 7 - 8 for families • NOTE: individuals and families who score higher - in the PSH range - may be placed in TH as Interim Housing solution while awaiting PSH availability <strong>Populations/Subpopulations</strong> ✓ Local population/subpopulation priority points (points can be aggregated) • 2 points: youth/young adults, ages 18-24 • 1 point: families with children • 2 points: veterans • 3 points: frail health</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PROGRAM TYPE</th>
<th>CLIENT ELIGIBILITY SCREENING CRITERIA</th>
<th>PRIORITIZATION/POPULATION FACTORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rapid Re-Housing</td>
<td>• Literal homelessness (Cat. 1) and fleeing domestic violence (Cat. 4) • Additional eligibility and prioritization requirements may apply</td>
<td><strong>Prioritization:</strong> Only households within a targeted population will be eligible for transitional housing, and will be prioritized in the following order: ✓ <strong>Vulnerability</strong> • VI-SPDAT scores of (with highest scores prioritized) • 4 - 5 for individuals</td>
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</tbody>
</table>
- Local client background limitations:
  - See attached CoC Local Standards on Client Background Limitations by Program Type

<table>
<thead>
<tr>
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<th>CLIENT ELIGIBILITY SCREENING CRITERIA</th>
<th>PRIORITIZATION/POPULATION FACTORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Shelter</td>
<td>• Literal homelessness (Cat. 1), at imminent risk (Cat. 2), and fleeing domestic violence (Cat. 4)</td>
<td>✅ <strong>First-come first-serve</strong> for all emergency shelters except the following:</td>
</tr>
<tr>
<td></td>
<td>• Additional eligibility and prioritization requirements may apply based on other funder requirements</td>
<td>• As referred by the County for County-funded shelters serving persons with psychiatric disabilities.</td>
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<td></td>
<td>• Local client background limitations:</td>
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<td></td>
<td>- See attached CoC Local Standards on Client Background Limitations by Program Type</td>
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</tr>
<tr>
<td>Prevention</td>
<td>• At risk of homelessness (ESG Cats. 1 - 3), and at imminent risk (CoC Cat. 2)</td>
<td>✅ <strong>Placeholder</strong>: A pre-screening process and priorities for referring at risk persons to prevention resources will be developed in the next year</td>
</tr>
</tbody>
</table>

**Populations/Subpopulations**

- **Local population/subpopulation priority points (points can be aggregated)**
  - 2 points: youth/young adults, ages 18-24
  - 1 point: families with children
  - 2 points: veterans
  - 3 points: frail health
Importance of Housing First Goal to Minimize Barriers to Housing: Housing First is a national best practice strategy, adopted by the Monterey and San Benito Counties Continuum of Care, in which people experiencing homelessness are provided with housing directly and with few to no treatment preconditions, behavioral contingencies, or barriers. In light of these goals, agencies should carefully consider any mitigating circumstances or evidence of rehabilitation before denial of admission in cases where program admission may be prohibited. Rehabilitation includes, but is not limited to, evidence that a prohibited act or acts were related to untreated mental illness and/or substance abuse, and that the person is undergoing, has agreed to undergo, or has successfully completed a program of appropriate treatment. Upon consideration of such factors, the program may, on a case-by-case basis, decide not to deny assistance. Remember: The goal is to screen people into housing rather than out of housing where possible to help with the process of ending homelessness for all people.
The chart below sets forth local housing eligibility limitations for housing programs participating in CARS.

**Not prohibited** – means a person cannot be denied program admission for this reason.

**May be prohibited** – means the agency has discretion to accept or deny the person program admission, usually based upon mitigating factors.

**Always prohibited** – means the person must be denied admission.

<table>
<thead>
<tr>
<th>Local Housing Eligibility Limits &amp; Definition</th>
<th>Permanent Supportive Housing (PSH)</th>
<th>Transitional Housing (TH)</th>
<th>Rapid Rehousing (RRH)</th>
<th>Emergency Shelter (ES)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Violent Criminal Activity In Past 5 Years - includes:</td>
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</tr>
<tr>
<td>1. The criminal use, attempted use, or threatened use of physical force substantial enough to cause, or be reasonably likely to cause, serious bodily injury or property damage;</td>
<td>PSH Individuals – May be prohibited</td>
<td>TH Individuals – May be prohibited</td>
<td>RRH Individuals – May be prohibited</td>
<td>ES Individuals – May be prohibited</td>
</tr>
<tr>
<td>Local Housing Eligibility Limits &amp; Definition</td>
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<td>Emergency Shelter (ES)</td>
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<tr>
<td>2. Criminal activity that threatens the health, safety, or right to peaceful enjoyment of the premises by other residents or persons residing in the immediate vicinity (defined as within a three-block radius of the premises); or</td>
<td>PSH Families – May be prohibited</td>
<td>TH Families – May be prohibited</td>
<td>RRH Families – May be prohibited</td>
<td>ES Families – May be prohibited</td>
</tr>
<tr>
<td>3. Criminal activity that threatens the health or safety of property owners, management staff, program staff, volunteers, agents, and persons performing contract functions or other responsibilities on behalf of the program.</td>
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Evidence must be written and includes:
1. Conviction for violent criminal activity within the past 5 years
2. Any documentation (such as arrest records) that shows evidence of violent criminal activity within the past 5 years (less weight than conviction).

<p>| B. Arson – is the crime of intentionally, deliberately and maliciously setting fire to buildings, wildland areas, dumpsters, vehicles or other property with the intent to cause damage. | PSH Individuals – May be prohibited | TH Individuals – May be prohibited | RRH Individuals – May be prohibited | ES Individuals – May be prohibited |</p>
<table>
<thead>
<tr>
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<th>Transitional Housing (TH)</th>
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<td>PSH Families – May be prohibited</td>
<td>TH Families – May be prohibited</td>
<td>RRH Families – May be prohibited</td>
<td>ES Families – May be prohibited</td>
</tr>
<tr>
<td>1. Conviction for arson within the past 10 years</td>
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<tr>
<td>2. Any arrests for arson within the past 10 year</td>
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<tr>
<td>3. Any documentation (such as arrest records) that shows evidence of intentionally, deliberately and maliciously setting fires in the past 10 years (less weight than conviction).</td>
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<tr>
<td>C. Methamphetamine Manufacturing on the Premises – is the illegal manufacture, or intent to manufacture, methamphetamine on the premises occupied by the person.</td>
<td>PSH Individuals – Always prohibited</td>
<td>TH Individuals – Always prohibited</td>
<td>RRH Individuals – Always prohibited</td>
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<td>1. Any conviction of methamphetamine manufacturing</td>
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<td>2. Any documentation (such as arrest records) that shows evidence of methamphetamine manufacturing on the premises (less weight than conviction).</td>
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</table>
**D. Registered Sex Offender** - is a person, male or female, who has been convicted of a crime involving a sexual act where the law requires them to be placed on the Sexual Offender Registry. Tier 1 offenses are typically of a non-violent nature with persons of the age of majority and include registration for a minimum of 15 years. Tier 2 offenses are typically also of a non-violent nature, but involve minors, and require being registered for no less than 25 years. Tier 3 offenses are the most serious; including those convicted of violent and non-violent acts, with minors or adults, and require being for the offender’s lifetime.

Evidence must be written and includes:

1. Listing in a Sexual Offender Registry.

<table>
<thead>
<tr>
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<tr>
<td><strong>PSH Individuals</strong> – Always prohibited if (1) subject to lifetime (Tier 3) registration requirement, or (2) depending on location, where legally restricted from living near families, schools, parks, or other restrictions; otherwise not prohibited</td>
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### E. Current Use of Illegal Drugs

- **Means** that a person is currently engaged in the use of illegal drugs as defined in the federal Controlled Substances Act. *Currently engaged in the illegal use of a drug* means a person has engaged in the behavior recently enough to justify a reasonable belief that there is continuing illegal drug use.

Evidence must be written and includes:

1. Any conviction for illegal drug use in the past 2 years.
2. Any documentation (such as arrest records in the past two years) that shows evidence of current illegal drug use (less weight than conviction).

### F. Alcohol Use on or Around the Premises

- **Means** any use or sharing of alcohol in or in the immediate vicinity of the premises occupied by the person.

Evidence includes:

1. Any documented credible evidence of current alcohol use in or around the premises.

#### Local Housing Eligibility Limits & Definition

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<td><strong>G. Pattern of Abuse of Alcohol</strong> – means a pattern of abuse of alcohol that may threaten the health, safety or right to peaceful enjoyment of the premises by other residents.</td>
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<td><strong>H. Abusive, Threatening, or Violent Conduct Toward Staff, Property Management, or Other Residents</strong> – includes any verbal or physical conduct, such use of racial epithets, or other language, written or oral, that is customarily used to intimidate may be considered disrespectful or abusive. <strong>Threatening</strong> or violent refers to oral or written conduct.</td>
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**Evidence must be written and includes:**

1. More than one conviction related to alcohol abuse in the past 2 years
2. Any documentation (such as arrest records in the past two years) that shows evidence of current alcohol abuse.
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<td>threats or physical gestures that communicate intent to commit violence, or the actual committing of violence. Evidence includes: 1. Any documented credible evidence of abusive, threatening, or violent conduct toward staff, property management, or other residents.</td>
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Memorandum of Understanding (MOU) Between
Agencies Participating in CARS, Monterey & San Benito Counties CoC, and Coalition of Homeless Service Providers (CARS Administrator)

Agencies signing this MOU agree to participate in the Coordinated Assessment and Referral System (CARS) and to comply with the following standards:

- Maintaining user access to the HOME App.
- Maintaining at least one staff person trained and authorized both to use of the HOME app and to conduct the VI-SPDAT assessment.
- Ensuring that clients seeking assistance have prompt access to screening and assessment in a safe and welcoming environment.
- Carrying out screening and assessment of clients, responding to their immediate needs, using CARS tools and technology, supporting referral of clients per CARS protocols, accepting client referrals per CARS protocols.
- Unless prohibited from doing so by law, use the HOME app to for recording of the assessment.
- Obtain a client release before entering client information into the HOME app.
- Following CARS policies and procedures, community guidelines for conducting assessments and communicating about coordinated entry.
- Providing additional referrals to other community services, as appropriate, to people completing the assessment.
- Attending CARS trainings.
- Attending CARS meetings.
- Following CARS policies and procedures.
- For agencies that receive CARS referrals:
  - Accepting and promptly acting on client referrals through CARS.
  - Participating in case conferences requested to resolve housing placement issues or concerns.
  - Abide by client eligibility and acceptance determination decision.
  - Comply with fair housing legal requirements in all housing transactions and tenant selection plans and procedures.

Please sign and date below if you agree to the above.

Name: ________________________________

Agency: ________________________________

Date: ______________

Version #1: September 2016