

Lynn Continuum of Care MA-502

Coordinated Entry Policies and Procedures

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1 - Introduction and Overview

1.0 – Background and Purpose

The U.S. Department of Housing and Urban Development (HUD) requires all Continuums of Care (CoCs) to adopt “written policies and procedures” to guide the general operations and day-to-day activities of their coordinated entry (CE) system as detailed in HUD’s 2017 Coordinated Entry Notice CPD-17-01.

At a minimum, these written standards must include:

- Policies and procedures for the evaluation of the eligibility of persons experiencing homelessness for assistance in the CoC Program; and,
- Policies and procedures for determining and prioritizing which persons experiencing homelessness will receive assistance for permanent supportive housing assistance, transitional housing assistance, and rapid rehousing assistance.

The goals of the written standards are to:

- Establish community-wide expectations on the operation of projects within the community;
- Ensure that the system is transparent to users and operators;
- Establish a minimum set of standards and expectations in terms of the quality expected of projects;
- Make the local priorities transparent to recipients and sub-recipients of funds;
- Create consistency and coordination between recipients’ and sub-recipients’ projects within the Lynn Continuum of Care MA-502 geographic area (City of Lynn) and;
- CoC Program standards must be in accordance with Violence Against Women Act (VAWA) regulations.

The Coordinated Entry System is the Lynn Continuum of Care’s (CoC’s) approach to organizing and providing services and assistance to persons experiencing a housing crisis within the City of Lynn. All persons seeking homeless or homelessness prevention assistance are directed to defined entry points, assessed in a uniform and consistent manner, prioritized for housing and services, and then linked to available interventions in accordance with the intentional service strategy defined by the Lynn Continuum of Care leadership and approved by the full membership. Participants in CE system are documented in the CoC’s Homeless Management Information System (HMIS) using appropriate privacy and security protocols. The CE and HMIS flowchart at Appendix A shows the process between these two systems.

All projects funded through the CoC Program or the ESG Program are required to participate in the local CE. The CoC still aims to have all homeless assistance projects participating in its CE process regardless of

funding source and will work with all local projects and funders in the City of Lynn to facilitate their participation.

As part of the annual CoC and ESG application processes, each project must submit a report that identifies the number of participants its project referred, accepted, rejected, and/or served from the CE process.

1.2 – CoC and ESG Coordination

These CE policies and procedures coordinate with the written standards for providing ESG and CoC assistance which are part of the Lynn CoC Governance Charter. Each CoC and ESG recipient or sub-recipient operating within the CoC's geographic area must work together to ensure the CoC's coordinated entry process allows for coordinated screening, assessment, and referrals for ESG- and CoC-funded projects per the CoC Program interim rule: 24 CFR 578.7(a)(9) and the ESG interim rule: 24 CFR 576.400(d) and (e).

Per these regulations, the CoC, in consultation with recipients of ESG Program funds within the geographic area, must establish and consistently follow written standards for providing Continuum of Care assistance that can guide the development of formalized policies and procedures for the coordinated entry process. Specifically, these include:

- Written standards provide guidance for evaluating individuals' and families' eligibility for assistance under 24 CFR Part 578.
- Written standards provide guidance for determining and prioritizing which eligible individuals and families will receive transitional housing assistance.
- Written standards provide guidance for determining and prioritizing which eligible individuals and families will receive rapid re-housing assistance.
- Written standards provide guidance for determining what percentage or amount of rent each program participant must pay while receiving rapid re-housing assistance.
- Written standards provide guidance for determining and prioritizing which eligible individuals and families will receive permanent supportive housing assistance.

The CoC is committed to aligning and coordinating CE policies and procedures governing assessment, eligibility determinations, and prioritization with its written standards for administering CoC and ESG Programs funds as defined throughout these policies and procedures and in the Lynn CoC Governance Charter.

To ensure this coordination, the CoC will include at least one representative from the local ESG recipient in its membership of the CE Committee. Additionally, at least annually, representatives from the CoC and

the ESG recipient agencies will identify any changes to their written standards and share those with the CoC's CE Committee so that the changes may be reflected in the CE Policies and Procedures document.

1.3 – Guiding Principles

The Lynn CE System establishes the following guiding principles for its CE:

1. The CE will operate with a person-centered approach, and with person-centered outcomes.
2. The CE will ensure that participants quickly receive access to the most appropriate services and housing resources available.
3. The CE will reduce the stress of the experience of being homeless by limiting assessments and interviews to only the most pertinent information necessary to resolve the participant's immediate housing crisis.
4. The CE will incorporate cultural and linguistic competencies in all engagement, assessment, and referral coordination activities.
5. The CE will implement standard assessment tools and practices, and will capture only the limited information necessary to determine the severity of the participant's needs and the best referral strategy for him or her.
6. The CE will integrate mainstream service providers into the system, including local Public Housing Authorities and VA medical centers.
7. The CE will utilize HMIS for the purposes of managing participant information and facilitating quick access to available CoC resources.
8. The CE will strive to ensure that participants do not wait on the prioritization waiting list for periods in excess of 60 days.

1.4 – Governance, Roles, and Responsibilities

The CE is governed by the Lynn Continuum of Care, with oversight from the CoC's CE Committee. Day-to-day operation of the CE is the responsibility of the CE Specialist, a staff member of the CE management entity, LEO Inc. (LEO), and funded through the annual NOFA process. Further responsibilities of the CE Specialist are detailed throughout these policies and procedures and include, but are not exclusive to, conducting intake and assessment, agency and client outreach, and data management and reporting for the CE.

Changes to the CE may be made on a pilot or trial basis by the CE lead in consultation with the CoC CE Committee and participating agencies, provided that any such changes be presented to, reviewed, and approved, altered, or declined by the CoC full membership prior to being permanently adopted.

The Table below provides definitions of the roles within the CE system.

ROLES AND RESPONSIBILITIES	
CoC Board	Responsible for the general oversight of the CE system, including the approval of the CE Policies and Procedures document created by the CE Committee.
Coordinated Entry Specialist	Staff position responsible for supporting the CE Management Entity by managing day-to-day functions of CE, which may include any combination of the following: maintaining a prioritization list, assisting with matching participants to available housing resources, communicating referrals, facilitating case conferencing meetings, assisting with grievance and appeal processes, monitoring CE activity, and preparing CE monitoring and evaluation reports.
Coordinated Entry Lead/Management Entity	Organization designated by the CoC to oversee all aspects of CE implementation. Functions include, facilitating CE Committee and case conferencing meetings, oversight of CE system compliance, reporting and data monitoring, maintaining prioritization list(s), and staffing and operation of a CE access point.
CE Committee	Primary governing body for coordinated entry. Meets at least monthly to oversee the implementation and evaluation of the CE system, convenes regular case conferencing, reviews and updates the CE Policies and Procedures annually, or more frequently as needed. Committee members should make every attempt to have at least one member of their agency to participate in CE sub-committee meetings.
Collaborative Applicant	Entity that must (at the request of the CoC Board) apply for HUD funding for coordinated entry, including planning grants.
HMIS Lead Agency	Operates the Homeless Management Information System (HMIS) on the CoC's behalf. Ensures the CE system has access to HMIS software and functionality for the collection, management, and analysis of data on persons served by coordinated entry. Entity designated by the CoC in accordance with HUD's CoC Program interim rule to operate the HMIS on the CoC's behalf. The HMIS Lead designated by the CoC may apply for CoC Program funds to establish and operate its HMIS.
Participating Project	Agency or organization that has agreed to provide homelessness supports/services on behalf of the CoC. A participating project must execute a CE Participation Agreement with the CoC. The Participation Agreement outlines the standards and expectations for the project's participation in and compliance with the policies and procedures governing CE operations. For a project to receive CoC or ESG Program funding from HUD, it is required to participate in coordinated entry.
Referral Partner	A type of participating project. Referral partner will receive and consider referrals to its project from the CE system. It will sign a Referral Partner Agreement with the CE management entity affirming it is aware of and will adhere to all expectations for coordinated entry.
Mainstream System Provider	Agency or entity that can provide necessary services or assistance to persons served by coordinated entry. Examples of mainstream system providers include hospitals, mental health agencies, employment assistance programs, and schools.

1.5 – Affirmative Marketing and Outreach

The CoC Program interim rule at 24 CFR 578.93(c) requires recipients of CoC Program funds to affirmatively market their housing and supportive services to eligible persons regardless of race, color, national origin, religion, sex, age, familial status, or disability who are least likely to apply in the absence of special outreach, and maintain records of those marketing activities. Housing assisted by HUD and made available through the CoC must adhere to all applicable fair housing and anti-discrimination laws and regulations.

All persons participating in any aspect of CE such as access, assessment, prioritization, or referral shall be afforded equal access to CE services and resources without regard to a person's actual or perceived membership in a federally protected class such as race, color, national origin, religion, sex, age, familial status, or disability. Additionally, all people in different populations and subpopulations in the CoC's geographic area, including people experiencing chronic homelessness, veterans, families with children, youth, and survivors of domestic violence, shall have fair and equal access to the coordinated entry process.

Each project participating in CE is required to post or otherwise make publicly available marketing material approved by the CE committee that describes coordinated entry and its access points. This notice should be posted in the agency's waiting areas, as well as any areas where participants may congregate or receive services (e.g., dining hall). Information should also be available virtually via the participating project's agency website or social media platform if applicable. All staff at each agency are required to know which personnel within their agency can discuss and explain CE to a participant who seeks more information.

1.6 – Safety Planning and Risk Assessment

As defined in the Coordinated Entry Notice, CDP-17-01, the CoC must have a specific written CE policy and procedure to address the needs of individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking, but who are seeking shelter or services from non-victim service providers. At a minimum, people fleeing or attempting to flee domestic violence and victims of trafficking must have safe and confidential access to the coordinated entry process and victim services, including access to the comparable process used by victim service providers, as applicable, and immediate access to emergency services such as domestic violence hotlines and shelter.

All CoC providers shall incorporate a safety risk assessment as part of initial CE triage and intake procedures, evaluating, to the greatest extent possible, the physical safety and well-being of participants and prospective participants.

All CoC-defined access points shall conduct an initial screening of risk or potential harm perpetrated on participants as a result of domestic violence, dating violence, sexual assault, or stalking. In the event defined risk is deemed to be present, the participant shall be referred or linked to available specialized

services and housing assistance, using a trauma-informed approach designed to address the particular service needs of survivors of abuse, neglect, and violence.

1.7 – Non-Discrimination

Recipients and subrecipients of CoC Program- and ESG Program-funded projects must comply with the nondiscrimination and equal opportunity provisions of federal civil rights laws, as specified at 24 CFR. 5.105(a), including the following: (a) Fair Housing Act prohibits discriminatory housing practices based on race, color, religion, sex, national origin, disability, or familial status; (b) Section 504 of the Rehabilitation Act prohibits discrimination on the basis of disability under any program or activity receiving federal financial assistance; (c) Title VI of the Civil Rights Act prohibits discrimination on the basis of race, color, or national origin under any program or activity receiving federal financial assistance; and (d) Title II of the Americans with Disabilities Act prohibits public entities, which includes state and local governments, and special purpose districts, from discriminating against individuals with disabilities in all their services, programs, and activities, which include housing, and housing-related services such as housing search and referral assistance. Title III of the Americans with Disabilities Act prohibits private entities that own, lease, and operate places of public accommodation, which include shelters, social service establishments, and other public accommodations providing housing, from discriminating on the basis of disability.

2 – Access

2.0 – Access Model

The CoC adopts a “no wrong door” approach to CE, which ensures that no matter which homeless assistance provider a person goes to for assistance, they will have access to the same resources, referrals, and assessment and prioritization processes. Through this model, participants are able to access CE by presenting at any homeless assistance agency within the community.

Each homeless assistance provider designated by the CE Committee as an access point will provide access to crisis response services for persons experiencing homelessness or at imminent risk of literal homelessness as defined by the Department of Housing and Urban Development (HUD). All designated access points shall execute a CE Participation Agreement with the CE Committee that documents all required functions and responsibilities.

2.1 – Lynn CoC CE Access Points

Potential participants may access the CES through one of the several access points throughout the CoC’s service area. These access points are:

Lynn Housing Authority and Neighborhood Development (LHAND)
Family Success Center
39 Curwin Terrace
Lynn, MA 01905

LEO Inc. (LEO)
181 Union Street
Suite 209J
Lynn, MA 01901

Bridgewell, Inc.
Affordable Housing
534 Essex Street
Lynn, MA 01902

Lynn Shelter Association
Emergency Shelter
100 Willow Street
Lynn, MA 01901

Recuperative Care Center/ Lynn Community Health Center
73 Buffum Street
Second floor
Lynn, MA 01902

Youth Dedicated Access Point
Haven Project
57 Munroe Street
Lynn, MA 01901

Agencies operating access points are responsible for determining hours of operation for their CE site, as well as ensuring adequate assessment staffing during such times. Except in instances where a household is seeking emergency services (e.g., emergency shelter) or presents outside of normal hours of operation, households presenting at an *access point*, seeking housing and/or services, shall receive an initial intake, administered by *access point* staff upon initial contact. In instances where a household has accessed emergency services or presented outside of normal hours of operation, initial intake shall be offered, and if accepted, conducted within a reasonable timeframe, ideally within 24 hours of resumption of CE

operations. Initial intake consists of the CE intake form (Appendix C), gathering pertinent information regarding household composition, the household's current housing crisis and history of homelessness.

All access points shall provide CE intake and assessment to any household presenting for services, regardless of household composition or characteristics. Though agencies operating access points may have a focus on specific sub-populations, exclusivity to such sub-populations is not permitted in administration of CE assessments. All people in different populations and subpopulations in the CoC's geographic area, including households experiencing chronic homelessness, veteran households, families with children, unaccompanied youth, and survivors of domestic violence, shall have equal access to the CE regardless of which access point they seek services through. Additionally, households may not be screened out of the coordinated entry process due to perceived barriers to housing or services (lack of income, substance use, domestic violence history, etc.).

Coordinated Entry access points with access to the HMIS software will complete intake forms, assessments and documentation directly in the HMIS system. CE access points without HMIS access will send intake forms, assessments and documentation directly to the CE lead.

2.2 – Emergency Services

The CE process shall not disrupt access to emergency services by households seeking housing and/or services. Participation in CE may not be a precondition to access emergency services, including emergency shelter, at any access point.

In the event prospective participants attempt to access designated access points during non-business hours, those persons will still be able to access emergency shelter without first receiving an assessment through coordinated entry. CE screening and assessment will be completed on all ES participants within 3 days after entry to ES.

2.3 – Street Outreach

To ensure that intake and assessment are accessible to all potentially eligible households intake and assessment may be conducted outside of regular access points provided that the assessor conducting the intake and assessment has completed the most recent CE annual training. Examples of instances in which outreach intake and assessment may be appropriate include, but not be limited to, providing accommodation for persons with disabilities, engaging with unsheltered households reluctant to seek services via an *access point*, or for households reluctant to engage in services who may have existing service connections with agencies not operating an *access point*.

2.4 – Prevention Services

In accordance with the Coordinated Entry Notice, CPD-17-01, the Lynn CoC ensures that persons seeking access to homelessness prevention services funded with ESG Program funds and private funding may do so through CE. The CE System will ensure that all potentially eligible homelessness prevention participants will be screened for homelessness prevention assistance, regardless of the access point at which they initially see assistance.

Homeless prevention access points and general homeless assistance access points will coordinate information and referrals back and forth to ensure persons at imminent risk of literal homelessness are provided coordinated access to CoC and ESG homelessness prevention services regardless of where the participant first contacts the CoC.

2.5 – Access to Coordinated Entry for Households Experiencing Domestic Violence¹

In accordance with 24 CFR 578.7(a)(8), the CE will ensure that households experiencing domestic violence be provided immediate referral and connection to victim service providers (if desired), full access to the housing and services available through CE, and accommodation in procedures for intake and assessment to protect household safety.

Referral to Victim Service Provider– Households identified as experiencing domestic violence who seek services via the CE are to be provided information on, and offered referral to, a local victim service provider by the agency conducting the assessment.

Full CE Access – Regardless of whether a household pursues and/or receives services from a victim service provider, they will be provided full access to the housing and services available via CE. Households experiencing domestic violence must not be ‘steered’ towards or away from participation in any particular program or service, but should be presented with all available options, except insofar as an evidence-based assessment tool may indicate a higher level of service need for households experiencing domestic violence and insofar as all households experiencing domestic violence will be offered referral to a victim service provider.

Alternative Assessment Procedures – In situations where seeking services in-person at a CE access point would pose or create a safety risk for the household, participating agencies may conduct assessment via virtual means (e.g., phone or email), provided that data is collected and stored in a manner consistent

¹ The phrase ‘households experiencing domestic violence’ shall be used to encompass households fitting category 4 of HUD’s Definition of ‘Homeless’ (24 CFR 578.3), as well as those at-risk of experiencing homelessness who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking (including human trafficking).

with applicable CoC and HMIS confidentiality requirements (for non-victim service providers) or VAWA confidentiality requirements (for victim service providers).

2.6 – Access to Coordinated Entry for Veteran Households

Through the standardized assessment tool veteran households are identified at intake. All veteran households experiencing, or at-risk of experiencing, homelessness shall be referred to the Lynn CoC's Veteran's Committee for connection with all applicable veteran specific resources, including those offered through the Department of Veterans Affairs (VA) and the City of Lynn Department of Veterans Services. All veteran households shall also have full access to the housing and services available through CE and related programs.

2.7- Access to Coordinated Entry for Other Subpopulations

Through the standardized assessment tool households of certain sub-populations are identified at intake. Any household experiencing, or at-risk of experiencing, homelessness in which there are sub-population specific projects/services the household should be referred to projects/services with all applicable specific resources. For example, participants who are living with HIV/AIDS should be referred to the Housing Opportunities for Persons with AIDs Program (HOPWA). All households referred shall also have full access to the housing and services available through CE and related programs.

3 – Assessment

3.0 – Standardized Assessment Approach

The CoC's CE process will provide a standardized assessment process to all CE participants, ensuring uniform decision-making and coordination of care for persons experiencing a housing crisis. Access points are staffed with assessors trained in conducting intake and assessment, and utilize a standardized, multi-tiered assessment process. The assessment gathers pertinent information and documentation to establish a client record, identify programs and services for which household may be eligible, and, if applicable, establish the severity of a household's service need via a vulnerability index.

All persons served by CE will be assessed using the Lynn CoC Assessment Tool attached as Appendix C. All access points must use this tool to ensure that all persons served are assessed in a consistent manner, using the same process. The tool documents a set of participant conditions, attributes, need level, and vulnerability, allowing the access point and/or CE Specialist to identify a service strategy including placement on the CoC's prioritization list if appropriate. Access points with access to HMIS will complete intakes and assessments directly through the HMIS. The CE Lead will make final determination if the client meets the criteria to be placed on the prioritization waitlist for all available projects, or if the participant

is to be referred to diversion/prevention services. Determination of eligibility is made based on a combination of information received from assessment, HUD criteria/definitions of homelessness, and other sub-committee approved determinants for prioritization. The CE lead will notify the caseworker of potential housing and service opportunities for assessed participants. Access points without HMIS access will complete the same intake and assessment in PDF form and submit completed documentation to the CE lead.

3.1 – Assessment Phases

All projects participating in CE will follow the assessment and triage protocols of the CE system. The assessment process will progressively collect only enough participant information and documentation to prioritize and refer participants to available CoC housing and support services.

The CoC has adopted the following phased approach to engage and appropriately serve persons seeking assistance through the CE system:

1. Initial Triage (Immediately): This first phase will focus on identifying the immediate housing crisis, and clarifying that the CoC crisis response system is the appropriate system to address the potential participant's immediate needs.
2. Diversion or Prevention Screening (Immediately): The second phase of assessment can also happen immediately upon engaging with a participant. During this phase, CE staff will examine existing CoC and participant resources and options that could be used to avoid the participant entering the homeless system of care.
3. Crisis Services Intake (Immediately): The third phase should also happen immediately, as it is intended to collect all information necessary to enroll the participant in a crisis response project such as emergency shelter or other homeless assistance project.
4. Initial Assessment (Within 2 business days): During the fourth phase, assessors will collect information to identify a participant's housing and service needs with the intent to resolve that participant's immediate housing crisis. During this phase, assessors will begin collecting the required documentation necessary for referral. Assessors should also identify what documentation the client is missing and support the client in obtain any missing documents.
5. Comprehensive Assessment (Within 7 days after initial assessment): In the fifth phase, the assessor will seek information necessary to refine, clarify, and verify a participant's housing and homeless history, barriers, goals, and preferences. Assessment information supports the evaluation of the participant's vulnerability and prioritization for assistance. During this phase, assessors should collect all required documentation necessary for referral.
6. Next Step / Move On Assessment (Ongoing): The final phase will collect information revealed or known after an Initial Assessment is conducted when that new information might suggest a revised referral strategy. Or it will re-evaluate participants who have been stably housed for some time and who might be ready for less-intensive housing and service strategies. Those on the waiting list will be reviewed in the regular Case Conferencing meeting.

The Lynn CoC CE prohibits screening people out of the CE process due to perceived barriers to housing and services, including, but not limited to, too little or no income, active history of substance abuse, domestic violence history, resistance to receiving services, the type or extent of disability-related services or supports that are needed, history of evictions or poor credit, lease violations or history of not being a leaseholder, or criminal record. Further, the CE process may collect and document participants' membership in Civil Rights protected classes but will not consider membership in a protected class as justification for restricting, limiting, or steering participants to particular referral options.

3.2 – Assessor Training

The CoC is committed to ensuring that all staff who assist with CE operations receive sufficient training to implement the CE system in a manner consistent with the vision and framework of CE, as well as in accordance with the policies and procedures of its CE system.

The CoC will provide at least annual training for persons who will manage access point processes and conduct assessments for CE. In-person or video conferencing training will be offered at no cost to the agency or staff. Topics for training will include the following:

- Review of CoC's written CE policies and procedures, including variations adopted for specific subpopulations;
- Requirements for use of assessment information to determine prioritization;
- Intensive training on the use of the CE assessment tool;
- Review of all required forms and client documentation; and
- Criteria for uniform decision-making and referrals.

Training materials will cover the assessment process, including when and how assessments should be administered, required forms and documentation, as well as the prioritization and referral process, including the criteria for uniform decision making. All training materials are made available to current subcommittee members. New staff who assist with CE operations must inform the CE Lead so training(s) can be provided.

3.3 – Participant Autonomy

Participants in CE should be afforded the maximum amount of autonomy and participation in service-planning practical when access the CE. This includes declining to answer intake and/or assessment questions without penalty to housing and service options, as well as declining specific referral options without penalty to the availability of other housing or service options. The assessment process may not require disclosure of specific disabilities or diagnosis; such disclosures may only be obtained for purposes of determining program eligibility to make appropriate referrals. Participant choice shall be incorporated throughout all stages of the CE to the maximum extent practical.

3.4 – Nondiscrimination Complaint and Appeal Process

The CoC is committed to ensuring that no information is used to discriminate or prioritize households for housing and services on a protected basis such as race, color, religion, national origin, sex, age, familial status, disability, actual or perceived sexual orientation, gender identify, or marital status.

The participant information packet must include a form that details who the point of contact is for filing and addressing any nondiscrimination complaints, which can be filed by participants if they believe the nondiscrimination policy has been violated in their case during the CE process. Additionally, this form will describe and provide contact information on how to access the appeal process if they are not satisfied with or have any questions regarding how their complaints are handled. This form must be reviewed at the access point by CE staff, and must be signed by each participant.

3.5 – Privacy Protections

CE participating agencies are required to notify and obtain participant consent for the collection, use, and disclosure of participants' personally identifiable information (PII). A participant's request for housing crisis response assistance initiated through phone or email communication will be considered notification of intent and inferred to be client consent to collect, use, and disclose that PII collected via phone or email. CE participating agencies shall obtain written client consent from the participant when they come into the agency and additional data are collected during an in-person assessment.

All participant information collected, stored, or shared in the operation of CE functions, regardless of whether or not those data are stored in HMIS, shall be considered personal and sensitive information worthy of the full force of protection and security associated with data collected, stored, or shared in HMIS. The CoC must protect all participants' personally identifiable information (PII), as required by HUD's HMIS Data and Technical Standards, regardless of whether or not PII is stored in HMIS. All CE participating projects will ensure participants' PII will only be collected, managed, reported, and potentially shared if those data are able to be secured in compliance with the HUD-established HMIS privacy and security requirements.

3.6 – Disclosure of Disability or Diagnostic Information

Throughout the assessment process, participants must not be pressured or forced to provide CE staff with information that they do not wish to disclose, including specific disability or medical diagnosis information.

3.7 – Updating the Assessment

Participant assessment information should be updated at least once a year, if the participant is served by CE for more than 12 months. The CE lead will notify the casework when an annual assessment needs to be completed. The updated assessment must be submitted to the CE lead within 30 days from notification. If an annual assessment is not received, then the participant will be exited from the program. Upon reengagement with the CE an updated intake assessment would need to be completed.

Additionally, staff may update participant records with new information as new or updated information becomes known by staff or becomes apparent during case conferencing.

Individuals who choose not to participate in data collection upon initial assessment or project entry may later decide that their information can be collected and entered into HMIS. Participant data in HMIS can be updated after an initial CE data collection period and throughout project enrollment to reflect emergence of new information, corrections to previously collected information, or additions of previously unanswered questions. CoCs should continuously work to improve participant engagement strategies to achieve completion rates of required HMIS data elements that are as high as possible.

Participants should be re-assessed or applicable updates made in the event that the assessment tool is changed or amended. Re-assessment ensures that all individuals are being assessed in the same manner and prioritized based on the same vulnerability criteria and risk factors.

4 – Prioritization

4.0 – Standardized Prioritization

The CoC will use data collected through the CE process to prioritize homeless persons within the CoC geography. The CoC will also utilize case conferencing held during the CE Subcommittee meetings to assist in the prioritization process. Client case conferencing will be an opportunity for providers to collaboratively discuss high-risk clients and client updates. This process can assist in keeping client data up-to-date and reflect the client's current needs and concerns.

Permanent Supportive Housing (PSH): The prioritization for PSH is consistent with HUD's Prioritization/PSH Notice. Persons eligible for PSH will be prioritized for available units based on the following criteria (applying the definition of chronically homeless set by HUD in its December 2016 Final Rule):

- 1st Priority—Chronically homeless individuals and families with the longest history of homelessness and with the most severe service needs measured by the CoC assessment tool.
- 2nd Priority— Homeless individuals and families who are not chronically homeless but have a disability, the longest history of homelessness and most severe service needs measured by the CoC assessment tool.
- .
- Tie Breaker—When two households in the same priority are scored equally on the Prioritized List, the following tiebreakers will be used in this order:
 - A Veteran household

- Earliest date of original assessment Lowest household income.

Transitional Housing (TH): The prioritization for persons who are determined to be eligible for TH will be consistent with the CoC's scoring range for need and vulnerability associated with TH projects. The CoC will prioritize the following persons for TH:

- 1. Households fleeing or experiencing domestic violence as the primary cause of their current housing crisis.
- 2. Households consisting of unaccompanied youth.
- 3. Participants seeking treatment services for behavioral health conditions such as mental illness and/or substance use disorders.

Rapid Re-Housing (RRH): The prioritization for persons who are determined to be eligible for RRH will be consistent with the CoC's scoring range for need and vulnerability associated with RRH projects. Additionally, the CoC has opted to prioritize the following persons for RRH:

- chronically homeless households who do not meet programmatic eligibility criteria for available PSH placement; and
- homeless households not meeting the criteria of *chronic homelessness* with the longest histories of homelessness and severe service needs

Emergency Services (ES): Emergency services are a critical crisis response resource, and access to such services will not be prioritized.

Emergency Housing Voucher (EHV): The prioritization for persons who are determined eligible for an EHV will be consistent with the CoC's scoring range for need and vulnerability as outlined in the Memorandum of Understanding(s) (MOU). Additionally, the CoC has opted to prioritize the following persons for RRH:

- Longest stayers in Permanent Supportive Housing (PSH) units facing the highest risk factors and boundaries (for EHV's allocated directly to Lynn only)
- Households that meet the HUD definition of homeless facing the highest risk factors and boundaries
- Households that meet the HUD definition of at risk of homelessness facing the highest risk factors and boundaries
- Households fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or human trafficking facing the highest risk factors and boundaries
- Households who were recently homeless or have a high risk of housing instability

Emergency Solutions Grants (ESG): ESG funds are prioritized according to their program component, but may be distributed on a first-come first serve basis.

Youth-Specific Projects (Including Youth Homelessness Demonstration Program): Youth-specific projects (including YHDP-funded projects) prioritize housing and services based on severity of service need across all project components (TH, RRH, etc.).

4.1 – Prioritization List

The CoC has established a community-wide list of all known homeless persons who are seeking or may need CoC housing and services to resolve their housing crisis. The prioritization list, also known as the waiting list, will be organized according to participant need, vulnerability, and risk. The prioritization list provides an effective way to manage an accountable and transparent prioritization process.

The CoC's prioritization list will be managed by the CE coordinating entity. New participants will be added to the prioritization list and existing participants' rank order on the prioritization list will be managed according to the prioritization principles as established by these written policies and procedures governing CE operations and decision-making. Participating agencies are required to provide the following information about participants: assessment score, participant preferences for housing type and location, and any additional special housing needs such as physically accessible units or other accommodation needs.

5 – Referral

5.0 – Client Referrals

The CE Lead is responsible for sending referrals containing client assessments and documentation to partnering housing projects enrolling new participants through the CoC's CE program. Intake, assessment information, and documentation (e.g., verification of homelessness) are to be input directly into the HMIS for those agencies with access. Agencies without HMIS access will send intakes, assessments, and documentation to the CE Lead directly.

Housing and service providers are responsible for reporting all applicable eligibility requirements necessary for placement to the CE Lead. Upon notification of a vacancy or project availability, the CE Lead will determine the highest priority participant likely to meet the eligibility as prescribed by the participating project. It is the sole responsibility of participating projects to determine eligibility for placement or service.

5.1 – Notification of Vacancies

All CE participating providers will enroll new participants only from the CoC's CE referral process. To facilitate prompt referrals and to reduce vacancy rates, participating providers must notify the CE coordinating entity of any known and anticipated upcoming vacancies. Vacancies will also be reported and tracked within the HMIS system as available.

When a TH, RRH, PH, or PSH vacancy occurs or is expected to occur in the immediate future, the provider agency with the vacancy must alert the CE lead via email within 2 business days of the vacancy. The notification must include specific details of the vacancy, including the project name, unit size, location, and any funder-defined eligibility requirements. The CE lead will provide vacancy information to the CE

Committee and work to identify a prioritized household to fill the vacancy during the next regularly scheduled housing referral coordination meeting.

5.2 – Participant-Declined Referrals

One of the guiding principles of CE is participant choice. This principle must be evident throughout the CE process, including the referral phase. Participants in CE are allowed to reject service strategies and housing options offered to them, without repercussion.

Individuals and families will be given information about the programs available to them and provided choices whenever feasible based on assessment information, vulnerability and need scores, preliminary eligibility predeterminations, and available resources. Of the options available, participants will be afforded their choice of which project to be referred to. If an individual or family declines a referral to a housing program, they remain on the prioritization list until the next housing opportunity is available.

5.3 – Provider-Declined Referrals

There may be instances when agencies decide not to accept a referral from the CE system. When a provider agency declines to accept a referred prioritized household into its project, the agency must notify the CE lead in writing of the denial and the reason for the denial. Denials will also be documented in HMIS.

Refusals by projects are acceptable only in certain situations, including these:

- The person does not meet the project's eligibility criteria.
- The person would be a danger to self or others if allowed to stay at this particular project.
- The services available through the project are not sufficient to address the intensity and scope of participant need.
- The project is at capacity and is not available to accept referrals at this time.
- The project has made 3 distinct outreach attempts over a period of 5 business days and is unable to make contact with the client.
- Other justifications as specified by the "referred to" project.
- The person has missed two intake appointments with the project
- The person has not supplied documentation as required by the housing provider's prescribed eligibility determination process

Individuals and families who are unresponsive to outreach attempts (as defined in section 5.2 and 5.5) for referrals will be marked as inactive on the waiting list. Inactive clients will not be referred for placement until contact is made by a participating agency and it is determined the client is still actively seeking services. Clients will be notified by the Coordinated Entry Lead informing them of the reason why their referral was unsuccessful and will remain on the appropriate CE list unless they inform the CE Lead that they are no longer interested.

5.4 – Emergency Solutions Grants Referrals

Within the Lynn CoC's geographic service area, Emergency Solutions Grants (ESG) funds are utilized for housing and services via two funding streams, one directly via the City of Lynn and one via the Massachusetts Department of Housing and Community Development. Funds are utilized for a variety of activities supporting rapid re-housing programs, homelessness prevention programs, and the operation of street outreach, among others.

The Lynn CoC coordinates activities with ESG recipients and has established linkages for CES clients to and from ESG funded activities. All local sub-recipients of ESG funding are participating agencies in the CES. Clients are referred directly to the CES from ESG sub-recipient outreach activities. In instances where a household seeking assistance through the Coordinated Entry System is at-risk of experiencing homelessness, a referral is made to the appropriate homelessness prevention resources for the household's situation, including ESG prevention assistance (see Coordination with Homelessness Prevention Programs for further details).

Rapid Re-Housing (RRH) Assistance

RRH assistance is available within the CoC's geographic service area for households experiencing homelessness as defined under paragraphs 1 and/or 4 of the HUD definition. Clients for this assistance are taken exclusively through the CES according to CoC/ESG recipient priority ranking guidelines. Currently, the households prioritized for assistance via ESG RRH funding are:

- chronically homeless households who do not meet programmatic eligibility criteria for available PSH placement; and
- homeless households not meeting the criteria of *chronic homelessness* with the longest histories of homelessness and severe service needs.

To direct assistance to the above noted priority groups, referrals will be pulled from the full CE client list, sorted by system-wide priority indicators (see Section 4 - Prioritization). All potentially eligible households may be referred for ESG RRH assistance, including those not in a high priority group, and assistance may be distributed on a first-come-first-serve basis.

5.5 – Coordination with Homelessness Prevention Programs

In addition to RRH assistance programs, the Lynn CoC's geography is served by several homelessness prevention programs, via both ESG programs as well as mainstream, state-funded programs.

Coordination between these programs and CE provide linkages for households to be referred either from the CE to applicable prevention programs or from prevention programs to CE.

The Lynn Housing Authority and Neighborhood Development administers homelessness prevention programs via ESG funding and state-funding (e.g., RAFT). Households being assessed as part of Coordinated Entry that are not experiencing homelessness, but are at-risk of experiencing homelessness shall be referred to homelessness prevention resources at the LHAND after initial intake and before a vulnerability assessment is conducted. Referral shall be made directly by the staff conducting assessments at the applicable *access point*. Due to the LHAND's role in operating an *access point* as part of the CES, households seeking assistance through homelessness prevention programs who are experiencing homelessness may access the CES directly through LHAND's Family Success Center access point.

5.6 – Placement

Once a household has been referred and determined eligible by the accepting program, placement into the applicable program shall be made as soon as logistically possible. If a household is unresponsive after having been determined eligible, defined as unreachable for a minimum of five (5) consecutive business days and a maximum of ten (10) business day with three (3) distinct outreach attempts, the accepting program or referring agency may opt to reject the referral and move to the next household awaiting referral. In such cases, the originally referred household will retain their priority ranking upon re-engagement with the CE.

6 – Data Systems

6.0 – Data Handling Protocol

CE process partners and all participating agencies contributing data to CE must ensure participants' data are secured regardless of the systems or locations where participant data are collected, stored, or shared, whether on paper or electronically. Additionally, participants must be informed how their data are being collected, stored, managed, and potentially shared, with whom, and for what purpose.

Participants must receive and acknowledge a "Participant Consent" form prior to the collection of data for CE. The form identifies what data will be collected, where those data will be stored/managed, how those data will be used for the purposes of helping the participant obtain housing and assistance and for other administrative purposes, and what data will be shared with others (if the participant consents to such data sharing).

6.1 – Participant Consent Process

Data must not be collected without the consent of participants, according to the defined privacy policies adopted by the CoC.

As part of the assessment process, participants will be provided with a written copy of the CoC's "Participant Consent" form, which identifies what data will be collected, what data will be shared, which agencies data will be shared with, and what the purpose of the data sharing is. Participants will have the option to decline sharing data; doing so does not make them ineligible for CE.

7 – Evaluation

7.0 – Evaluation Process

As a funded CoC project, CE will participate in the annual project monitoring described in the CoC Governance Charter. In addition, the CE system will be regularly evaluated for effectiveness, efficiency, and quick placement of participants into housing.

Regular and ongoing evaluation of the CE system will be conducted to ensure that improvement opportunities are identified that results are shared and understood, and that the CE system is held accountable. CE will be evaluated using HMIS data on a quarterly basis. Results will be shared with the full membership in the regular meeting, after they have been reviewed by the CE Committee. The CE Committee has selected the following as key outcomes for CE:

1. Reduction in the length of time homeless (system and project level).
2. Reduction in the number of persons experiencing first-time homelessness (system and project level).
3. Increase in the number of placements into permanent housing (system and project level).

7.1 – Role of Participating Agencies in CE

Participating agencies play a crucial role in the evaluation of CE. They must collect accurate and meaningful data on persons served by CE. In addition, participating agencies will review evaluation results and offer insights about potential improvements to CE processes and operations.

At least one representative from each participating agency will be sent the draft results of the CE System evaluation, prior to its distribution to the CE Committee. Representatives will have 3 business days to review and provide feedback on the results. While reviewing the data, agency representatives are encouraged to communicate directly with the CE coordinating entity about any concerns or questions that they have, and to be detailed in their suggestions to the CE coordinating entity about how best to interpret and use the evaluation results.

7.2 – Provider & Participant Feedback

At least annually, the CE Lead shall survey current participating agencies as well as current and former participating clients regarding their experiences working with the CE system. Questions shall cover, at a minimum, clarity of CE communications, understanding of CE processes, and satisfaction with overall

system performance. Summary results shall be presented to the CE committee and made available to full membership upon completion.

8 - Subcommittee Meetings

Each meeting includes discussion of problems that have occurred such as barriers to placement, client and/or provider placements rejections, gaps in services and housing search, and any other challenges that persons served through the CoC may experience. Attendees are encouraged to provide updates to reflect changes in available housing and service resources. In addition to case conferencing the CE lead will provide updates on pending referrals, participants with projected move-in-date housing, and housed clients.

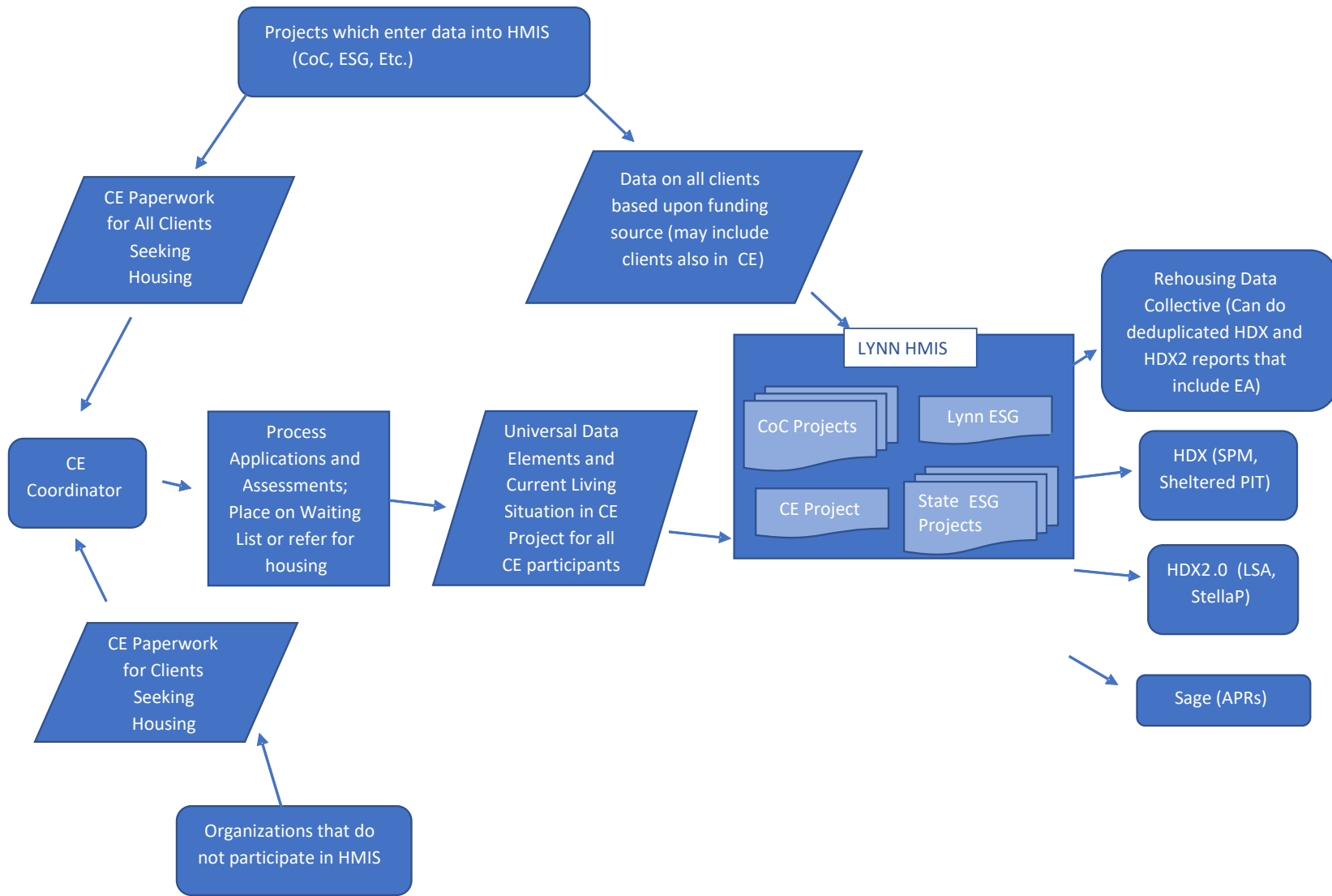
Notices of the time and place of the CE sub-committee meetings are widely disseminated via the Lead Agency's distribution list.

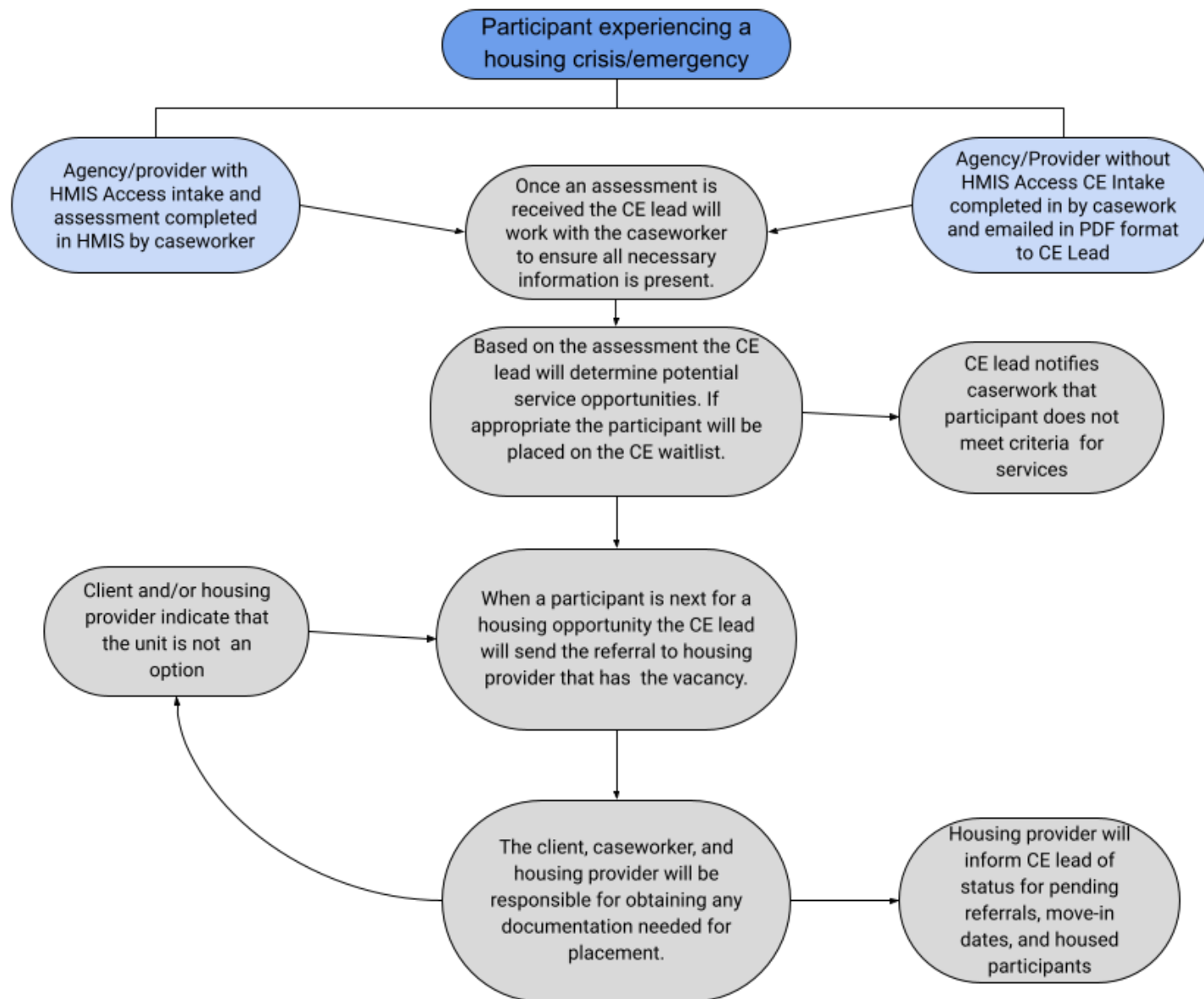
Appendix A – HMIS and CE Flowchart

Lynn Continuum of Care

HMIS and CE Processes and Definitions

LCoC HMIS AND CE Intake & Referral Process





DEFINITIONS, EXAMPLES, AND CLARIFICATIONS

What is the difference between the Lynn CoC HMIS and CE?

The Lynn CoC HMIS is an electronic data system that holds information on homeless persons throughout the Lynn CoC (City of Lynn) geography. These programs include CoC-funded projects, ESG and ESG-CV, Emergency Shelter, and the Coordinated Entry project. It is important to note that the Lynn HMIS does not capture EA shelter data or HomeBASE, but this data is recorded in the state Rehousing Data Collective (RDC). In addition, if a homeless family or individual participates in a program in the City that does not participate in this HMIS, their information will not be included.

A Lynn CoC-funded project, Coordinated Entry (CE) works with the Lynn CoC CE Committee and agencies throughout Lynn to maintain a waiting list of those who are homeless, connect them with housing when it becomes available, and maintain the data for this project in the CoC's HMIS. In the past this project accepted applications only for chronically homeless people. As of May, 2021, referrals will be accepted for any homeless person or family seeking housing in the City of Lynn including from agencies that do not participate in the Lynn CoC HMIS.

HUD DEFINITIONS

Homeless Management Information System (HMIS)

A Homeless Management Information System (**HMIS**) is a local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness.

This system uses **HMIS Data Standards** <https://files.hudexchange.info/resources/documents/HMIS-Data-Standards-Manual.pdf> which formalize the **data** that agencies collect on individuals experiencing homelessness across the nation. The HUD data standards help HMIS vendors and HMIS system administrators understand and implement the fields needed to capture these required data elements.

HUD requires that all projects collect Universal Data Elements (UDE) in their HMIS. These include: Name, SSN, DOB, Race, Ethnicity, Gender, Veteran status, Disabling Conditions, Project Start Date (participant enrollment date), Project exit date, relationship to head of household, client location (select CoC code), housing move-in date, prior living situation.

Program Specific Data Elements collected may include income and sources, non-cash benefits, health insurance, physical disability, developmental disability, chronic health conditions, HIV AIDS, Mental health conditions, substance abuse, DV, current living situation, date of engagement, among others depending upon the type of project.

Coordinated Entry (CE)

Coordinated entry is a process developed to ensure that all people experiencing a housing crisis have fair and equal access and are quickly identified, assessed for, referred, and connected to housing and assistance based on their strengths and needs. Coordinated entry processes help communities prioritize assistance based on vulnerability and severity of service needs to ensure that people who need assistance the most can receive it in a timely manner. Coordinated entry processes also provide information about service needs and gaps to help communities plan their assistance and identify needed resources.

The Coordinated Entry project in HMIS must include all Universal Data Elements as well as the current living situation of the participant.

Point in Time (PIT)

The Point-in-Time (PIT) count is a count of sheltered and unsheltered people experiencing homelessness on a single night in January. HUD requires that Continuums of Care conduct an annual count of people experiencing homelessness who are sheltered in emergency shelter, transitional housing, and Safe Havens on a single night. Continuums of Care also must conduct a count of unsheltered people experiencing homelessness every other year (odd numbered years). Each count is planned, coordinated, and carried out locally.

Housing Inventory Count (HIC)

The Housing Inventory Count (HIC) is a point-in-time inventory of provider programs within a Continuum of Care that provide beds and units dedicated to serve people experiencing homelessness (and, for permanent housing projects, where homeless at entry, per the HUD homeless definition), categorized by five Program Types: Emergency Shelter; Transitional Housing; Rapid Re-housing; Safe Haven; and Permanent Supportive Housing. This count is conducted in tandem with the PIT count.

The PIT and HIC counts are entered into HUD's Homeless Data Exchange (HDX).

Annual Performance Reports (APRs)

Recipients with HUD funding received through CoC homeless assistance grants are required to submit an Annual Performance Report (APR) electronically to HUD every operating year through the Sage platform. Data collection for the APR is aligned with the most recent version of the Homeless Management Information System (HMIS) Data Standards.

Stella P

Stella is a strategy and analysis tool to help CoCs understand how their system is performing and model an optimized system that fully addresses homelessness in their area.

Available to all CoCs through HDX 2.0, Stella has one module currently available:

- **Stella Performance Module (Stella P):** Available now, Stella P uses dynamic visuals of CoCs' LSA data to illustrate how households move through the homeless system and highlight outcome disparities. Stella P does the analytical heavy lifting, so your CoC can focus on planning and improving your crisis response system.

Longitudinal Systems Analysis (LSA) and the System Performance Measures (SPM)

LSA and SPM provide CoCs with a look at their overall system functioning. The SPM report is a summary and year-to-year comparison of system wide counts, averages, and medians related to seven areas of performance. The LSA upload also includes data related to several of the same areas of performance, but the business logic defined by HUD for the two reports differs substantially. The results should not be expected to match.

The core difference between the two is that LSA performance data looks at how *households* are moving through a CoC's system (using the head of household's data), while the SPM report is based on *all persons served*. This difference is because SPMs are intended to be overall CoC benchmarks, while the LSA is intended to give CoCs detail about system functioning to inform interventions to improve that functioning. The LSA focuses on household-level performance, since programmatic decisions are implemented for different households and populations separately.

Below are other core differences in the LSA upload and SPM business logic:

- The LSA upload separates RRH and PSH project types and does not include data related to any other PH project types; the SPM report combines RRH, PSH, and OPH project types into a single PH category.
- In addition to system wide totals, the LSA provides detailed breakdowns for household types, populations, and demographic characteristics; the SPM report does not.
- Instead of reporting medians as the SPM report does throughout, the LSA provides distributions of lengths of time wherever they are relevant (e.g. LOTH, length of time served in a particular project, length of time to return). Both provide averages.

Examples

Example of Process Scenarios:

1. Client served in an EA Shelter —————> Application to Coordinated Entry —————> Housing Placement in CoC funded PSH/RRH

In this scenario the client is entered into both DHCD's HMIS- ETO and the Lynn CoC HMIS causing a duplicate record to be created. The state's RDC (data warehouse) will deduplicate and create aggregated reports for federal reporting (SPM, LSA, PIT).

2. Client served in an EA Shelter —————> Application to Coordinated Entry —————> Housing Placement in City of Lynn

In this scenario the client is entered into DHCD's HMIS-ETO, the LCoC CE project in the CoC's HMIS, and LCoC's Coordinated Entry System.

Appendix B – Definitions and Key Terms

This section defines key terms related to the Lynn CoC's Coordinated Entry System. For terms defined statutorily, in instances where an official change has been made resulting in a discrepancy with the definitions listed below, the statutory definition shall prevail.

Access Point

An *access point* is a location designated by the CoC to serve as an entry point to the CES. All potential clients may access the CES at any such location. *Access points* are staffed with trained assessors who provide intake, assessment, and/or referral for clients seeking services.

Case Conferencing

The local process for CE and partner agencies to coordinate and discuss ongoing work with persons experiencing homelessness in the community, including prioritization and review of the active list. The goal of case conferencing is to provide holistic, coordinated, and integrated services across providers, and to reduce duplication.

Chronically Homeless (HUD Definition)

(1) A "homeless individual with a disability," as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:

- (i) Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
- (ii) Has been homeless and living as described in paragraph (1)(i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1)(i).

Stays in institutional care facilities for fewer than 90 days will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility;

(2) An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or

(3) A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Homeless (HUD Definition)

(1) An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;

- (ii) An individual or family living in a supervised 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, or local government programs for low-income individuals);
- or

- (iii) An individual who is exiting an institution where he or she 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;
- (2) An individual or family who will imminently lose their primary nighttime residence, provided that: (i) The primary nighttime residence will be lost within 14 days of the date of application for homeless assistance;
 - (ii) No subsequent residence has been identified; and
 - (iii) The individual or family lacks the resources or support networks, e.g., family, friends, faith-based or other social networks, needed to obtain other permanent housing;
- (3) Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who:
 - (i) Are defined as homeless under section 387 of the Runaway and Homeless Youth Act (42 U.S.C. 5732a), section 637 of the Head Start Act (42 U.S.C. 9832), section 41403 of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2), section 330(h) of the Public Health Service Act (42 U.S.C. 254b(h)), section 3 of the Food and Nutrition Act of 2008 (7 U.S.C. 2012), section 17(b) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)), or section 725 of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a);
 - (ii) 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;
 - (iii) Have experienced persistent instability as measured by two moves or more during the 60-day period immediately preceding the date of applying for homeless assistance; and
 - (iv) Can be expected to continue in such status for an extended period of time because of chronic disabilities, chronic physical health or mental health conditions, substance addiction, histories of domestic violence or childhood abuse (including neglect), the presence of a child or youth with a disability, or two or more barriers to employment, which include the lack of a high school degree or General Education Development (GED), illiteracy, low English proficiency, a history of incarceration or detention for criminal activity, and a history of unstable employment; or
- (4) Any individual or family who:
 - (i) Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, 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)

HUD provides that “[a] Homeless Management Information System (HMIS) is the local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness. Each Continuum of Care is responsible for selecting an HMIS software solution that complies with HUD's data collection, management, and reporting standards.”

Prioritization

Prioritization refers to the process by which client assessment data is ranked to direct the most intensive services to the households with the highest service need. The process takes into account whether a household is chronically homeless,

the length of time the household has experienced homelessness, and severity of service need as determined by a uniform vulnerability index. Under no circumstances does prioritization take into account specific diagnoses or disabilities when ranking households for referral to housing and/or services.

Appendix C – Assessment Tools

PATH HMIS DATA COLLECTION

HMIS ID KEY #: _____

CASE MANAGER: _____

☐ Project Start

☐ Occurrence Point

☐ Annual Assessment

☐ Project Exit

☐ Share Data – HMIS Disclosure Authorization Signed

* * * FILL OUT A SEPARATE FORM FOR EACH HOUSEHOLD MEMBER AND CLIP TOGETHER * * *

Project Entry (All Clients)	Project Entry Date:
Update Only (Head of Household and Adults) [Skip Page 2]	Update Date:
Project Exit Only (All Clients) [Skip Page 2]	Project Exit Date:

HEAD OF HOUSEHOLD: ☐ Yes ☐ No		Social Security Number:	
Head of Household Name:			Veteran: ☐ Yes ☐ No
Household Member Name:		Date of Birth:	
Project Entry Only	Gender: ☐ Woman (Girl, if child) ☐ Man (Boy, if child) ☐ Culturally Specific Identity (e.g., Two-Spirit) ☐ Transgender ☐ Non-Binary ☐ Questioning ☐ Different Identity: _____ ☐ Client doesn't know ☐ Client prefers not to answer		
	Race and Ethnicity: ☐ American Indian, Alaska Native, or Indigenous ☐ Asian or Asian American ☐ Black, African American, or African ☐ Hispanic/Latina/e/o ☐ Middle Eastern or North African ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Client doesn't know ☐ Client prefers not to answer Additional Detail: _____		

Project Entry Only	Does the client have a disabling condition: ☐ Yes ☐ No
	Relationship to Head of Household: ☐ Self (Head of Household) ☐ Head of household's Child ☐ Head of household's spouse or partner ☐ Head of household's other relation member (other relation to head of household) ☐ Other: non-relation member

PATH HMIS DATA COLLECTION

Project Entry Only	LIVING SITUATION (Head of Household and Adults)
↓	Residence Prior to Project Entry: ----- HOMELESS SITUATION ----- ☐ Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside) ☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or RHY-funded Host Home shelter ☐ Safe Haven ----- INSTITUTIONAL SITUATION ----- ☐ Foster care home or foster care group home ☐ Hospital or other residential non-psychiatric medical facility ☐ Jail, prison or juvenile detention facility ☐ Long-term care facility or nursing home ☐ Psychiatric hospital or other psychiatric facility ☐ Substance abuse treatment facility or detox center ----- TRANSITIONAL AND PERMANENT HOUSING SITUATION ----- ☐ Host Home (non-crisis) ☐ Hotel or motel paid for without emergency shelter voucher ☐ Owned by client, no ongoing housing subsidy ☐ Owned by client, with ongoing housing subsidy ☐ Permanent housing (other than RRH) for formerly homeless persons ☐ Rental by client in a public housing unit ☐ Rental by client, no ongoing housing subsidy ☐ Rental by client, with GPD TIP subsidy ☐ Rental by client, with HCV voucher (tenant or project based) ☐ Rental by client, with RRH or equivalent subsidy ☐ Rental by client, with VASH subsidy ☐ Rental by client, with other ongoing housing subsidy ☐ Residential project or halfway house with no homeless criteria ☐ Staying or living in a family member's room, apartment or house ☐ Staying or living in a friend's room, apartment or house ☐ Transitional housing for homeless persons (including homeless youth)
↓	Length of Stay in Previous Place: ☐ One night or less ☐ One week or more, but less than one month ☐ 90 days or more, but less than one year ☐ Two to six nights ☐ One month or more, but less than 90 days ☐ One year or longer
↓	On the night before did you stay on the streets, ES or SH? ☐ Yes ☐ No
↓	Approximate date homelessness started:
↓	Regardless of where they stayed last night – Number of times the client has been on the streets, in ES, or SH in the past three years including today: ☐ One time ☐ Two times ☐ Three times ☐ Four or more times
↓	Total number of months homeless on the street, in ES or SH in the past three years: ☐ One month (this is the first month) ☐ If 2-12 months, specify number of months: ☐ More than 12 months

PATH HMIS DATA COLLECTION

☐ Project Entry ☐ Update ☐ Annual Assessment ☐ Project Exit	INCOME AND SOURCES (Head of Household and Adults)		
	Income from any source?: ☐ Yes ☐ No		
	If yes, check the source below and enter the monthly amount based on current income. Round amount to the nearest dollar.		
	Start Date	Source of Income (Monthly)	Amount
		☐ Alimony or Other Spousal Support	\$
		☐ Child Support	\$
		☐ Earned Income	\$
		☐ General Assistance	\$
		☐ Other:	\$
		☐ Pension or retirement income from another job	\$
	☐ Private Disability Insurance	\$	
	☐ Retirement Income from Social Security	\$	
	☐ SSDI	\$	
	☐ SSI	\$	
	☐ TANF	\$	
	☐ Unemployment Insurance	\$	
	☐ VA Non-Service Connected Disability Pension	\$	
	☐ VA Service Connected Disability Compensation	\$	
	☐ Worker's Compensation	\$	
↓	Total Monthly Income from All Sources		\$
NON-CASH BENEFITS (Head of Household and Adults)			
Non-cash benefits from any source?: ☐ Yes ☐ No			
If yes, check the source below and enter the monthly amount based on current income. Round amount to the nearest dollar.			
Start Date	Source of Non-cash Benefit	Amount	
	☐ Supplemental Nutrition Assistance Program (Food Stamps)	\$	
	☐ Special Supplemental Nutrition Program for WIC	\$	
	☐ TANF Child Care Services	\$	
	☐ TANF Transportation Services	\$	
	☐ Other TANF-Funded Services	\$	
	☐ Other Source:	\$	
↓			

PATH HMIS DATA COLLECTION

HEALTH INSURANCE (All Clients)	
Covered by Health Insurance?: ☐ Yes (If yes, check all that apply) ☐ No	
Start Date	Health Insurance Type ☐ MEDICAID ☐ MEDICARE ☐ State Children's Health Insurance Program ☐ Veteran's Administration (VA) Medical Services ☐ Employer – Provided Health Insurance ☐ Health Insurance obtained through COBRA ☐ Private Pay Health Insurance ☐ State Health Insurance for Adults ☐ Indian Health Services Program ☐ Other:

DISABILITIES (All Clients)		
☐ <i>Project Entry</i> ☐ <i>Update</i> ☐ <i>Annual Assessment</i> ☐ <i>Project Exit</i>	Start Date	Disability Type ☐ Substance Use Disorder ☐ Chronic Health Condition ☐ Developmental ☐ HIV/AIDS ☐ Mental Health Disorder ☐ Physical If Yes, expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? -Select- -Select- -Select- -Select- -Select- -Select-

DOMESTIC VIOLENCE (Head of Household and Adults)	
☐ <i>Project Entry</i> ☐ <i>Update</i>	Domestic violence victim/survivor: ☐ Yes ☐ No If yes for Domestic Violence victim/survivor, when experience occurred: ☐ Within the past three months ☐ Three to six months ago ☐ From six to twelve months ago ☐ More than a year ago If yes for Domestic Violence victim/survivor, are you currently fleeing?: ☐ Yes ☐ No

PATH HMIS DATA COLLECTION

	LIVING SITUATION (Head of Household and Adults)
Occurrence Point Only (only SO, ES NbN, certain SO projects)	Current housing status: ----- HOMELESS SITUATION ----- ☐ Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside) ☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or RHY-funded Host Home shelter ☐ Safe Haven ----- INSTITUTIONAL SITUATION ----- ☐ Foster care home or foster care group home ☐ Hospital or other residential non-psychiatric medical facility ☐ Jail, prison or juvenile detention facility ☐ Long-term care facility or nursing home ☐ Psychiatric hospital or other psychiatric facility ☐ Substance abuse treatment facility or detox center ----- TRANSITIONAL AND PERMANENT HOUSING SITUATION ----- ☐ Host Home (non-crisis) ☐ Hotel or motel paid for without emergency shelter voucher ☐ Owned by client, no ongoing housing subsidy ☐ Owned by client, with ongoing housing subsidy ☐ Permanent housing (other than RRH) for formerly homeless persons ☐ Rental by client in a public housing unit ☐ Rental by client, no ongoing housing subsidy ☐ Rental by client, with GPD TIP subsidy ☐ Rental by client, with HCV voucher (tenant or project based) ☐ Rental by client, with RRH or equivalent subsidy ☐ Rental by client, with VASH subsidy ☐ Rental by client, with other ongoing housing subsidy ☐ Residential project or halfway house with no homeless criteria ☐ Staying or living in a family member's room, apartment or house ☐ Staying or living in a friend's room, apartment or house ☐ Transitional housing for homeless persons (including homeless youth)
↓	
↓	
↓	----- OTHER ----- ☐ Other ☐ Worker unable to determine ☐ Client doesn't know ☐ Client refused ☐ Data not collected
↓	Is client going to have to leave their living situation withing 14 days? -Select- If yes, then: Has a subsequent residence been identified? -Select- Does individual/family have resources or support networks to obtain other permanent housing? -Select- Has the client had a lease or ownership interest in a permanent housing unit in the last 60 days? -Select- Has the client moved two or more times in the last 60 days? -Select-

PATH HMIS DATA COLLECTION

Project Exit Only	EXIT DATA (All Clients)
↓	Reason for Leaving: ☐ Completed Program ☐ Criminal activity/violence ☐ Death ☐ Disagreement with rules/persons ☐ Needs could not be met ☐ Non-compliance with program ☐ Non-payment of rent/occupancy change ☐ Other: ☐ Reached maximum time allowed ☐ Unknown/Disappeared ☐ Left for housing opportunity before completing program
End	Destination: ☐ Deceased ☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or RHY-funded Host Home shelter ☐ Foster care home or foster care group home ☐ Hospital or other residential non-psychiatric medical facility ☐ Host Home (non-crisis) ☐ Hotel or motel paid for without emergency shelter voucher ☐ Jail, prison or juvenile detention facility ☐ Long-term care facility or nursing home ☐ Moved from one HOPWA funded project to HOPWA PH ☐ Moved from one HOPWA funded project to HOPWA TH ☐ No exit interview completed ☐ Other ☐ Owned by client, no ongoing housing subsidy ☐ Owned by client, with ongoing housing subsidy ☐ Permanent housing (other than RRH) for formerly homeless persons ☐ Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway stations/airport or anywhere outside) ☐ Psychiatric hospital or other psychiatric facility ☐ Rental by client in a public housing unit ☐ Rental by client, no ongoing housing subsidy ☐ Rental by client, with RRH or equivalent subsidy ☐ Rental by client, with VASH housing subsidy ☐ Rental by client, with HCV voucher (tenant or project based) ☐ Rental by client, with GPD TIP housing subsidy ☐ Rental by client, with other ongoing housing subsidy ☐ Residential project or halfway house with no homeless criteria ☐ Safe Haven ☐ Staying or living with family, permanent tenure ☐ Staying or living with family, temporary tenure (e.g., room, apartment or house) ☐ Staying or living with friends, permanent tenure ☐ Staying or living with friends, temporary tenure (e.g., room, apartment or house) ☐ Substance abuse treatment facility or detox center ☐ Transitional housing for homeless persons (including homeless youth)

**MA-502 Lynn Continuum of Care
Coordinated Entry Client Assessment**

Date of Assessment	
Referring Agency	
Caseworker Name	
Caseworker Phone Number	
Caseworker Email	
Client Name	
Client Contact Info	

Household Type: *(choose one)*

- ☐ **Single Adult**
- ☐ **Adults, No Children**
- ☐ **Households With Children**

Section A: Housing History Score:	
Section B: Vulnerability Score:	
B.I Households WITHOUT Children (Domains 1 - 11)	
B. II Households WITH Children (Domains 1 - 16)	
TOTAL PRIORITY SCORE (A plus B)	

Section A: Housing History

1. Number of full months homeless during last 3 years? Length of most recent episode?	
2. Has prior experience of domestic violence impacted your current housing situation? (add 3 points if yes) Are you currently fleeing and/or attempting to flee Domestic Violence? (Add 6 points if yes)	
3. Have you been directly impacted by COVID-19? (add 3 points if yes)	
4. Have you experienced discrimination in securing housing as a result of your race, gender identity, ethnicity, income or family composition? (add 3 points if yes)	
Sub-Total: Section A	

Section B: Client Standardized Assessment(Vulnerability)

B.I. For All Households

Select one level of functioning for each of the ten domains for all households

(households without children, households with children) (Circle the adjacent score)

1. Tenancy and Housing History

4	Highly Vulnerable (Street homeless)
3	Vulnerable (Currently in housing search; Newly in shelter, safehaven, etc. within last 60 days; At risk of eviction; Homeless)
2	Stable (In housing more than 60 days, less than 12 months, responsible for lease but with some difficulty)
1	Thriving (In housing and some history of successful tenancy; Retained housing for 1+ year)
0	Self-Sufficient (In housing, Retained housing for 1+ year and is able to live independently without stabilization services)
Notes:	

2. Substance Abuse/Risk Reduction

4	Highly Vulnerable (Active, serious substance abuse; or risk of overdose that could be life-threatening)
3	Vulnerable (Negative consequences due to behaviors associated with substance use. Frequent relapses)
2	Stable (Ability to identify risks and access tools/support systems to decrease harm. Sporadic relapses)
1	Thriving (Regular use of supports. Positive results due to increased safety. Abstinent <12 months, without relapse)
0	Self-Sufficient (No history of substance abuse/use. Abstinent 12+ months, without relapse)
Notes:	

3. Mental Health

4	Highly Vulnerable (Major mental illness not controlled with medication; or, danger to self or others)
3	Vulnerable (Serious mental illness controlled with medication or other significant mental health issue(s))
2	Stable (Some ability to identify and access support services. Recurrent MH symptoms, but not a danger to self/others)
1	Thriving (Mild/minimal symptoms are transient and only slight impairment in functioning. Ongoing use of supports)
0	Self-Sufficient (No history of mental illness. Symptoms are absent or rare)
Notes:	

4. Legal Issues

4	Highly Vulnerable (Criminal history prevents access to mainstream housing)
3	Vulnerable (Open cases, warrants)
2	Stable (No recent criminal activity. Probation/parole compliant. No open cases, warrants)
1	Thriving (No recent criminal activity. No probation/parole)
0	Self-Sufficient (No criminal history. No criminal activity in 5+ years)
Notes:	

5. Physical Health

4	Highly Vulnerable (Chronic serious health condition(s))
3	Vulnerable (High utilizer of emergency services. Significant medical issues)
2	Stable (Some medical issues. Some ability to manage healthcare)
1	Thriving (Ability to participate in healthcare and manage health issues as they arise)
0	Self-Sufficient (Manages and directs own healthcare network)
Notes:	

6. Income

4	Highly Vulnerable (No income or ability to manage money appropriately)
3	Vulnerable (Inability to access benefits. Inadequate income and/or spontaneous or inappropriate spending)
2	Stable (Can meet basic needs with subsidy; Has accessed all mainstream benefits/resources and spending is appropriate)
1	Thriving (Meeting basic needs and managing budget with little or no assistance)
0	Self-Sufficient (Financially stable, income is well managed and client is saving money)
Notes:	

7. Work

4	Highly Vulnerable (No ability for or interest in age-appropriate work)
3	Vulnerable (Unemployed or underemployed; temporary, seasonal or part-time work; inadequate pay; no benefits)
2	Stable (Employed full-time; inadequate pay; limited or no benefits)
1	Thriving (Employed full-time; adequate pay and benefits)
0	Self-Sufficient (Maintains full-time employment; adequate pay and benefits)
Notes:	

8. Independent Living Skills

4	Highly Vulnerable (Unable to demonstrate ability for self-care, or living in a safe manner, avoiding imminent danger, etc.)
3	Vulnerable (Unable to meet basic needs such as food, hygiene, housekeeping, or appropriately supervise children)
2	Stable (Can meet most daily living skills adequately)
1	Thriving (Can meet all daily living skills as well or better than the average person)
0	Self-Sufficient (High functioning person)
Notes:	

9. Community Engagement

4	Highly Vulnerable (Not applicable due to crisis situation; in "survival" mode; no social supports)
3	Vulnerable (Socially isolated/no social skills/no motivation to become socially involved)
2	Stable (Ability to identify and utilize support systems. Becoming familiar with resources. "Good neighbor" behavior)
1	Thriving (Regular use of support systems. Some participation in recreation; work; education; vocation programs)
0	Self-Sufficient (Fully participating and engaged in community activities)
Notes:	

10. Survival Skills/Risk of Exploitation/Safety

4	Highly Vulnerable (Very poor skills, highly dependent, or actively controlled by partner or others; current residence is not safe and needs relocation)
3	Vulnerable (Susceptible to exploitation; over-dependent or easily controlled; safety is threatened in current housing)
2	Stable (Occasionally in dangerous situations, detrimental social networks, safety of current environment is minimally adequate)
1	Thriving (Has decent survival skills, unlikely to be exploited or controlled by others)
0	Self-Sufficient (Capable of self-advocacy; avoids detrimental social networks; Fully participating and engaged in community activities)
Notes:	

11. Head of Household Education

4	Highly Vulnerable (Literacy problems, language is a barrier to employment, and/or no high school diploma/GED)
3	Vulnerable (Enrolled in literacy and/or GED program)
2	Stable (Has High School diploma/GED)
1	Thriving (Needs additional education/training to improve employment options)
0	Self-Sufficient (No literacy or education problems)
Notes:	

Sub-Total: Section B.I. For All Households: _____

B.II. For Households With Children (NOT for Households Without Children)

Select one level of functioning for each of the additional five domains: Circle the Adjacent Score

12. Family Mobility

4	Highly Vulnerable (No access to transportation, public or private; may have car that is inoperable)
3	Vulnerable (Transportation is available, but unreliable, unpredictable, unaffordable; may have car but no insurance, license, etc.)
2	Stable (Transportation is available and reliable, but limited and/or inconvenient; drivers are licensed and minimally insured)
1	Thriving (Transportation is generally accessible to meet basic travel needs)
0	Self-Sufficient (Transportation is readily available and affordable; car is adequately insured)
Notes:	

13. Family Food Access

4	Highly Vulnerable (No food or means to prepare it. Relies heavily on free or low-cost food)
3	Vulnerable (Household is on food stamps/quality of food or nutritional choices available are poor)
2	Stable (Can meet basic food needs, but requires occasional assistance)
1	Thriving (Can meet basic food needs without assistance)
0	Self-Sufficient (Can choose to purchase any food household desires)
Notes:	

14. Children's Education

4	Highly Vulnerable (One or more school-aged children not enrolled in school)
3	Vulnerable (One or more school-aged children enrolled in school, but not attending classes)
2	Stable (Enrolled in school, but one or more children only occasionally attending classes)
1	Thriving (Enrolled in school and attending classes most of the time)
0	Self-Sufficient (All school-aged children enrolled and attending on a regular basis)
Notes:	

15. Child Care

4	Highly Vulnerable (Needs child care, but none is available/accessible and/or child is not eligible)
3	Vulnerable (Child care is unreliable or unaffordable, inadequate supervision is a problem for child care that is available)
2	Stable (Affordable subsidized child care is available, but limited)
1	Thriving (Reliable, affordable child care is available, no need for subsidies)
0	Self-Sufficient (Able to select quality child care of choice)
Notes:	

16. Parenting Skills

4	Highly Vulnerable (There are safety concerns regarding parenting skills)
3	Vulnerable (Parenting skills are minimal)
2	Stable (Parenting skills are apparent but not adequate)
1	Thriving (Parenting skills are adequate or better than average)
0	Self-Sufficient (Parenting skills are well developed)
Notes:	

Sub-Total: B.I AND B.II (For Households WITH Children ONLY): _____

Section C: Barriers to Placement or Special Needs

	<i>Circle Yes or No</i>
CORI	Yes / No
Pet(s)	Yes / No
Credit History	Yes / No
Needs first floor unit	Yes / No
Required to Register as Sex Offender	Yes / No
History of Arson	Yes / No
Prior Evictions/Poor Rent History	Yes / No
Needs ADA unit	Yes / No
Other:	

Section D: Documentation Available

Does the Caseworker have on file: <i>(Circle Yes or No)</i>	
Proof of Identification	Yes / No
Documentation of US citizenship or 'qualified alien' status	Yes / No
Copy of Social Security card	Yes / No
Documentation of homelessness or housing emergency	Yes / No
Documentation of income	Yes / No
Documentation of disability	Yes / No
Release of Information	Yes / No

Section E: Summary

Overall the level of services needed to secure and maintain stable housing based on criteria

	<i>Circle Yes or No</i>
Does client meet CH requirements (add 6 points) or DedicatedPLUS (add 3 points)? <i>(Choose one if applicable)</i>	
Does the client meet the HUD definition of homeless	Yes / No
Does the client meet the HUD definition for being at imminent risk of imminent homelessness	Yes / No
Sub-Total: B.I, B.II (For Households WITH Children ONLY), and Section E	

Client outcome after assessment: (Choose one)

- ☐ Client was referred to permanent supportive housing
- ☐ Referred to diversion/prevention

Comments:

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Lynn Continuum of Care (CoC) MA-502
HMIS / Coordinated Entry
Client Consent Form

What is the Lynn CoC HMIS / Coordinated Entry?

The Homeless Management Information System (HMIS) is a computerized data collection system designed to collect client information about the characteristics and service needs of individuals and households at risk of or experiencing homelessness. The information collected in HMIS will help us to analyze and improve service delivery, identify programs you are eligible for, better understand homelessness, and evaluate the effectiveness of our services. The Lynn Housing Authority and Neighborhood Development (LHAND) is the HMIS Lead Agency for the Lynn CoC as defined by HUD. ETO has been the HMIS application used by the Lynn Continuum of Care (CoC) to date, but as of June 15, 2021 we have begun the transition to Bitfocus' Clarity Human Services System, which is expected to be complete by October 1, 2021. The Coordinated Entry System (CE) is the coordinated homeless response system for the City of Lynn, MA.

In Lynn, all the agencies that participate in entering client data in HMIS share some of that data with each other if needed. This means that if you receive services from a program participating in the Lynn HMIS and later need assistance in another program that also participates, staff at the second agency will search for your name and be able to find your profile. Then you will be asked to confirm your existing information in HMIS (like your name, date of birth and social security number). The second agency will be able to see what kind of services you've received in the past. If you are enrolling in Coordinated Entry, staff you work with will be able to use your HMIS record to help provide documentation of your time experiencing homelessness.

If you would like to see a list of the agencies that participate in the Lynn CoC HMIS, please ask the agency you are receiving services from presently for a list of the Participating Agencies.

*Please note that the list of agencies contributing data to HMIS can change frequently and without notice.

Because Lynn HMIS/CE contains sensitive data, we take your privacy very seriously. The following protections for your data are in place:

- Individual client data is only viewable by certain qualified staff at each participating agency
- In order to participate in the Lynn CoC HMIS/CE, leaders at each agency must sign a Partner Agency Agreement that includes a commitment to protecting client data and maintaining confidentiality.
- In order to use HMIS/CE, agency staff must successfully complete trainings that inform them of how to protect client privacy.
- The Lynn HMIS is hosted on a secure server and is data encrypted.



What information is collected in the HMIS database?

We collect Personal Identifying Information (PII) and general information obtained during your intake and assessment, which may include but is not limited to:

- Your name and your contact information and address
- Your social security number and date of birth
- Your basic demographic information such as gender, race and ethnicity
- Your veteran status
- Your history of homelessness and housing (including your current housing status, and where and when you have accessed services)
- Documents related to housing eligibility

If you are assessed for Coordinated Entry, we also may share self-reported medical history and disability status, including mental and physical health concerns, substance abuse history, and HIV/AIDS status, income sources and amounts, and non-cash benefits, information about other members of your household and your self-reported history of domestic violence.

Why is this information collected?

- To provide and coordinate services
- To assess your needs and the needs of others in our community
- To reduce the duplication of information
- To reduce the amount of time you spend trying to get services and make sure you get the services you need
- To meet requirements of funders such as the U.S. Department of Housing and Urban Development (HUD)
- To develop and improve programs to work towards ending homelessness in our community

How is the information used?

- Based on your needs, social service and housing provider agencies may use HMIS to exchange, share and/or release information collected about you. The purpose of this form is to receive your permission to share this information as needed.
- This may include coordinating referrals for housing services and, if applicable, help in verifying instances of homelessness.
- Information may be used for research and evaluation. If so, your personal identity will never be a part of any research reports.

What are my rights?

- You have the right to receive services, even if you do not sign this consent form. Providers may not refuse to provide you with services if you refuse to sign, but they are still required to ask you questions for intake and enter that information into HMIS, however, they will either lock the



record (preventing it from being seen by other participating agency staff) or de-identify it so there is no way of determining your identity. If you are actively fleeing domestic violence, we are prohibited from entering any identifying data about you in HMIS. If you are assessed for Coordinated Entry, your signature on this document will help us determine your eligibility for housing programs.

- If you have enrolled in Coordinated Entry, you may stop your participation in that program at any time by contacting the CE Team at LEO Inc. via coordinatedentry@leoinc.org
- You have a right to see a copy of the information in your HMIS record and to ask for changes upon written request.
- You have a right to request a copy of our Privacy Notice, which provides more detail on how we may use or disclose information collected in HMIS.
- This form will expire seven years from the date you signed it. You may revoke your consent at any time prior, but your revocation must be provided in writing. You understand that revoking consent will not change anything about information disclosures that have already occurred.
- If you have any questions or you feel your information has been misused in any way you can contact the Lynn CoC by emailing drossewey@lhand.org or calling 339-883-2607.

SIGNATURE AND ACKNOWLEDGEMENT

By signing below, I affirm that I have read this document, or it was read to/or explained to me and I understand and agree with the terms of this document.

Participant Name (Print): _____

Participant Signature: _____ Date: _____

Agency Witness Name (Print): _____

Agency Witness Signature: _____ Date: _____