Mahoning County Coordinated Entry Policy and Procedures Manual

Revised July 2017

Overview

Coordinated Entry (CE) is a standardized access and assessment for all individuals, as well as a coordinated referral and housing placement process to ensure that people experiencing homelessness, per U.S. Department of Housing and Urban Development (HUD) Guidelines, receive appropriate assistance with both immediate and long-term housing and service needs. The entire CE process, within the Mahoning County geographical region with participation of its agencies and organizations, will use a "centralized entry" approach to ensure a thorough, standardized process from initial engagement to successful housing placement.

The Mahoning County Homeless Continuum of Care (MCHCoC) has adopted Coordinated Entry Assessment Referral System (CEARS) to implement its coordinated housing and services components.

Full Coverage

The CEARS service coverage area is the entire geographical area of Mahoning County inclusive of the City of Youngstown which includes access to Crisis Response Services, assessment of clients and referral options for housing and/or services.

Stakeholder Inclusion

The MCHCoC supports the implementation, expansion and ongoing operation and evaluation of CEARS by annually soliciting feedback from randomly selected participating projects and from households that participated in CEARS during that time frame. Solicitations will address the quality and effectiveness of the entire CEARS experience for both participating projects and households. Solicitations will include surveys designed to reach a representative sample of participating providers and households. If additional information is required, focus groups of five or more participants that approximate the diversity of the participating providers and households and individual interviews with participating providers and enough participants to approximate the diversity of participating households will be implemented.

The participants selected by MCHCoC to participate in the evaluation must include individuals and families currently engaged in the CEARS process or who have been referred to housing through CEARS in the last year.

CEARS Design Principles

1. **Adopt countywide standards** yet allowing flexibility beyond baseline standards.
2. **Promote client-centered practices**: Every program participant will be treated with dignity and respect, offered at least minimal assistance and participate in their own housing plan. The CoC will provide ongoing opportunities for client participation in the evaluation of CEARS. Clients will be offered a choice of housing, whenever possible.
3. **Prioritize the most vulnerable population:** Resources should be first directed to persons and families who are most vulnerable – Chronically homeless, Disabled, Veteran, DV Survivor & Youth. Less vulnerable individuals and families will be assisted as resources allow.
4. **Eliminate barriers to housing access:** The MCHCoC has identified system practices and individual project eligibility criteria and worked to eliminate those

barriers, which may have contributed to the exclusion of clients from housing and services.

5. **Transparency:** The CoC has made every effort to ensure clear communication and transparency to stakeholders, funders, service and housing providers as well as the community in areas making thoughtful and precise decisions for the betterment of the community.
6. **Exercise continuous Quality Improvement efforts:** The CoC will continually strive to be effective and efficient and will make changes when those objectives are not achieved.
7. **Promote collaborative and inclusive planning and decision making practices.**
8. **Diversity:** The CoC will continue to acknowledge, honor and respect cultural, regional, programmatic differences.
9. **Use CE data** to analyze local housing needs and reduce the time span of homelessness for individuals and families in Mahoning County.

Low Barrier Policy

CoC providers will make housing and/or service enrollment determinations based on the Housing First Model of limiting barriers. No client may be turned away from crisis response services or homeless designed housing due to lack of income, employment, disability or substance use. Unless the Project's primary funder requires the exclusion, and has a previously documented neighborhood covenant/good neighbor agreement that explicitly limits enrollment to clients with a specific set of attributes or characteristics. The documentation must be provided to the CoC showing just cause for their enrollment policy.

Fair and Equal Access

The MCHCoC will ensure fair and equal access to CEARS programs and services for all clients regardless of race, color, religion, natural origin, age, gender identity, pregnancy, citizenship, familial status, household composition, disability, Veteran status, or sexual orientation. If an individual's self-identified gender or household composition creates challenging dynamics among residents within a facility, the program will make every effort to accommodate the individual or assist in locating alternative accommodations that is appropriate and responsive to the household's needs. Translation services will be made available to program participants requiring assistance. Upon request, CEARS staff will meet program participants in person at the Community Center located at 1344 Fifth Avenue, Youngstown, OH 44504.

CEARS Hours of Operation

HEC is available Monday through Friday, 8:00am to 3:00pm.
211 phone room staff is available 24 hours per day, 365 days per year.
TDD (Telephone Device for the Deaf) is available at 330-744-0579 or 1-800

Emergency Services

The after-hours Crisis Response access is available via telephone through Help Network of Northeast Ohio (211), which coordinates with police, emergency and medical care services for clients seeking emergency assistance at all hours of the day and all days of the year.

Safety Planning

The MCHCoC has provided necessary safety and security protections, through specially designed programs for persons fleeing or attempting to flee Domestic Violence, Dating Violence, Sexual Assault, Stalking or other domestic violence situations. Client information is confidential, only the HMIS ID number is used for identification purposes.

Privacy Protections

CEARS operations and staff must abide by all Federal and State defined privacy protections as defined by the HMIS End User Agreement. Client consent protocols, data use agreements, data disclosure policies and other privacy protections offered to program participants upon entry into CEARS.

Program participants have the right to refuse to answer any questions, though that may impact their assessment score and appropriate referrals. Participants will not be denied services for refusal to provide certain information.

Universal Registry in Homeless Management Information System (HMIS)

Client assessments, including the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT) must be recorded in HMIS within **seven** (7) **business days** from when the information was first collected. Each assessment is included in a weekly report and clients are placed on the Master Housing Priority List within the HMIS System for the type of housing that aligns with their assessment score.

Inclusivity of Subpopulations

All subpopulations including Chronically Homeless (CH) individuals and families, Veterans, Youth, persons and households fleeing domestic violence, and transgendered persons MUST be provided access to CoC Crisis Response Services.

Key Terms

1. **Housing First**. A model of housing assistance that prioritizes rapid placement and stabilization in permanent housing that does not have service participation requirements or preconditions for entry (such as sobriety or a minimum income threshold). HUD encourages all recipients of CoC Program-funded PSH to follow a Housing First approach to the maximum extent practicable.

2. **Chronically Homeless.** The definition of "chronically homeless", as stated in Definition of Chronically Homeless final rule is:
   (a) 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 (a)(i) continuously for at least 12 months or on at least four 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 (a)(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 an institutional care facility;

(b) 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 (a) of this definition, before entering the facility;

(c) 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 (a) or (b) of this definition (as described in Section I.D.2.(a) of this Notice), including a family whose composition has fluctuated while the head of household has been homeless.

3. **Severity of Service Needs.** This Notice refers to persons who have been identified as having the most severe service needs.

(a) For the purposes of this Notice, this means an individual for whom at least one of the following is true:

i. History of high utilization of crisis services, which include but are not limited to, emergency rooms, jails, and psychiatric facilities; and/or

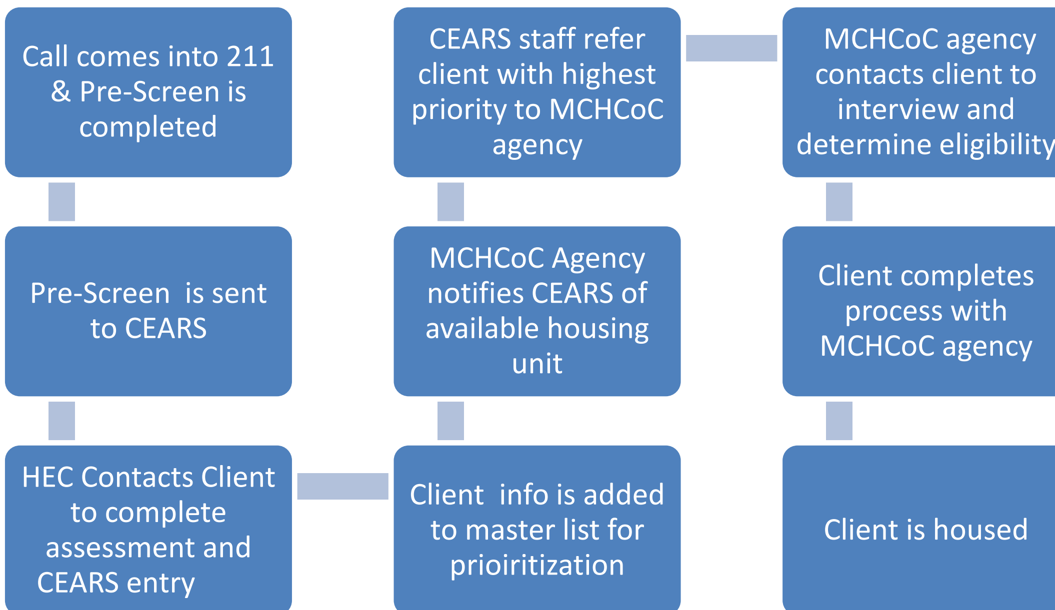
ii. Significant health or behavioral health challenges, substance use disorders, or functional impairments which require a significant level of support in order to maintain permanent housing.

iii. For youth and victims of domestic violence, high risk of continued trauma or high risk of harm or exposure to very dangerous living situations

iv. When applicable CoCs and recipients of CoC Program-funded PSH may use an alternate criteria used by Medicaid departments to identify high-need, high cost beneficiaries.

(b) Severe service needs as defined in paragraphs i.-iv. above should be identified and verified through data-driven methods such as an administrative data match or through the use of a standardized assessment tool and process and should be documented in a program participant's case file. The determination must not be based on a specific diagnosis or disability type, but only on the severity of needs of the individual. The determination cannot be made based on any factors that would result in a violation of any nondiscrimination and equal opportunity requirements, see 24 C.F.R. § 5.105(a).

CEARS Process



Initial Engagement

When a client contacts any CoC provider or outreach team member regarding homelessness, the client will be referred to Help Network of Northeast Ohio's call room (211) for an Initial Engagement Pre-Screen. The client will be asked a series of simple questions to determine if the client will need further assessment by a HEC; this information will be collected on the Initial Engagement Pre-Screen Sheet (**Appendix A**). If the caller requires diversion to other services, the call room worker will offer other agency and service information based on the caller's situation and needs.

Callers experiencing any type of emergency, domestic violence, or runaway youth situation will be referred to a shelter or other emergency services and if the caller agrees, an Initial Engagement Pre-Screen is completed. These callers are also informed that they can call back once they arrive at the shelter.

Agencies and case managers already working with clients can assist them with contacting CEARS and completing the pre-screen or assessments. Case managers/staff can also be included in case conferencing at the client's discretion.

Once the Initial Engagement Pre-Screen is conducted, the Help Network of Northeast Ohio Call room worker will then forward the Pre-Screen to the HEC for tracking purposes and referral within the CoC. The HEC will contact the literally homeless individuals for additional information and entry into HMIS as an active client. The HEC will also inform the client of the documentation needed for housing, i.e. ID, Homeless Certification, Documentation of Disability, birth certificate, etc…

In accordance with training, CEARS staff makes every effort to understand the sensitivity of a client's lived experiences in every aspect of the program processes to minimize risk and harm.

HMIS

The MCHCoC has a homeless database program called Homeless Management Information System (HMIS). This program, created by Mediware, (previously Bowman Systems) and administered by the Coalition on Homelessness and Housing in Ohio (COHHIO) manages data related to CEARS operations. At minimum, data collected and managed in HMIS must include the following:

- All HUD mandated HMIS Universal Data Elements *(UDEs)*
- Assessment Dates: Dates that each stage of the client assessment is completed
  - Pre-Screening
  - Assessment
- VI-SPDAT score: The VI-SPDAT as determined by the administration of the VI-SPDAT assessment tool
- CEARS Referral Determination: The service strategy referral as determined by the VI-SPDAT assessment score
  - Rapid Re-Housing
  - Transitional Housing
  - Permanent Supportive Housing
- Placement of client on the Master List: (If no available housing based on match referral is available.)
- CEARS Placement: The Provider name and CoC component type of the final disposition for each referred client.
- Reason for Denial: If the CEARS referral sources denies or rejects a referral or a client denies or rejects a referral, the reason for the rejection MUST be noted in HMIS (*See Referral Rejection Policy Section*).

Release of Information (ROI)

If an individual agrees to participate in the CEARS process, then the client will be asked for verbal consent to the Release of Information (ROI) before proceeding with the assessment. The HMIS ROI is utilized by the HECs to input all pre-screen assessments into the HMIS program and authorizes the sharing of the client's data with other service providers.

Assessment

The HEC will utilize the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT) as the common assessment tool used to screen any single individual experiencing homelessness. The common assessment tool used to screen any family experiencing homelessness is the F VI-SPDAT and the TAY VI-SPDAT is the assessment tool for Transitional Age Youth. Individuals or families NOT identifying themselves as homeless do not receive an assessment. The assessment is conducted by a provider who has been trained to use the tool by the HMIS Team or other authorized personnel trained as a trainer using the locally approved training curriculum.

The assessment will take 10 minutes to complete. The primary benefit of completing the assessment is to determine the individual's needs and resources for referral. Participants have the right to refuse to answer any questions but that could have an impact on their assessment score. The assessment information will be shared with

service providers eliminating the need for completion of multiple assessments. Providers will use the assessment to connect clients with resources and/or services when they become available.

Client entries and assessments in CEARS are date and timestamped. Clients who present at the same time, will be assessed, prioritized, and placed on the prioritization list based on the Prioritization Standards.

Prioritization Standards

The order of client prioritization entering into CEARS will be based on the following HUD guidelines:

First Priority–Homeless Individuals and Families with a Disability with Long Periods of Episodic Homelessness and Severe Service Needs
An individual or family that is eligible for CoC Program-funded PSH who has experienced fewer than four occasions where they have been living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter but where the cumulative time homeless is at least 12 months **and** has been identified as having severe service needs.

Second Priority–Homeless Individuals and Families with a Disability with Severe Service Needs.
An individual or family that is eligible for CoC Program-funded PSH who is residing in a place not meant for human habitation, a safe haven, or in an emergency shelter and has been identified as having severe service needs. The length of time in which households have been homeless should also be considered when prioritizing households that meet this order of priority, but there is not a minimum length of time required.

Third Priority—Homeless Individuals and Families with a Disability Coming from Places Not Meant for Human Habitation, Safe Haven, or Emergency Shelter Without Severe Service Needs.
An individual or family that is eligible for CoC Program-funded PSH who is residing in a place not meant for human habitation, a safe haven, or an emergency shelter where the individual or family has not been identified as having severe service needs. The length of time in which households have been homeless should be considered when prioritizing households that meet this order of priority, but there is not a minimum length of time required.

Fourth Priority–Homeless Individuals and Families with a Disability Coming from Transitional Housing.
An individual or family that is eligible for CoC Program-funded PSH who is currently residing in a transitional housing project, where prior to residing in the transitional housing had lived in a place not meant for human habitation, in an emergency shelter, or safe haven. This priority also includes individuals and families residing in transitional housing who were fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking and prior to residing in that transitional housing project even if they did not live in a place not meant for human habitation, an emergency shelter, or a safe haven prior to entry in the transitional housing.

Once a client has entered into CEARS, a HEC will be assigned to the household. The minimum score range associated with the assessments for housing resources of Rapid Re-Housing (RRH), Transitional Housing (TH) or Permanent Supportive Housing (PSH) is as follows:

1. Households will be referred to **RRH** based on the availability of resources and the client's VI-SPDAT score.

2. Households will be referred to **TH** based on the availability of TH units, the client's VI-SPDAT score, and at least one of the following criteria:
   - **Youth** – All individuals between the ages of 15-24 who present as a household. This can include unaccompanied youth (household size of one) or multiple youth who are related, such as siblings, cousins, or other family members who are seeking assistance together.
   - **Youth Parent(s)** – Women and men between the ages of 15-24 who are the parent(s) of at least one (1) child and are seeking assistance with that child(ren).
   - **Domestic Violence Survivors** – Households with at least one person who identifies a domestic violence experience as the primary reason causing their housing crisis.
   - **Persons Being Released From Correctional Facilities** – and are homeless before entering prison/jail and/or homeless (as per HUD definition) when released.
   - **Pregnant Women** – Women who are pregnant regardless of their age or whether they have additional children.
   - **Persons in the Early Stages of Alcohol or Drug (AOD) Addiction Recovery**- Households with at least one (1) person who recently began receiving services to assist in their recovery from alcohol or other drug addiction. This can include (but not limited to) people who were recently released from a treatment center or other institution.
   - **Veterans** – (choosing Grant and Per Diem – GPD).

3. Households will be referred to **PSH** based on the VI-SPDAT score and the following specific criteria:
   - Chronic Homelessness as defined by HUD
   - Long-Term Homelessness as defined by Federal and State mandates
   - Longest history of homelessness
   - Most severe Service Needs as determined by the VI-SPDAT

Housing Matching Prioritization Process for Permanent Supportive Housing (PSH)

The following represents the uniform process to be used across the community within the MCHCoC for assessing individuals and matching them to an intervention. Within each category, prioritization of placement into housing is paramount.

Individuals who score an eight (8) or above on the VI-SPDAT or a score of twelve (12) or above on the F VI-SPDAT, which signals the need for Permanent Supportive Housing will be prioritized based on the following criteria:

1. **Length of Time Homeless**: Priority is given to individuals or families that have experienced homelessness consecutively for the least twelve (12) months or longer OR have been homeless more than four (4) times within the last three (3) years and with a disabling condition of long duration.

2. **Medical Vulnerability**: Homeless individuals with severe medical needs who are at greater risk of death will receive expedited placement. This determination is based on questions 22-34 of the VI-SPDAT with a maximum score of five (5).

3. **Overall Wellness**: Individuals with similar medical needs as criteria #1, will be prioritized when the individual has behavioral health conditions or histories of substance use, which may either mask or exacerbate medical conditions. This score will be based on questions 21-50 of the VI-SPDAT (i.e., the "Wellness Domain").

4. **Unsheltered Sleeping Location**: Unsheltered individuals will be given priority over sheltered individuals.

5. **Age**: The age of the individual or Head of Household, giving priority to elderly clients.

6. **Veterans**: Veterans who score an eight (8) or above on the VI-SPDAT or those veterans who are identified as chronically homeless and clinically appropriate for Grant Per Diem (GPD), VA contracted housing or community shelter in the interim are referred to HUD VA Supported Housing (VASH). Veterans not accepted into HUD-VASH who scored eight (8) or above on the VI-SPDAT are then placed on the priority list in HMIS to engage in other permanent housing options.

Housing Matching Prioritization Process for Transitional Housing (TH) and Rapid Re-Housing (RRH)

For individuals scoring 4-7 on the VI-SPDAT or 5-11 on the F VI-SPDAT, the following process will be used to prioritize for Transitional Housing or Rapid Re-Housing Placement:

Scores of 4-7 on the VI-SPDAT for individuals or 8-11 on the F VI-SPDAT for families will be referred to Transitional Housing (TH).

Scores of 4-7 on the VI-SPDAT for individuals or 5-7 on the F VI-SPDAT for families will be referred to Rapid Re-Housing (RRH).

Individuals that score 4-7 on the VI-SPDAT, or families that score 5-11 on the F VI-SPDAT will be prioritized based on the following criteria:

1. **Date of Assessment**: The date of the individual's assessment (giving priority to the most recent date of assessment).

2. **Unsheltered Sleeping Location**: Unsheltered individuals will be given priority over sheltered individuals.

3. **Length of Time Homeless**: The length of time an individual has experienced homelessness, giving priority to the person that has experienced a longer period of homelessness.

4. **Overall Wellness**: Homeless individuals with medical needs will be prioritized when they have behavioral health conditions or histories of substance use, which may either mask or exacerbate their medical conditions.

5. **Medical Vulnerability**: Homeless individuals with severe medical needs who are at greater risk of death will receive expedited placement into housing.

6. **Veterans**: Veterans who receive a score of 0-9 on the VI-SPDAT and who are NOT chronically homeless (CH) and are identified as clinically appropriate for Grant Per Diem (GPD), will be referred to VA contracted housing and to Supportive Services for Veteran Families (SSVF). Veterans may also have the option of being served by other community housing providers for TH or RRH.

Participant Appeal Process

If a participant disagrees with the CEARS decision, they may request an appeal hearing of their placement on the master list. The request must be in writing to: CEARS Management Staff, P. O. Box 46, Youngstown, Ohio 44501. A hearing will be scheduled promptly with the CEARS Management Staff and the individual will be notified in writing of the date, time, and location of the hearing.

Referral Process

The MCHCoC has established written protocols for referrals that explicitly identify the VI-SPDAT score, or score range associated with referrals to each CoC Component Type. This will include PSH, TH, RRH and self-resolve strategies. Clients will be provided the ability to enroll in CoC component types that are less intensive, but not more intensive, than offered by CEARS referral.

CEARS staff will assist program participants to support the safe transition from an access point or emergency shelter to entry in housing.
When offering referral options to clients, the following information must be provided:

- Information about the referred housing providers including the program's rate of success, and housing types using CoC inventory information,
- Referral Rejection Policy,
- Right to choose options less intensive than the CEARS referral,
- And Planning resources

Referral Rejection Policy

Both CoC Providers and Program Participants may deny or reject referrals from the defined CEARS access point. Service denials should be infrequent and must be documented in HMIS with specific justification as prescribed by the CoC. The specific allowable criteria for denying a referral as established by the MCHCoC and must be shared with each project and client. All participating projects and clients must provide the reason for service denial. Aggregate counts of service denials, categorized by reason for denial, must be reported by the CoC annually.

If a participant is denied service, the agency will notify the participant and CEARS. The participant will retain their position on the prioritization list.

In the event of a service denial, or participant denial, the following steps must be followed:

1. Any referral provisionally reviewed by CEARS with a preliminary enrollment determination must be communicated back to the CEARS Housing Navigator, within **three** (3) **business days**.
2. All referral denials must be reviewed by the CoC Program Manager and referred to the CoC Executive Board for finalization.
3. If a referral is finalized and returned to the CoC Program Manager, the HMIS record must reflect the reason for the denial.
4. The CoC Project denying the referral must notify the CEARS Management Staff within twenty-four (24) hours. Furthermore, communication must include a detailed written justification of the denial provided within **three** (3) **business days**. In addition, a written justification of service denial must also be shared with the client.
5. A provider who denies three (3) sequential referrals will be required to participate in a case conferencing meeting with CEARS Management Staff outlining the pattern of referral denials.
6. A client who denies three (3) sequential referrals will be required to participate in a case conferencing meeting with the CEARS Management Staff, the client's case manager (if they have one), and peer support to discuss declined referrals. The client will remain on the housing waiting list without priority until a resolution can be reached.

Housing Navigation

Once a client has been referred to a housing program, that agency will serve as the Housing Navigator to assist a client and guide them through their matched housing program. Housing Navigators are those who currently work for/with agencies participating in CEARS. Prior to and throughout the housing assignment process, the navigator may also do regular outreach to an individual in an effort to build rapport with him/her. The housing program will and must always determine final client eligibility for the housing opening. In the event the client cannot be located, is incarcerated or hospitalized long term, the client will be returned to the Priority List and another client can be matched with the housing.

Housing Navigator Training

The MCHCoC will make annual training available for all CEARS staff. Training topics will include, but are not limited to: effective client engagement techniques, interviewing skills, collection of quality data, sensitivity training, trauma informed care, cultural and linguistic competency practices and maintenance of CEARS records and processes.

Housing Providers

Continuum of Care (CoC) funded housing projects are required to participate in CEARS. These organizations must provide housing to those experiencing homelessness and dedicate all of their housing vacancies to Coordinated Entry, and agree to the following:

1. Identify the type of housing which is being provided as PSH, TH, or RRH.

2. The Housing/Service Provider HMIS Lead End User will be responsible for updating their agency information and available housing inventory.

3. The Housing/Service Provider HMIS Lead End User will be responsible for assisting individuals or families referred to each of their housing type and/or agency.

4. The Housing Provider commits to following the Housing Matching Prioritization Process for Permanent Supportive Housing (PSH), Transitional Housing (TH) and Rapid Re-Housing (RRH).

5. Housing Providers agree to accept referrals from CEARS to fill vacant units.

6. Upon receiving the referral and/or match, the Housing Provider will first attempt to contact the client within three (3) days, using the contact information provided by CEARS.

7. If the provider is unable to locate the client, contact should be made with specialized outreach teams to assist with locating the client. The provider must show documentation of 3 attempts to contact the individual in HMIS.

8. The provider commits to documenting in HMIS when each referral does NOT lead to successful program entry, and provide a reason(s) why the client was not serviced/housed. The individual will be unassigned from the provider in HMIS by CEARS Admin. If the client is referred for additional services, it must be documented in HMIS where the client was then referred for additional services.

9. The provider commits to documenting in HMIS when a referral results in a successful program entry.

EXCEPTIONS:

Due to the nature of their programs, the following agencies do not participate in the CEARS program: Sojourner House, Daybreak Youth Crisis Center, and Mahoning Valley Dispute Resolution Services.

Monitoring and Reporting of CEARS

The MCHCoC has defined a monitoring process that will report on performance objectives related to CEARS utilization, efficiency and effectiveness.

The MCHCoC CEARS committee will review the priority list and policy if the process of housing participants takes longer than 60 days.

The MCHCoC CEARS Reporting requirements will include the following elements to be reported annually to the full CoC Board.

1. Narrative description of the status of CEARS implementation, barriers and challenges experienced and plans for expansion and improvements in the future. CEARS performance indicators will include the following:
    a. Number seeking assistance/referred to CEARS
    b. Number completing initial pre-screening
    c. Number completing assessment (VI-SPDAT)
2. Demographics and attributes of persons/households receiving CEARS assistance.
3. Number of persons/ individuals by VI-SPDAT score
4. Number of persons/individuals receiving CEARS referrals to the following:
    a. Self-Resolve
    b. Rapid Re-Housing
    c. Transitional Housing
    d. Permanent Supportive Housing
5. Destination of persons/individuals to each service strategy as a result of CEARS referral
    a. Rapid Re-Housing
    b. Transitional Housing
    c. Permanent Supportive Housing
6. Length of time from completion of CEARS assessment to program entry
    a. Average length of time from assessment to referral entry for each component type
    b. Average length of time waiting on prioritization (Master List) list for each component type
7. Number of persons who waited for each CoC component type for greater than 30 days.

APPENDIX A:

For Mahoning County ONLY

CEARS Initial Engagement Pre-Screen

Date:______________________

Client Name:____

Client Birthdate:__________________________ Veteran: Yes No

Currently Fleeing DV: Yes No Income: Yes No

Household Size: ___________

Are you homeless? Yes No How Long?________________________

Where did you sleep last night?____

What caused you to be homeless?____

How many times have you been homeless in the past 3 years?_____________________________

Where was client prior to above?____

*Does this client qualify as Literally Homeless? Yes No

Disability? Yes No Type:____

Documented? Yes No Substance Abuse?_______________________________________

Contact phone numbers:____

If not accessible by phone, where is the best place to find you?__________________________

Counselor Contact info:____

Does Client give permission to share this information with other agencies? Yes No

Please note the agencies this client was referred to for services:___________________________

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Please fax form to: 330-746-3042 or email to: cduff@helphotline.org

for tracking purposes and entry of literally homeless clients into Coordinated Entry

***See HUD definitions of homeless**

PLEASE NOTE: Staying with a friend or family member is not considered homeless.

Even though the caller may not have a place of their own, they have a safe place to stay.