MONTGOMERY COUNTY CONTINUUM OF CARE

COORDINATED ENTRY SYSTEM (CES) POLICIES & PROCEDURES MANUAL

Coordinated Entry System (CES) Subcommittee
Montgomery County Continuum of Care
September 1, 2025

Services to End & Prevent Homelessness

Montgomery County Continuum of Care Coordinated Entry System

Revision History

Section of Manual	Date of Implementation
Initial Release	09/01/2025

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How to Use This Document

1. Take a moment to check in with yourself.
    a. What is your role in the Continuum of Care?
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    a. What questions do you have?
4. Read the Introduction.
5. Review key terms in Glossary.

What is the Purpose of This Policies & Procedures Manual?

This manual provides the policies and procedures of the Montgomery County Continuum of Care (CoC) Coordinated Entry System. This manual is intended as guidance for all staff and providers within the Montgomery County CoC to comprehend the different areas of Coordinated Entry. This manual is also intended to centralize all policies and procedures related to Coordinated Entry.

The first section of this manual is meant to establish a foundation of knowledge about our coordinated entry system, visions and principles, and how our Coordinated Entry is organized and governed in Montgomery County.

The next section details the organization and workflow of our Coordinated Entry System. This consists of different housing interventions, access to Coordinated Entry, the process for prioritizing clients and matching them to appropriate interventions, program transfers, and specific populations within Coordinated Entry. The purpose of this section is to provide information on these components and list instructions or processes for guidance.

The third section contains the appendix and glossary. Staff can view copies of different assessments and forms that they can utilize as needed. They can also view definitions for key terms mentioned in this manual.

Staff using these policies and procedures should also reference the HMIS Policies and Procedures Manual, as well as Montgomery County CoC's Written Standards, for more guidance.

Section I: Introduction and Background

I. Introduction

a. Montgomery County Continuum of Care

What is a CoC?

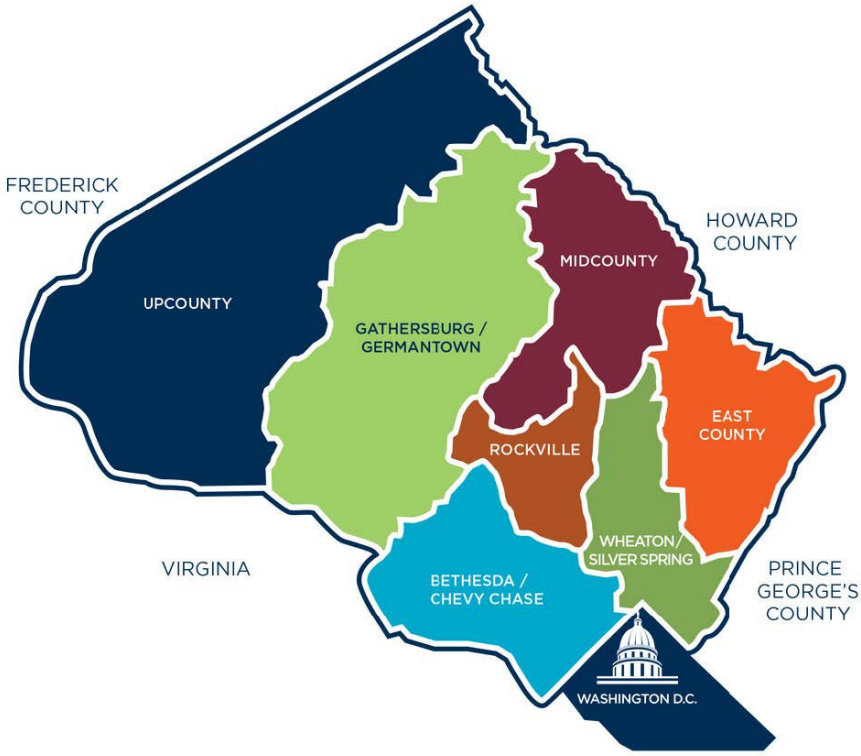
A Continuum of Care (CoC) is a local or regional system for serving people who are experiencing homelessness or at imminent risk of homelessness in the community, from homeless prevention to permanent housing. It is a collaborative funding and planning entity that helps its local community or specific region plan and provide housing services and resources to address the needs of those who are at risk of or experiencing homelessness.

A Continuum of Care (CoC) has an agency or organization that is designated by the CoC to submit the annual CoC Notice of Funding Opportunity (NOFO) grant application to the U.S. Department of Housing and Urban Development (HUD). This entity is referred to as the Lead Agency, and is responsible for coordinating and overseeing CoC planning, in addition to certifying and submitting CoC homeless funding applications. The Lead Agency is also typically the designated HMIS Lead and CES Lead, although that is not always the case. The Department of Health and Human Services, Services to End and Prevent Homelessness, is the CoC Lead Agency for Montgomery County.

A Continuum of Care (CoC) has a primary decision-making group that manages its planning and strategies. For Montgomery County, this is the Interagency Commission on Homelessness (ICH), and it oversees efforts such as determining what committees are needed, setting agendas for different meetings and events, developing projects and monitoring, developing goals and strategies, and providing approval for changes in priorities and policies.

Geographical area in CoC

The areas located in the Montgomery County CoC are Upcounty, Midcounty, East County, which consist of smaller communities, in addition to Germantown, Gaithersburg, Rockville. Wheaton, Silver Spring, and Bethesda. The map below displays where each community is located:



Montgomery County CoC Governance

Interagency Committee on Homelessness (ICH)

The Interagency Committee on Homelessness (ICH) is the governing board on behalf of the CoC. The Montgomery County CoC established six committees to conduct the CoC's work. These committees include the Programs and Operations Committee, Strategy and Planning Committee, Outcomes and Improvement Committee, Partnerships and Funding Committee, People's Committee, and Communications Committee.

The ICH has the authority to modify the committee structures and composition to reflect the current strategic plan. The CES manual focuses on the committees and subcommittees directly related to CES. Please refer to the Montgomery County Continuum of Care Governance Charter for details regarding the rest of the committees.

DHHS – Services to End and Prevent Homelessness (SEPH)

The Services to End and Prevent Homelessness (SEPH) service area of the Department of Health and Human Services serves as the Lead Agency for the Montgomery County CoC, the Collaborative Applicant for the CoC NOFO, HMIS Lead, and CES Lead. SEPH is responsible for the day-to-day administration of the CES, oversight of the CoC, and system performance evaluation.

Basic duties of the SEPH in its management role include:

- Providing training to CoC membership organizations, including but not limited to process training on CES, best practice service delivery strategies and CoC requirements.
- Monitoring data collection in the HMIS, providing reports on outputs and outcomes for CES.
- Overseeing eligibility determination, appeals processes, client placement declines, provider placement rejections, and grievance protocols.
- Improving CES protocols to ensure client access to services and housing is completed in an expedited manner.
- Overseeing Housing Prioritization lists.
- Facilitating CES Housing Prioritizing, case conferencing, and joint leadership meetings.
- Updating policies and procedures.

Coordinated Entry System (CES) Subcommittee

The Coordinated Entry System (CES) subcommittee is comprised of members from both SEPH and our CoC partners. The subcommittee is responsible for the following tasks:

- Serve as representatives of key stakeholder groups who are committed to ending homelessness for all residents of Montgomery County.
- Identify and implement improvements to our coordinated response to homelessness through a data driven systems approach.
- Create, revise, and recommend for approval the Montgomery County Coordinated Entry Policies and Procedures.
- Conduct an annual evaluation of the community's Coordinated Entry system in compliance with HUD regulations.
- Host and actively participate in monthly subcommittee meetings and work groups as needed.

Montgomery County CoC Staffing

Coordinated Entry System Program Manager, SEPH

The Program Manager role includes management and oversight of the CES, including but not limited to the following:

- Liaison with community partners.
- Reviewing and monitoring CES system performance and client outcomes.
- Overseeing Housing Prioritization lists.

- Facilitating CES Housing Prioritization and case conferencing meetings.
- Collaborating with providers to achieve Built for Zero goals.
- Providing training to CoC membership organizations, including process training on CES.
- Monitoring data collection in the HMIS, providing reports on outputs and outcomes for CES.
- Overseeing eligibility determination, appeals processes, client placement declines, provider placement rejections, and grievance protocols.
- Improving CES protocols to ensure client access to services and housing is completed in an expedited manner.

ICH/CoC Coordinator

The ICH/CoC Coordinator role includes management and oversight of the CoC, including but not limited to the following:

- Provide leadership and oversight to ensure CoC programs comply with all federal, state, and local regulations and align with best practices in system design and service delivery.
- Educate CoC membership on regulatory requirements and offer technical assistance to members and administrators, with a focus on Housing First principles and evidence-based practices.
- Foster collaboration with SEPH leadership, the Interagency Commission on Homelessness, and CoC workgroups and committees to promote strategic alignment and collective progress.
- Lead the development and implementation of program evaluations to improve performance and support ongoing organizational growth across the CoC.
- Lead the preparation and submission of the annual CoC Consolidated Application in response to HUD's Notice of Funding Opportunity (NOFO).
- Oversee implementation of the CoC strategic plan and ensure continued compliance with the CoC Governance Charter.

b. <u>What is a Coordinated Entry System?</u>

A Coordinated Entry System (CES) is an evidence-based strategy that focuses on housing and service coordination to link households experiencing homelessness to the most appropriate housing solution based on their needs. The U.S. Department of Housing and Urban Development (HUD) requires all homeless services Continuums of Care (CoC) to utilize CES as stated in 24 CFR 578.7 (a)(8) of the CoC Program Interim Rule.

The goals of an effective CES are to quickly identify households experiencing homelessness, to prevent it whenever possible, to appropriately assess the needs of clients that request help and to connect them to housing and services quickly. Key elements of CES include:

- Low Barrier: operating programs that do not screen clients out for assistance because of possible barriers to housing or services, including, but not limited to, lack of employment or income, drug or alcohol use, or having a criminal record.
- Housing First Orientation: housing clients quickly without preconditions or service participation requirements.
- Person-Centered: incorporating client choice in the type of housing and level of services needed for success.
- Fair and Equal Access: developing processes in which all clients have fair and equal access to the coordinated entry process, regardless of where or how they present for services.
- Emergency Services: ensuring that CES does not unintentionally impede access to emergency shelter.

The Montgomery County CoC and Emergency Solutions Grant (ESG) programs and all other federal, state, and county-funded homeless programs must comply with the CES as outlined in this document. Further, these programs must use the CES as the only referral source to fill housing vacancies. The CES is open to all Montgomery County residents who meet the HUD definition of homelessness, as outlined in the HEARTH Act regulations.

HUD requires that a CES utilizes a database or system to record information from the coordinated entry process. The Montgomery County CoC uses the Homeless Management Information System (HMIS). The HMIS, a shared human services database, allows authorized personnel at homeless and human service provider agencies throughout Montgomery County Homeless Continuum of Care (MC CoC), to enter, track, and report on information concerning their own clients and to share information, subject to appropriate interagency agreements, on common clients. In compliance with all state and federal requirements regarding client/consumer confidentiality and data security, the HMIS is designed to collect and deliver quality data about services and homeless persons, formerly homeless persons, and/or persons at risk of being homeless. For further information about HMIS, please reference the HMIS Manual.

What Are the Benefits of CES?

There are several benefits to using a Coordinated Entry System within a Continuum of Care to improve service delivery. A Coordinated Entry System:

- Coordinates with the CoC participants to identify the prioritization process.
- Communicates transparent housing match process, through the Coordinated Entry staff.
- Documents needs for different types of housing and services, facilitating the ability to advocate for more resources.
- Identifies gaps in the system that impact the length of time and access to services for households.
- Is inclusive of projects that serve all household types and target populations.

c. Goals

As a network of service providers, funders, advocates, utilizers and community partners, the Montgomery County CoC has a mission to end and prevent future homelessness. This mission is tied to three goals:

1. To make homelessness a rare, brief, and non-recurring event.
2. Ensure safe housing is accessible and available to all people.
3. To functionally end homelessness in Montgomery County.

d. Vision and Guiding Principles

The vision of the Montgomery County CoC is embodied in the Housing Together campaign. Paramount to this vision is the fundamental belief that homelessness is a solvable problem for all Montgomery County residents.

Housing Together embodies the guiding principles and shared values of our County and CoC, which are:

- Operation of a person-centric system of care
- Commitment to a comprehensive crisis response system
- Expansion of housing solutions based on the needs of the community

The Montgomery County CoC practices a person-centered model that strongly incorporates participant choice and inclusion of people present in Montgomery County, including, but not limited to, veterans, youth, families with children, and victims of domestic violence. We aim to uphold a solutions-oriented system that centers fair and impartial practices, policies, and programs. Participants within the CoC and Emergency Solutions Grant (ESG) programs are expected to operate with a common vision: access by all to safe, affordable housing, and opportunities to improve the quality of life. Montgomery County has the expectation that all CoC participants implement and uphold low-barrier and trauma-informed practices and policies to ensure a Housing First Approach. CoC and ESG programs are expected to operate with the understanding that everyone is always ready to be housed, regardless of their behavior or additional complications. Additionally, our approach to Housing First principles seeks to decenter mental illness, poverty, joblessness, or disability as reasons for homelessness, but rather to center homelessness as the main barrier to stabilization.

The Montgomery County CoC is also dedicated to these additional values, practices, and policies: person-centered culture, coordination, inclusion of persons with lived experience (PWLE), the No Wrong Door Approach, Trauma Informed Care, and the Housing Justice Act, described in detail in the Written Standards.

Fidelity to Housing First

Housing First is a programmatic and systems approach that centers on quickly providing housing to households experiencing homelessness and then providing services as needed.

- Housing is not contingent on compliance with services.
- Participants are expected to comply with a standard lease agreement and are provided with services and supports to help maintain housing and prevent eviction.
- Services are provided post-housing to promote housing stability and well-being.
- All programs are expected to ensure low barriers to program entry for program participants.

e. How is the CES Organized in Montgomery County CoC

The Coordinated Entry System is organized through four core elements: Access, Assessment, Prioritization, and Referral.

Access

Access points are points of entry for households experiencing homelessness. The Montgomery County CoC access points cover the entire geographical area of Montgomery County. CoC staff connect households seeking services to the appropriate resources such as prevention, diversion, outreach, and shelter.

Assessment

Households at risk or experiencing homelessness will be asked to complete an assessment with trained staff to help determine their strengths, existing resources, and individual and systemic barriers to housing stability.

Prioritization

The prioritization process is a structured approach designed to ensure that households experiencing homelessness are matched with appropriate housing and services based on their specific needs and vulnerabilities. Montgomery County Services to End and Prevent Homelessness continually seeks to achieve all the following system objectives:

1. Most vulnerable persons are prioritized for housing matches.
2. All available CoC resources are leveraged in the most flexible manner possible
3. CoC is working towards continuous improvement of system improvement measures

Referral

Households entering our Coordinated Entry System through the various access points will be referred to supportive services and permanent housing interventions.

f. Populations Served

HUD Categories of Homelessness

1. Homeless Category 1: Literally Homeless (§ 578.3)

A household that lacks a fixed, regular, and adequate night-time residence, meaning:

1. Has a primary night-time residence that is a public or private place not meant for human habitation; **or**

2. Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); **or**
3. Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

Note: A household only needs to meet one of the three subcategories to qualify as Homeless Category 1: Literally Homeless.

2. Homeless Category 2: Imminent Risk of Homelessness (§ 578.3)

A household that will imminently lose their primary nighttime residence, provided that:

1. Residence will be lost within 14 days of the date of application for homeless assistance.

2. No subsequent residence has been identified; *and*

3. The individual or family lacks the resources or support networks needed to obtain other permanent housing.

Note: Includes households who are within 14 days of losing their housing, including housing they own, rent, are sharing with others, or are living in without paying rent.

3. Homeless Category 3: Homeless Under Other Federal Statutes (§ 578.3)

Unaccompanied youth under 25 years of age, or families with Category 3 children and youth, who do not otherwise qualify as homeless under this definition, but who:

1. Are defined as homeless under the other listed federal statutes.
2. Have not had a lease or ownership interest in permanent housing during the 60 days prior to the homeless assistance application.
3. Have experienced persistent instability as measured by two moves or more during the preceding 60 days.
4. Can be expected to continue in such status for an extended period of time due to special needs or barriers.

Note*:* HUD has not authorized any CoC to serve the homeless under Category 3. Montgomery County CoC does not utilize Category 3.

4. Homeless Category 4: Fleeing/Attempting to Flee Domestic Violence (§ 578.3)

Any household who:

1. Is fleeing, or is attempting to flee, domestic violence
2. Has no other residence
3. Lacks the resources or support networks to obtain other permanent housing

Note: Domestic Violence includes dating violence, sexual assault, stalking, human trafficking, and other dangerous or life-threatening conditions that relate to violence against the individual or family member that either takes place in, or him or her afraid to return to, their primary nighttime residence.

g. Population Types

Adult-Only Households

Adult-only households consist of individuals who are all over the age of 18. This term is used for general purposes and HUD grants, but you may hear the term "Singles" colloquially used to reference adult-only households within the Montgomery County CoC. However, there are different subpopulations of adult-only households. Please ensure that despite the definitions and titles of the subpopulations listed below, that you refer to a client's preferred definition.

Domestic Violence (DV) Survivor

The Violence Against Women Act (VAWA) defines DV survivors as someone who has previously or is currently experiencing domestic violence, sexual assault, dating violence, or stalking

Veterans

HUD defines a Veteran as "A person who served in the active military, naval, air, or space service, regardless of length of service, and who was discharged or released therefrom," excluding anyone who received a dishonorable discharge from the Armed Forces or was discharged or dismissed from the Armed Forces by reason of the sentence of a general court-martial (38 USC § 2002 (b)).

Young Adults

A Young Adult is an individual, or the oldest family member in a household, who is between the ages of 18 and 24.

Single Adults

A Single Adult is an individual who is 18 years of age or older and is the sole occupant in a household.

Families Without Minor Children

Families without minor children are adult-only households that contain more than one individual all over the age of 18. This could be a parent and an adult child, grandparent and adult grandchild, or an adult couple.

Returning Citizens

Returning citizens refers to individuals who have been released from incarceration in a jail, prison, or detention center, who are returning back to their community.

Older Adults (55+)

Older Adults are individuals who are 55 years of age or older. This subpopulation is also referred to as “Seniors” by different providers, organizations, or housing such as senior living and retirement communities.

Households With Dependent Children

Households consist of at least one adult over the age of 18, and at least one child aged 17 years or younger.

II. Policies

a. Residency Eligibility for Homeless Services Programs

Prevention

Households must live in Montgomery County to be considered for assistance. The documentation required for verifying housing can be found on the program's website.

Diversion

Households with Children

Households with children must be considered homeless under the HUD categories 1, 2, and 4 (see attachment). Households under category 4 (fleeing Domestic Violence/Human Trafficking) do not have to demonstrate residency in Montgomery County. The provider must then make an effort to connect the household to services that will divert it from shelter or unsheltered homelessness. However, if a safe alternative to shelter is not identified the household should be referred to an emergency shelter. Please inform households at the time of referral that they must demonstrate residency in Montgomery County to be eligible for emergency shelter. Documentation may be provided **after** shelter entry but within five business days.

Adult-Only Households

Adult-only households must be considered homeless under the HUD categories 1 and 4 (see attachment). Households under category 4 (fleeing Domestic Violence/Human Trafficking) do not have to demonstrate residency in Montgomery County.

If diversion is not possible, staff may refer the individual to an emergency shelter after they explain the eligibility for shelter policy. Please inform individuals at the time of referral that they must demonstrate residency in Montgomery County to be eligible for emergency shelter. Documentation may be provided after shelter entry but within five business days.

Outreach

All persons experiencing unsheltered homelessness in Montgomery County are eligible for outreach services regardless of where they lost housing or for how long they have resided and experienced unsheltered homelessness in the county.

Emergency Shelter

Households with Children

To be eligible for emergency shelter services: Households with children must be considered homeless under the HUD categories 1 and 4 (see attachment). Households under category 4 (fleeing Domestic Violence/Human Trafficking) do not have to demonstrate residency in Montgomery County. Diversion options must be explored, pursued, and documented before referring a household to an emergency shelter.

Adult-Only Households

To be eligible for emergency shelter services:

Adult-only households must be considered homeless under the HUD categories 1 and 4 (see attachment). Households under category 4 (fleeing Domestic Violence/Human Trafficking) **do not** have to demonstrate residency in Montgomery County.

Emergency shelters that provide shelter due to inclement weather (hypothermia or hyperthermia) may serve all Households seeking shelter regardless of their residency in Montgomery County.

Diversion options should be explored, pursued, and documented before referring a household to an emergency shelter and after shelter entry.

Residency Documentation

At least two of the below are needed to verify residency in Montgomery County. Staff should assist households in obtaining the necessary documentation and make every attempt to minimize barriers to shelter entry. Please inform households at the time of referral that they must demonstrate residency in Montgomery County to be eligible for emergency shelter. Documentation may be provided after shelter entry but within five business days.

List of possible determining factors and documentation:

- Receiving benefits (including health insurance) from Montgomery County.
- Photo ID showing a Montgomery County address.
- Government or utility mail showing a Montgomery County address.
- Documentation of last (most recent) place of residency.
- Eviction notice (informal or formal) for a residential unit located in Montgomery County.
- Pay stubs or proof of employment in Montgomery County.
- Legal document explaining mandate to remain in Montgomery County.
- Experiencing unsheltered homelessness in Montgomery County.

If the household does not provide these documents, the provider and individual will create a rapid exit from the shelter plan. The provider must make an effort to connect the individual to services to ensure they have access to resources that meet their basic needs.

Transparency and outlining clear program expectations with program participants are essential to providing Trauma-Informed Services. Please explain this policy to program participants before program entry and during intake.

<u>Coordinated Entry – Housing</u>

Households eligible for housing through the continuum of care programs may be added to the Coordinated Entry List for housing matches once their residency documentation is uploaded to HMIS regardless of where they lost housing and for how long they have resided in Montgomery County.

To be eligible for assistance through Continuum of Care programs providing Rapid Rehousing Assistance (RRH) or Permanent Supportive Housing (PSH), referring providers must demonstrate that the program participant resides in Montgomery County and is not better served in another jurisdiction.

All other program eligibility requirements remain the same.

b. Non-discrimination

Providers must have non-discrimination policies and assertively reach out to people least likely to engage in the homeless system.

Providers must comply with all federal statutes, including the Fair Housing Act, Section 504 of the Rehabilitation Act, Title VI of the Civil Rights Act, and Title II and III of the Americans with Disabilities Act (ADA).

The Montgomery County CoC practices a person-centered model that strongly incorporates participant choice and inclusion of subpopulations present in Montgomery County, including, but not limited to, homeless veterans, youth, families with children, and victims of domestic violence.

The CES assessment procedures follow federal Fair Housing Laws for protected classes such as race, color, religion, national origin, sex, age, familial status, disability, actual or perceived sexual orientation, gender identity, or marital status. Data will be protected by the Homeless Management Information System (HMIS) and only shared as allowed for based on the client's consent.

c. Reasonable Accommodation

The Fair Housing Act provides clients with disabilities the right to request reasonable accommodations when needed to participate in, and benefit from, housing and related programs and services. The ADA and Section 504 of the Rehabilitation Act have similar requirements. These laws apply throughout the entire CoC process, from initial contact through permanent housing placement. Examples of reasonable accommodation requests include assisting a client with a learning disability with completing or collecting eligibility documents; providing a Sign Language interpreter for a client who is deaf; moving a bed near an electrical outlet for someone using a medical device; or permitting a service animal into a shelter to assist a client with a disability. Montgomery County CoC programs must have a reasonable accommodation policy in place. Policies must be reviewed by the Services to End and Prevent Homelessness (SEPH) ADA/Fair Housing Coordinator. Responses to the requests must be made in a timely fashion. Programs may not deny a request for reasonable accommodations without prior consultation with the SEPH ADA/Fair Housing Coordinator.

d. Outreach to the Community

The Coordinated Entry System is publicized through Montgomery County's Department of Health and Human Services (DHHS) website, CoC website, County's 311 system, and through community events.

The entry points are also promoted through trainings for service providers, and information is shared with individuals experiencing literal homelessness by emergency shelter and street outreach workers. The broad advertisement of the system ensures that all people within Montgomery County in need of homeless services will have fair and equal access to the system regardless of where or how the household presents at any entry point. Outreach conducted by emergency shelter and street outreach workers ensures that individuals experiencing literal homelessness are fairly prioritized for assistance.

Montgomery County access points may utilize the Limited English Proficiency (LEP) services to help clients who present for services http://www.montgomerycountymd.gov/lep.

To improve linguistic access to services for people with limited English proficiency (LEP) language translation services are available for the most frequently spoken second languages in the County. These languages are Spanish, Chinese, French, Korean, Vietnamese and Amharic. The LEP services may also help with language access for other languages.

e. Data & Privacy

The Montgomery County CoC HMIS is administered by the County Department of Health and Human Services. Any service provider receiving county, state, or federal homeless funds must enter client information in the HMIS. All organizations that have a principal mission of serving the homeless, regardless of funding source, are invited to participate in the HMIS. The HMIS is an internet-accessible database that is used by homeless service organizations to record and store client-level information about the numbers, characteristics, and needs of households at risk of or experiencing homelessness. The HMIS is used to generate the by-name list called the "*Coordinated Entry System (CES) List.".* The CoC extends the same HMIS data privacy and security protections prescribed by HUD for HMIS practices in the HMIS Data and Technical Standards to the CES List.

f. Active/Inactive Policy

The active homeless number refers to the total number of individuals or families actively experiencing homelessness at the end of the reporting period, according to our community By-Name Data. Persons experiencing homelessness must meet HUD's Homeless definition. This count includes those who have received housing vouchers or subsidies but have yet to find permanent housing. Montgomery County CoC determines active homeless numbers based on open program entries, case notes, and service transactions within a certain period per program type.

The inactive homeless number refers to the total number of individuals or families who were previously served in Emergency Shelter, Street Outreach, Safe Haven, and Transitional Housing but exited from programs with no ongoing activity within a certain period per program type.

A household will be inactive if any of the following criteria apply:

Emergency Shelter, Safe Haven, and Transitional Housing

- A household will be moved to an inactive status after 30 days of no activity in HMIS. Activity is defined as documented case notes or service transaction notes.
- A household open with MC CoC Coordinated Entry project but closed with another Program will be moved to the inactive list on the 31st day after being exited from program Entry. Clients will remain active if there is an entry with any other provider in the CoC.

Street Outreach, Supportive Service Only

- A household will be moved to an inactive status after 60 days of no activity in HMIS. Activity is defined as documented case notes or service transaction notes.
- A household open with MC CoC Coordinated Entry project but closed with another Program will be moved to the inactive list on the 61st day after exiting program Entry. Clients will remain active if there is an entry with any other provider in the CoC.

A household will be active if any of the following criteria apply:

- Persons experiencing homelessness meet HUD's Category 1 Homeless definition.
- A household is open with Emergency Shelter, Street Outreach, Transitional Housing, and Safe Haven Programs.
- A household has a case note or service transaction in HMIS within 30 days for Emergency Shelter, Safe Haven, and Transitional Housing and within 60 days for Street Outreach and supportive services only

General guidelines apply to all programs

- Inactive households will remain on the CES List as inactive, but only active clients with a MC COC CES project entry and an open program entry, will be matched to housing intervention during the CES Housing prioritization process.
- Returned to active list from inactive status: Households who were previously designated as inactive but re- engaged with/ connected to Emergency Shelter, Street Outreach, Safe Haven, and Transitional Housing programs will automatically be active.

g. Grievance

All household concerns and grievances must be resolved promptly and fairly, in the most appropriate manner. Providers shall inform households of the following process for filing a grievance.

- COORDINATED ENTRY GRIEVANCES are grievances that are related to CES policies, procedures or housing placements. These grievances will follow the policies referenced in the CoC's Written Standards, "Utilizer Grievance Procedure".
- FAIR HOUSING GRIEVANCES are related to discrimination based on race, color, national origin, disability or family status. Grievances may be directed to the Montgomery Office of Human Rights at 240-777-8450 or to the Philadelphia Regional Office of HUD at 1-888-799-2085.

h. Evaluating the Coordinated Entry System

The CES will be periodically evaluated by Programs and Operations Committee of the ICH. The Programs and Operations Committee plays an important oversight role in evaluating

the success of new initiatives undertaken by the CoC. The Programs and Operations committee will primarily review outputs in the system to ensure that basic operations of CES, such as:

- Tracking the time it takes to match a client to a housing program
- Assessing the frequency of declines by the client or provider
- Reviewing the volume of vacancies across program types and the rate at which they are filled
- Documenting participation of service providers in training and planning, and
- Examining the number of exits to permanent housing.

To obtain broader stakeholder feedback on the overall implementation of CES, the Programs and Operations committee or CES subcommittee will also initiate a service provider survey annually to document areas of improvement and expansion. This is subject to change based on who is involved and how often this needs to be conducted.

i. Funding

The CoC programs and system utilizes local, state, and federal funding to support services. All programs are subjected to the availability of funds and demand.

Section II: Coordinated Entry Process

III. Access to Services

a. Entry Points for All Households

The CoC CES provides households at risk of or experiencing homelessness access to referrals to services at multiple entry points. Partnering agencies may refer households to services by contacting the Crisis Center, outreach providers, or the Central Intake and Diversion team. Households can also access services at drop-in centers and other support service providers. Hypothermia shelters are available from November 1 to April 1.

This comprehensive approach to eligibility determination and basic assessment of need ensures that virtually anywhere a homeless individual presents there will be an offer of a basic homeless eligibility screening, a triage assessment that focuses on determining immediate needs and a referral to a short-term shelter placement from which more comprehensive services may be accessed.

The current access points for all households are provided in the following chart.

Department of Health & Human Services (DHHS)	
Locations	**Services Provided**
Rockville 1301 Piccard Drive Second Floor Rockville, MD 20850 240-777-4550 **Germantown** 12900 Middlebrook Lane Second Floor Germantown, MD 20874 240-777-4448 **Silver Spring** 8818 Georgia Avenue Silver Spring, MD 20910 240-777-3075	**M-F, 8:30 am- 5 pm** • Housing loss prevention • Diversion from the experience of homelessness • Utility assistance • Domestic violence referral • Emergency shelter referral
Department of Corrections and Rehabilitation (DOCR)	
Locations	**Services Provided**
Montgomery County Detention Center 1307 Seven Locks Road Rockville MD 20854 240-777-9960 **CATS (Clinical Assessment & Transition Services)** 1307 Seven Locks Road Rockville MD 20854 240-777-9847 **Montgomery County Correctional Facility** 22880 Whelan Lane Boyds, MD 20841 240-773-9901	• MC Universal Referral Form completion • Basic eligibility determination • Referral to shelter for prevention shelter access or more comprehensive housing

Montgomery County Pre-Trial Services and Pre-Release Center 11651 Nebel Street Rockville MD, 20852 240-777-5400	
Hospitals	
Locations	**Services Provided**
MedStar Montgomery Medical Center 18101 Prince Philip Drive Olney, MD 20832 855-633-0207 **Suburban Hospital** 8600 Old Georgetown Road Bethesda, MD 20814 301-896-3100 **Holy Cross Hospital** 19801 Observation Drive Germantown, MD 20876 301-557-6000 **Adventist Health Shady Grove Medical Center** 9901 Medical Center Drive Rockville, MD 20850 240-826-6000 **Adventist Health Washington Adventist Hospital** 7600 Carroll Avenue Takoma Park, MD 20912 301-891-7600	• MC Universal Referral Form completion • Basic eligibility determination • Referral to shelter for prevention shelter access or more comprehensive housing
In-Reach	
Locations	**Services Provided**
Interfaith Works Drop-In Center 8106 Georgia Avenue, Second Fl. Silver Spring, MD 20910 301-585-4471 **Shepherds Table** 8106 Georgia Avenue, First Floor Silver Spring, MD 20910 301-585-6643	M-F, 8:30 am-6 pm • Diversion and case management • Primary medical care • Meals • Showers and laundry • VI-SPDAT • Emergency shelter • Housing referral
No Wrong Door	
Locations	**Services Provided**
A comprehensive list of local libraries can be found by clicking here.	• MC Universal Referral Form completion • Basic eligibility determination

	• Referral to shelter for prevention shelter access or more comprehensive housing

b. Entry Point for Households with Dependent Children

These access points are the Montgomery County Department of Health and Human Services (DHHS) offices. The DHHS offices also provide access to other critical interventions, such as Supplemental Nutritional Assistance Program (SNAP), and Temporary Assistance for Needy Families (TANF). The current access points for households with dependent children are provided in the following chart.

Households with Dependent Children	
Department of Health & Human Services	
Locations	**Services Provided**
Rockville 1301 Piccard Drive Second Floor Rockville, MD 20850 240-777-4550 **Germantown** 12900 Middlebrook Lane Second Floor Germantown, MD 20874 240-777-4448 **Silver Spring** 8818 Georgia Avenue Silver Spring, MD 20910 240-777-3075	**M-F, 8:30 am- 5 pm** • Housing loss prevention • Diversion from the experience of homelessness • Utility assistance • Domestic violence referral • Emergency shelter referral Triage hours are available on Tuesday evenings from 5-7 pm

c. Entry Points for Adult-Only Households

The current access points for adult-only households are provided in the following chart.

Adult-Only Households (Singles & Youth)	
In-Reach	
Locations	**Services Provided**
Interfaith Works Drop-In Center 8106 Georgia Avenue, Second Fl. Silver Spring, MD 20910 301-585-4471	M-F, 8:30 am-6 pm • Diversion and case management • Primary medical care

Shepherds Table 8106 Georgia Avenue, First Floor Silver Spring, MD 20910 301-585-6643	• Meals • Showers and laundry • VI-SPDAT • Emergency shelter • Housing referral
Youth Specific	
Locations	**Services Provided**
MoCo ReConnect- Youth Drop In Center 11319 Elkin St, Silver Spring, MD 20902 (301) 966-7587	**For youth ages 16-24** • Street Outreach • Housing case management • Laundry • Meals at noon and 5:00 pm • Hygiene items • Mental health supports • Case management & support

d. Domestic Violence Survivors

Households who are experiencing homelessness due to domestic violence may access the domestic violence shelter from the access points listed above. Intake workers are trained to serve domestic violence victims with care and confidentiality. Households who meet HUD's Category 4 and are served by the Domestic Violence shelter will not be entered into the HMIS.

The safety of persons fleeing domestic violence is a priority for Montgomery County. Households fleeing domestic violence will be immediately referred to the Montgomery County DHHS Behavioral Health Services, Abused Persons Program. These services provide crisis and ongoing counseling, group counseling, and support groups, crisis shelter, support, and advocacy services to victims of partner-related domestic abuse (domestic violence) and their families. Services provided through the Abused Persons Program include crisis shelter, abuse counseling and Family Violence Prevention.

Violence Against Women Act (VAWA) provides various protections to victims of domestic violence, dating violence, sexual assault, and stalking under the CoC Program and other HUD programs.

Domestic/Interpersonal Violence Resources **Resources**	
Family Justice Center	
Locations	**Services Provided**
600 Jefferson Plaza, Suite 500 Rockville, MD 20852 **Hours of Operation** Monday - Friday 8:30am - 5:00pm **Contact Information** Telephone: 240-773-0444	• Client Assistance • Counseling • Career Counseling • Basic Needs • Legal Advice & Representation • Video Conference Protective Order Program

	• Law Enforcement & Criminal Services
Abused Persons Program	
Locations	**Services Provided**
Mid County DHHS Building 1301 Piccard Drive, Suite 1400 Rockville, MD 20850 Victims: 240-777-4195 or 240-777-4210 Crisis line: 240-777-4673 (HOPE) Offenders: 240-777-4210	• Advocacy • Legal • Counseling • Group Therapy

e. Hotline & Crisis Services

Crisis Center

The Crisis Center provides free crisis services 24 hours a day/365 days a year. Services are provided by telephone or in person with o appointment needed. The Mobile Crisis Team (MCT) provides emergency crisis evaluations for individuals who are experiencing a mental health crisis. Full crisis assessments and treatment referrals are provided for all crises, both psychiatric and situational. In addition, the program has four crisis beds as an alternative to hospitalization for those who are uninsured or are insured within the public mental health system.

Access to Behavioral Health

Access to Behavioral Health Services assists Montgomery County residents with navigating the community behavioral health system. The program may provide telephone consultations, assessment and referral services, and brief mental health services.

Crisis & Behavioral Services	
Locations	
Crisis Center Location Mid County DHHS Building 1301 Piccard Drive, Rockville, MD 20850 (240)-777-4000	***Access to Behavioral Health Location*** 27 Courthouse Square, Suite 101 Rockville, MD, 20850. Phone: 240-777-1770 Fax: 240-777-4806. Hours: Monday through Friday from 8:30 am to 5pm.

IV. Data Quality

The Importance of Data Quality

Data quality is the reliability and validity of client-level data collected. High quality data accurately reflects client information and helps case managers determine appropriate services. Data quality is measured by several factors such as timeliness, completeness, and accuracy.

As mentioned in the HMIS Manual, the importance of HMIS data and reporting to tell us how we are doing at addressing and solving homelessness, cannot be overstated. A lack of HMIS data quality means that the story the community is presenting about homelessness is not a true reflection of reality, whether that story is being told nationally, statewide, or locally. Incomplete data can also negatively impact Montgomery County's ability to track patterns in client information and changes within the homeless population and adapt strategies appropriately.

Role of Providers and Staff in Data Quality

HMIS Utilizers, such case workers, outreach workers, and intake staff have one of the most important roles within the CoC. The work, assistance, and data entry that providers input into HMIS, is what allows Coordinated Entry to function smoothly. Without that information, there wouldn't be any data to review or track. It would be difficult to determine which clients are experiencing homelessness, what their history is, and what their needs or vulnerabilities are.

Within Coordinated Entry, the data that providers enter into HMIS is utilized to determine the appropriate intervention for clients based on their needs and vulnerabilities, tracking clients entering and exiting the homeless response system, identifying patterns and trends in homelessness, and more. The utilized data is collected from assessments, program entry/exit history, case notes, service transactions, and length of stay (LOS).

V. CES Responsible Record Keeping

As mentioned in the HMIS Manual, HMIS is a database that is regulated by privacy, confidentiality, and HIPAA rules and policies. This means that accurate record keeping is not only important to the support we provide to households experiencing homelessness, but to document the history of work and assistance that our providers delivered. Record keeping in HMIS should be considered with the same amount of importance as other health or technical databases.

Record keeping requirements include:

- All records containing personally identifying information (PII) must be kept secure and confidential, both digitally and physically.
- Programs must have a written confidentiality/privacy notice, provided to the system user if requested.
- Documentation of homelessness (following HUD guidelines).
- A detailed record of notes, services, assessments, and assistance provided to each system

user submitted in a timely manner.

- Documentation of any applicable requirements for providing services and assistance.
- Documentation of use of HMIS.
- Documentation of provider and client declines.
- Records must be retained for the appropriate amount of time as prescribed by HUD.

VI. Program Entries

There are two Coordinated Entry System (CES) projects: one for adult-only households and the other for households with minor children. For adult-only households the CES project is "*MC CoC Coordinated Entry Project (CES-IND)".* For households with minor children, the CES project is "*MC CoC Coordinated Entry Project (CES-FAM)".* The CES entry should be opened for all clients who have met HUD's definition of homeless.

The CES program entry includes the Coordinated Entry Assessment, the Coordinated Entry Event, and the Current Living Situation. The CE Assessment collects the assessment date, location, and result. The CE Event element is designed to capture key referral and placement events and their results. These two data elements are intended to standardize data collection on core components of Coordinated Entry, like access, assessment, referral, and prioritization.

For further information on how to enter program entries in HMIS, please refer to the HMIS Manual.

a. Households

Single Adults

Single adults do need households to be created.

Two Adult Households

If there is more than one adult that will be housed together, a household must be created. Please refer to the HMIS manual on the step-by-step explanation on how to do so. It is important that the Head of Household, or primary client, is established and that data elements or demographic information in entered. Household types that may apply are:

i. Couple with no kids
ii. Female single parent with an adult child
iii. Male single parent with an adult child
iv. Grandparent and adult grandchild
v. Other

Households with Dependent Children

Any households where there is an adult 18 years old and child below 17 years old needs to be created in HMIS. It is important that the Head of Household is established and that data elements or demographic information in entered.

b. When to Open Projects

MC CoC CES Entry

The CES project should be opened for households experiencing homelessness who have engaged with one the CoC's entry points or housing providers. The date of this project should align with the date that the household first engaged with that specific service or provider. Once

this project is entered into HMIS, it should remain open until the client exits for a permanent housing destination.

Housing Providers

Housing providers must open projects for their programs when they are working with clients. Clients who are referred to specific housing programs can choose to accept the housing opportunity or decline. If the client accepts, housing providers must open a new project under that client's "*Entry/Exit*" tab in HMIS. The date of the project entry is the date the client accepted.

c. When to Add Interim Updates

It is important to document changes that occur while a client is engaging with our homeless response system in HMIS. For households, all changes must be input in an interim through the Head of Household's project entry. The following are reasons that an Interim Update would need to be completed:

1. Anytime there is a change to the client's record (ex: income, disability, health insurance, non-cash benefits, etc.) that occurs after project entry, the changes must be reflected in an interim update.
2. Once the client is engaged with a provider, the date of engagement should be entered in an interim update.
3. Housing Move In Dates should be recorded through an interim update.

d. When to Close Projects:

Shelter

A client should be exited from the program the day they leave shelter. That will be considered their **Project Exit Date**.

Outreach

Per our CoC's Outreach Policy, a client should be exited from the program if there has been no contacts within 60 days of last contact.

Housing Providers

Clients should be exited from the programs if the client:

1. Entered another project type
2. Reached maximum time allowed
3. Loses current housing during their time working with the provider.
4. Is deceased
5. Moves into a permanent housing destination

If the provider is closing out a project due to a provider decline, contract monitor approval but be completed beforehand. For more details about decline, please reference Section 2, subsection 12: **Post Match Expectations**.

VII. Assessment

a. Purpose of Assessments

If a client is experiencing a housing crisis, the first step will be to connect the household to diversion, or outreach if they are experiencing unsheltered homelessness. A case manager will follow up with any clients that enter the homeless services system to complete more comprehensive assessment to help determine the level of support needed to obtain and maintain housing. The CoC sets a goal to complete the initial screening assessment, i.e. VI-SPDAT, within 5-7 business days from emergency shelter placement. This time period allows for singles and families who may be able to self-resolve their homelessness. Case Managers complete this assessment via HMIS and is the first step to placing them on the CES list. Case Managers also work to connect clients to direct housing placements, when possible. The second step needed for a client to be placed on the CES list is to complete the Montgomery County Acuity Scale, which should be completed within 1 month of the client entering emergency shelter to ensure the Case Managers have been able to observe a client's baseline behavior and collect collateral information. The assessment process will not require disclosure of specific disabilities or diagnosis. Specific diagnosis or disability information should only be obtained for purposes of determining program eligibility to make appropriate referrals. Finally, clients may refuse to answer any assessment questions. However, doing so may limit access to potential housing placements or possible service referrals.

b. Type, Background, Score Breakdown

In 2015, the County officially adopted two measurement tools – the "Vulnerability Index-Service Prioritization Decision Assistance Tool" (VI-SPDAT) and the Full "Service Prioritization Decision Assistance Tool" (SPDAT), which were both developed by OrgCode. Both the VI-SPDAT and Full SPDAT serve as the common assessment tool for the Montgomery County CES and is used to determine the most appropriate housing intervention for households experiencing homelessness. The VI-SPDAT and Full SPDAT are administered by Case Mangers and clients are given a score that represents their expected service needs in order to obtain and maintain housing.

The Vulnerability Index-Service Prioritization and Decision Assessment Tool (VI-SPDAT) is the initial screening tool used to assess individuals and families who need housing intervention(s) and is based on client self-report. There is a version of the VI-SPDAT for Single Adults (Version 2.0) and Families (Version 2.0). CES access points, typically at emergency shelter, use the tool to help prioritize the housing needs of each presenting household. The Full SPDAT has a version for Single Adults (Version 4.0) and for Families (F-SPDAT Version 2.0). Because the Full SPDAT is a more comprehensive assessment of level of need, it is used when a client's score on the VI-SPDAT does not accurately capture the client's or household's level of need. The Full SPDAT includes both client self-report and staff observations. The tools offer a uniform and transparent way to collect information necessary to initially assess individuals or families who enter the CES. The following table shows the scores needed for various housing considerations for each tool:

	Singles		Families	
	VI-SPDAT Score	FULL SPDAT Score	VI-SPDAT Score	FULL F-SPDAT Score

Prioritization for Permanent Supportive Housing (PSH)	High Intensity: 13+ Mid to Low Intensity: 8 to 12	High Intensity: 40+ Mid to Low Intensity: 35 to 39	9+	54+
Prioritization for Rapid Re-Housing (RRH)	4 to 7	20 to 34	4 to 8	27 to 53
Prevention	0 to 3	0 to 19	0 to 3	0 to 26
Diversion	0 to 3	0 to 19	0 to 3	0 to 26

i. **VI-SPDAT for Single Adults** (v.2 and listed under Singles above): has 27 questions and is based on client self-report. See **Appendix** to review the tool itself. HMIS scores this tool for staff. A short training is suggested by OrgCode and the CoC requires a 1-hour training video.

ii. **VI-SPDAT for Families** (v.2 and listed under Families above): has 39 questions and is based on client self-report. See **Appendix** to review the tool itself. HMIS scores this tool for staff. A short training is suggested by OrgCode and the CoC requires a 1-hour training video.

iii. **Full SPDAT for Single Adults** (v.4 and listed under Singles above): covers 15 domains and takes into account staff observations/collateral information. See **Appendix** to review the tool itself. HMIS scores this tool for staff. OrgCode requires a case manager to take a training by an approved trainer to use this tool. The CoC requires a training to gain access to the Measurements tab in HMIS and offers an online training in Talent.

iv. **Full F-SPDAT v.2**-listed under Families above and covers 20 domains and takes into account staff observations/collateral information. See **Appendix** to review the tool itself. HMIS scores this tool for staff. OrgCode requires a case manager train to gain access to the Measurements tab in HMIS, but the CoC does training by an approved trainer to use this tool. The CoC requires a training to gain access to the Measurements tab in HMIS, but the CoC does not yet have a training available in Talent. Some family providers attended an OrgCode train-the-trainer session paid for by Montgomery County and they are expected to train their staff. The Social Worker II on the PACS Team, Sarah Moore, can assist any Family service providers to complete a FULL SPDAT due to the lack of available training for them.

v. TAY-VI-SPDAT: Please see **Youth CES** Section for more information.

The **Montgomery County Acuity Scale** is a screening tool developed by Montgomery County Services to End and Prevent Homelessness (SEPH) to identify and assess a person's level of independence and support needed in a variety of areas related to housing stability, such as income and benefits or health. This tool is used in conjunction with the VI-SPDAT or Full SPDAT to help determine how a client is prioritized on the CES list and/or measure their progress over time after being housed. The Montgomery County Acuity can also be used to help

identify clients who are ready to consider other housing options with community-based supports outside of the supportive housing programs. Additionally, this assessment indicates the severity of a presenting issue: A higher score represents more complex, co-occurring issues that are likely to impact overall housing stability. The following table shows the scores that correspond to the various vulnerability levels for this tool:

	Acuity Scale for Singles	Acuity Scale for Families
Extreme Acuity	314+	312+
High Acuity	50 to 313	48 to 311
Mid Acuity	36 to 49	34 to 47
Low Acuity	35 or below	33 or below

i. **Acuity Scale for Singles** has 15 items and based on staff's observations/collateral information. See **Appendix** to review the tool itself. The tool is in HMIS, but staff must calculate the score. The CoC requires a training to use this tool and offers two different versions: online training (~90 min) or a live webinar (3 hours). Additionally, this training is split up into two different versions depending on the staff's role: Outreach/Shelter or RRH/PSH; because there are some differences in scoring if the client is currently homeless or housed.

ii. **Acuity Scale for Families** has 16 items and based on staff's observations/collateral information. It is used with households with any minor child present. See **Appendix** to review the tool itself. The tool is in HMIS, but staff must calculate the score. The CoC requires a training to use this tool and offers two different versions: online training (~90 min) or a live webinar (3 hours).

c. Special Instructions for Two or More Adult Only Households

If you are working with a household that has 2+ adults and no minor children, then each member of the household should be assessed using the assessments labeled for Singles above and connected in HMIS under the same household. The person in the household with the highest level of need for support and vulnerability will be how the household is prioritized on the CES list.

i. Example 1: A brother and sister are both in shelters in our CoC and want to live together. The brother's VI-SPDAT score is 7 and the sister's VI-SPDAT score is 13. The brother's Acuity Scale score is 35 and the sister's is 51. The sister's scores are how this household will be prioritized on the Singles CES List.

ii. Example 2: A same sex couple is at the shelter together and wants to be housed together. Each member of the couple will have a VI-SPDAT and Acuity Scale for Singles completed and entered into HMIS. The person with the highest level of need (aka highest scores) will be the person that CES List is going to use to prioritize housing for this household.

d. Reassessments

VI-SPDAT and Full-SPDAT assessments need to be updated on an annual basis unless a major life change occurs. The Acuity assessment, however, needs to be updated every six months for persons who score for Permanent Support Housing (PSH) on the VI-SPDAT. If a Case Manager observes any life changes for a client, then they can update the Montgomery County Acuity Scale to document these changes, and this may change a client's placement on the CES list. Some examples of changes that could affect the Montgomery County Acuity Scale scoring are: a new source of income or loss of income, emergency room visits, hospitalizations, learning about a new diagnosis (new to the client or newly revealed to the assessor), involvement in the child welfare system, changes in household size, or juvenile detention center encounters. If a client has refused to be assessed or participate in CES but later changed their mind then the client can choose to reengage at any time.

A reassessment ***should not*** be completed if the client has not experienced a major life-changing event, or it has been less than a year since the previous assessment was completed. Furthermore, once a Full-SPDAT has been completed for a client, that is the tool providers should be assessing the client with moving forward. A VI-SPDAT should not be completed after a Full-SPDAT has been completed for a client.

VIII. Housing Programs & Interventions

a. Supportive Service Only (SSO)

Supportive Service Only (SSO) programs provide a wide range of non-housing related services to households at risk of or experiencing homelessness. The purpose is to promote access to necessary resources that households can utilize to achieve housing stability. The type of services provided depend on the purpose and funding of different programs. Examples of services that SSO programs may provide are care/case management, outreach, medical services, referrals, basic needs, food, housing counseling, employment assistance, educational or vocational assistance, benefits assistance, and transportation services.

Organizations:

1. Bethesda Cares (BC)
2. Cornerstone Montgomery
3. Department of Correction and Rehabilitation (DOCR)
4. EveryMind
5. Interfaith Works (IW)
6. The Montgomery County Coalition for the Homeless (MCCH)
7. DHHS
    a. SEPH
    b. Behavioral Health and Crisis Services
8. Pathways to Housing DC
9. Shepherds Table

b. Housing Stabilization:

Prevention

Prevention provides conflict resolution, mediation, financial assistance, housing location, and case management to County residents at risk of or experiencing homelessness. The program's focus is to partner with households to resolve their housing emergencies through creative problem-solving. State and County grants are provided to prevent evictions and utility cut-offs or secure new housing. Short-term case management services are provided to help households at risk of housing loss develop and implement plans to prevent a future housing crisis.

Eligibility

Eligibility criteria for prevention programs vary depending on the program. The standard requirement across all prevention programs is that an applicant must be a Montgomery County resident.

Resources provided

Emergency Financial Assistance

Emergency Services can be offered once every 12 months. These services include, but are not limited to, eviction prevention, emergency relocation assistance, and burial/cremation assistance.

Eligibility criteria for Eviction Prevention assistance are:

1. Residency: Applicant must be a Montgomery County resident.
2. Income Limit: As of January 6, 2025, the household income must be at or below 60% of the area median income (AMI).
3. Prior Assistance: Household must not have received an eviction prevention grant in the past 12 months.
4. Eviction Documentation: Must have a court summons, judgment, or "red and white" notice from the Sheriff's Office related to an eviction, or a landlord-issued "put-out" notice.
5. Signed Release of Information: Documentation and permission to discuss your case within the COC to achieve resolution.

Home Energy Assistance

Provides assistance to low-income Montgomery County residents with residential home heating and electric costs. Eligible households can receive a benefit towards their heat and electric costs once a program year (July 1 - June 30). Households can receive arrearage benefits once every 5 years towards past due natural gas (up to $1,000) and electric utility costs (up to $2,000).

Rental Assistance Program (RAP)

The Rental Assistance Program (RAP) is a Montgomery County funded program, overseen by SEPH, to help low-income households meet their rental expenses. RAP's rental subsidy is issued on a monthly basis and issues benefits ranging from $100-$503 per month. Benefits are determined by an income/rent ratio and given a utility deduction.

This program operates on a budget, and when all funds are utilized for that fiscal year, further services cannot be offered.

Eligibility criteria for RAP are:

- You must be a Montgomery County resident
- Must be currently experiencing unsheltered or sheltered homelessness (living in a place not meant for human habitation or in a shelter) or at imminent risk of experiencing homelessness
- Have a disability OR be at least 55 years old
- Meets program requirements per the application
    - Income Allowable
    - Assets are $10k or less
- Benefits are redetermined annually.

Diversion

Diversion Services help households experiencing a housing crisis identify safe, alternatives to the experience of homelessness. Diversion Services leverage existing resources in the community, with family and friends by using mediation, providing financial assistance, and using problem-solving strategies. Diversion services can help reduce the number of individuals

and families entering homelessness, decrease the demand for shelter beds, and provide rapid resolution options to quickly address their housing crisis.

This approach is housing-focused, strength-based, and person-centered. It focuses on resolving the current housing crisis by exploring creative solutions. The goal is to help households find safer, more sustainable options instead of experiencing prolonged homelessness.

1. Eligibility
    a. HUD Categories 1, 2 (if prevention is not possible), and 4
2. Organizations
    a. SEPH
    b. EveryMind

c. Emergency Services

Emergency Shelter

Emergency shelters provide low-barrier access to shelter while offering person-centered services to those experiencing homelessness. Montgomery County CoC has year-round shelters and hypothermia shelters. The year-round shelters are open 24 hours a day, 7 days a week. The hypothermia shelters provide additional shelter beds during the winter season, typically from November 1 to March 31. However, this may change depending on that year's demand, funding, staffing, and policies.

Emergency shelters provide meals, basic necessities, laundry services, and housing focused case management.

1. Eligibility
    a. HUD Categories 1 and 4
    b. Montgomery County Resident
2. Organizations
    a. Interfaith Works
    b. The Montgomery County Coalition for the Homeless (MCCH)
    c. Rainbow Shelter
    d. National Center for Children and Families (NCCF)
    e. Helping Hands
    f. Stepping Stones
    g. Sheppard Pratt

Outreach

Outreach services in Montgomery County are committed to transforming the lives of individuals experiencing homelessness through comprehensive, person-centered street outreach. Grounded in dignity and trust, the program builds meaningful partnerships with individuals to support their housing and life goals.

Through a collaborative approach, outreach providers within the Continuum of Care (CoC) work together to:

- Identify, engage, and assess individuals in need of services
- Refer individuals to appropriate programs and maintain ongoing engagement
- Monitor and report changes in individual circumstances
- Document outreach efforts and gather required information for service referrals

These efforts begin by meeting people where they are—both physically and emotionally—to form trusting relationships. Outreach staff first address essential needs such as food, clothing, hygiene, transportation, and identification. Once trust is established, they help individuals navigate and access housing, healthcare, employment, mental health and substance use treatment, and other supportive services.

The program partners with community-based providers, including Healthcare for the Homeless, ACT teams, and the Mobile Crisis Team. These partnerships bring medical professionals and mental health clinicians directly to individuals living unsheltered, ensuring those with complex needs receive care even if they are not connected to traditional systems.

The ultimate goal is not just to provide services, but to connect people to permanent housing through the Coordinated Entry System (CES) and other community-based resources, based on their individual needs and level of vulnerability.

3. Eligibility
    a. HUD Categories 1
    b. Unsheltered in Montgomery County
4. Organizations
    a. Bethesda Cares
    b. City of Gaithersburg
    c. EveryMind
    d. Healthcare for the Homeless
    e. Pathways to Housing DC
    f. People Encouraging People

d. <u>Permanent Housing</u>

Rapid Rehousing

Rapid Rehousing (RRH) is a Housing First intervention designed to assist individuals and families experiencing homelessness quickly move into permanent housing. RRH provides time-limited financial and housing assistance, along with supportive services, to help these households stabilize their housing and achieve long-term stability.

1. Eligibility
    a. HUD Categories 1 and 4
2. Organizations
    a. Bethesda Care
    b. Catholic Charities
    c. Interfaith Works
    d. National Center for Children and Families (NCCF)
    e. SEPH

f. The Montgomery County Coalition for the Homeless (MCCH)

Transitional Housing

Transitional Housing provides temporary housing with supportive services to individuals and families experiencing homelessness with the goal of interim stability and support to successfully move to and maintain permanent housing. Transitional Housing projects can cover housing costs and accompanying supportive services for program participants for up to 24 months. In the Montgomery County CoC, clients in transitional housing are not prioritized through CES except for the youth program, Future Bound and Wells Robertson House. Clients residing in these specific transitional housing programs are eligible for housing prioritization through CES.

3. Eligibility
    a. HUD Categories 1 and 4
4. Organizations
    a. City of Gaithersburg
    b. National Center for Children and Families

Permanent Supportive Housing

Permanent Supportive Housing (PSH) is an evidence-based practice that provides immediate access to a permanent housing subsidy and long-term, wraparound support services to households with disabilities. All programs use a Housing First approach that offers housing without preconditions such as sobriety, treatment compliance, or participation in services.

5. Eligibility
    a. HUD Category 1 and 4
    b. Disability
6. Organizations
    a. Bethesda Cares (BC)
    b. City of Gaithersburg
    c. Community Reach of Montgomery County
    d. Cornerstone Montgomery
    e. Housing Opportunity Commission (HOC)
    f. Interfaith Works (IW)
    g. Pathways to Housing DC
    h. Sheppard Pratt
    i. The Coordinating Center (TCC)
    j. The Montgomery County Coalition for the Homeless (MCCH)

e. Other Permanent Housing

Short-term Housing Resolution Program (SHaRP)

Montgomery County Services to End and Prevent Homelessness (SEPH) Short-Term Housing and Resolution Program (SHaRP) provides short-term rental assistance and light touch case management to households with children, working with our Continuum of Care to exit homelessness and move into housing.

While funding is available, SHaRP will provide quarterly payments to cover 100% of household's base rent (up to the County average for that household/bedroom size). SHaRP does not pay for utilities, application fees, or other costs outside of base rent. Households must recertify every 90 days to continue to receive the benefit. Please note, if your rent is equal to or less than 40% of your income, the program will only provide security deposit and first month's rent. Households can only receive SHaRP once for a maximum of 12 months.

Eligibility criteria for SHaRP is:

- Anyone currently staying in a Montgomery County shelter or receiving services from our street outreach teams who obtains a minimum six-month lease is eligible to apply.
- Benefits are only provided to Montgomery County residents.
- There is no income maximum limit. However, if the household income is over $1000 per month, the household is required to pay rent, and the amount equals 40% of their income.
- If 40% of the household's net income is above the full rent amount, the household is not eligible for SHaRP.

f. Housing Choice Vouchers

HOC Vouchers

Housing Opportunities Commission (HOC) is the local public housing authority for Montgomery County, MD. They oversee all vouchers including housing stability, project based, and tenant based. For further information on how to obtain a voucher or the process, please visit their website: https://www.hocmc.org/housing-opportunities/housing-rental-assistance-programs/housing-choice-voucher-program/

IX. Prioritization

a. Transitional Housing

Transitional housing programs serve clients who meet HUD's categories 1 and 4. Only clients from the transitional youth program Future Bound or Wells Robertson House, are prioritized for housing matches through the CES prioritization process outlined below. Other transitional housing programs do not utilize the CES prioritization process.

The transitional housing programs' eligibility criteria is:

1. Clients in adult-only households with a score of 4-7 on the VI-SPDAT or a score of 20-34 on the Full SPDAT—based on their score, clients with the highest service needs will be prioritized first
2. Clients in households with minor children with a score of 4-8 on the VI-SPDAT or a score of 27-53 on the Full FSPDAT—based on their score, clients with the highest service needs will be prioritized first
3. Clients with the longest history of homelessness

b. Rapid Re-Housing

For Rapid Re-Housing Programs, clients must meet the HUD's definition of homelessness under Category I, any subsequent CoC Program Notice of Funding Availability (NOFA) eligibility requirements, and any additional funder eligibility requirements. Once meeting the rapid re- housing eligibility requirements, clients are then prioritized by Montgomery County's target populations.

The Montgomery County CoC has established the following priority populations for Rapid Re-Housing Programs for individuals and families because solving homelessness for Montgomery County CoC's most vulnerable people and highest users of resources will enhance the CoC's goal of quickly transitioning people who are homeless to rapid re-housing and ultimately eradicating homelessness throughout all the entire geographic area.

The CES is designed to ensure that clients with the most needs are referred to the appropriate model of rapid rehousing first. The process for prioritizing participants for rapid re-housing resources will include that participants are referred to the rapid re- housing program which they meet eligibility requirements and prioritized based on the following scores:

1. Clients in adult-only households with a score of 4-7 on the VI-SPDAT or a score of 20-34 on the Full SPDAT—based on their score, clients with the highest service needs will be prioritized first
2. Clients in households with minor children with a score of 4-8 on the VI-SPDAT or a score of 27-53 on the Full FSPDAT—based on their score, clients with the highest service needs will be prioritized first
3. Clients with the longest history of homelessness

c. Permanent Supportive Housing

For permanent supportive housing (PSH) programs, clients must meet both the HUD

definition of homelessness under Category I and have a disability. Once meeting the Category I eligibility requirements, clients are then prioritized by Montgomery County's target populations. Programs may not establish additional eligibility requirements beyond those specified in Category I and those required by funders.

The County prioritizes vulnerability before chronicity; therefore, the Acuity Scale is used to ensure consistency and inter-rater reliability. Individuals with high vulnerability and service needs must be prioritized for Permanent Supportive Housing using length of time homeless as a tiebreaker. Vulnerability and needs are assessed through Vulnerability Indicators. These indicators are combined to create a Vulnerability Score that is utilized for prioritization for Permanent Supportive Housing. The Vulnerability Indicators are:

- Poor Access to Mainstream Services: Is the person able to access Medicaid, SSI/SSDI, or other mainstream benefits?
- Poor Engagement with Services: How willing is the person to accept housing and services?
- Currently unsheltered
- Poor Management of ADLs (Activities of Daily Living): Is the person able to manage activities of daily living like cooking and cleaning without assistance?
- Veteran designation
- Risk / History of Exploitation: Is the person vulnerable to sexual financial, or other types of exploitation due to gender identity, ethnicity, developmental disabilities, etc.?
- Mental Health as defined by the Montgomery County Housing Support Services Acuity Scale
- Substance use as defined by the Montgomery County Housing Support Services Acuity Scale
- Cognitive Deficits as defined by the Montgomery County Housing Support Services Acuity Scale
- Medical Conditions as defined by the Montgomery County Housing Support Services Acuity Scale

PSH projects are expected to provide housing and supportive services to assist individuals with a disability, who are experiencing homelessness return to living independently in private housing. PSH is targeted to the most vulnerable with high vulnerability and service needs will be prioritized for PSH using length of time homeless as a tiebreaker.

The permanent supportive housing prioritization eligibility criteria are:

1. Clients in adult-only households with a score of 8+on the VI-SPDAT or a score of 35+ on the Full SPDAT
2. Clients in households with minor children with a score of 9+ on the VI-SPDAT or a score of 54+ on the Full FSPDAT first
3. Disability
4. Clients with the highest vulnerability score
5. Clients with the longest history of homelessness

X. Matching Eligibility

a. Program Vacancies

Program Vacancies are how clients are matched to housing opportunities. When a housing provider is aware that they have a vacancy, they must submit it using the "Montgomery County, MD Permanent Housing Vacancy Form". This Google form collects information on the contact person submitting the vacancy, the housing program, type of permanent housing, and eligibility criteria. Vacancies must be submitted before any considerations or matching can be completed. For transparency and impartiality purposes, vacancies cannot be reserved or held by providers for specific clients. If a vacancy is available due to a decline, all proper steps and approval must be completed before the vacancy can be submitted (For more information about declines, please refer to Section 2-12: **Decline Policy**). All vacancies are reviewed by the CES Program Manager and then added to the CES list for referrals. Vacancies can be filled on an on-going basis, but the preference is to match clients to vacancies during the CES meeting for collaborative decision making.

Eligibility criteria for every publicly funded program in the CoC must receive prior approval by the SEPH Department at the time of contract execution. This review of eligibility requirements ensures that all programs in the CoC follow Fair Housing Laws and have limited program barriers to entry.

b. CES List

For adult only households, a by-name registry called the "Coordinated Entry System (CES) List" is a data set created from a combination of reports generated from HMIS that records all clients experiencing homelessness in the CoC, organized by housing need and assessment scoring. For Adult only households, the CES List is an Excel spreadsheet that contains different relevant information for the purposes of Coordinated Entry and prioritization. The spreadsheet contains the CES list in addition to clients assigned to providers, clients in need of program transfers, program references, vacancies, shelter information, clients missing data entry or assessments, and declines. The data for the CES list is generated from a report based on the "MC CoC Coordinated Entry Project (CES-IND) (288)" entry in HMIS. The data for the Transfer list is generated from a report based on the "MoCo Program Transfer Ind (415)" entry in HMIS. CES list prioritization for housing referrals is based on the program eligibility requirements. Each housing program vacancy determines how the CES list will be filtered for prioritization. As a result of this, in addition to limited housing options within Montgomery County CoC, not every household experiencing homelessness will receive a referral to permanent housing.

A pre-list is generated, prepared, and emailed out prior to each CES Singles and Veteran meetings to prepare providers. After the meetings, a post-list is emailed with the updates and matches made.

c. CES Meetings

The CES Program Manager is responsible for hosting two CES meetings a month for Veterans, Adult-Only Households, and Families. All CES meetings will be hosted on their scheduled days of the month, unless stated otherwise. CES meeting are closed to anyone who is

not a partnering organization within the CoC. All attendees in the meeting should be a part of the mailing list for organizational and privacy purposes.

Providers should be attending all meetings that pertain to the client on their caseloads. Meaning, if a provider has a client who is a Veteran, they should be attending the Veterans Coordinated Entry meetings. Or if a provider works with both single adults and families, they should be attending both the Singles and Family CES meetings. Prior to each CES meeting, providers should preview the Veteran and Singles CES list that is sent out in advance and come prepared with updates regarding the clients on their caseload or working with their organization.

Veterans

For Veterans, the CES meetings are on the 2nd and 4th Monday of every month, for one hour. This meeting consists of update or announcements then reviewing clients who have been assigned to a housing provider and documenting updates on their housing process. Following that, the CES Program Manager will match clients to vacancies based on prioritization scores and program eligibility.

Adult-Only Households

For adult-only households (also known as “Singles”), the CES meetings occur on the 2nd and 4th Wednesdays of each month and are divided into two separate sessions, with RRH providers meeting first, followed by PSH. Each session lasts one hour and fifteen minutes, with a fifteen-minute break in between. The first meeting of the month focuses on Prioritization, where brief updates about the housing process for clients assigned to a housing provider are shared. This involves reviewing clients listed on the “Assigned Accepted" tab, in alphabetical order by provider. The second meeting is for Case Conferencing, which involves more detailed discussions about clients with the longest time on the list, reviewed from the same tab, focusing on those with the highest number of days since assignment. Due to time limits, not all clients can be reviewed. Afterwards, the CES Program Manager will match clients to available vacancies based on prioritization scores and program eligibility, with some vacancies reserved for program transfers. Each vacancy’s eligibility criteria are checked to determine how to sort the CES list for prioritization. For RRH, the list is automatically sorted to prioritize Veterans and longest length of time. The Program Manager then filters this list to include only clients who are Active, Scoring for RRH, Not Missing Acuity Assessments, and in Need of Housing. For PSH, the list is automatically sorted to prioritize Veterans, vulnerability scores, and the longest length of time. The list is then filtered to include only clients who are Active, Scoring for PSH, Not Missing Acuity Assessments, and in Need of Housing. PSH programs may have additional eligibility requirements beyond those for RRH, such as intensity, acuity scores, or history of unsheltered housing. Due to time constraints during the CES meeting, not all vacancies may be filled, often because some programs have multiple eligibility criteria that take time to sort, or because some vacancies require access to external databases like Medicaid, the Chesapeake Regional Information System for Patients (CRISP), or Maryland Case Search.

Households with Minor Children

For families, the CES meetings are the on 2nd and 4th Thursday of every month. This consists of brief updates about families both in need of housing and assigned to a housing

provider or program. Following that, the CES Program manager will match clients to vacancies based on prioritization scores and program eligibility.

d. Matching vs. Placement

Sometimes a client may be matched to a housing solution such as Rapid Rehousing or Permanent Supportive Housing, however, there may not be availability. In these circumstances, a client will receive a placement when it is available to an alternative temporary accommodation such as an emergency shelter or transitional housing. A temporary placement will not negate the housing solutions for which the client has been matched.

XI. Matching & Special Populations

Veterans (Vets)

The CoC will prioritize veterans over non- veterans in each prioritization category listed above. Essentially, this means that if two households present for assistance and both fall under the same order of priority (e.g. both chronically homeless and fall under Category 1), but one is a veteran household and the other is not, the veteran household should be prioritized first. In general, the CoC will prioritize veteran households that are not eligible for Veteran Administration housing or services.

XII. Post Match Expectations

a. Referrals

After the CES meeting, the Program Manager will send a referral email for each client matched to a vacancy within three business days. This allows the Program Manager time to review each client's program entries, case notes, service transactions, and assessment scores to identify any concerns that may affect the client's referral to the housing provider. This review may also include contacting case managers, checking Maryland Case Search for incarceration, the Medicaid database for active enrollment, or CRISP for hospitalization to ensure specific program eligibility criteria are satisfied.

If there is a concern that could affect a client's referral, the Program Manager will send the referral with a note identifying the concerns, the involved persons, the proposed solution, and whether the updates might alter the client's vulnerability or suitable intervention. This ensures that clients are matched with the appropriate interventions based on their needs and vulnerabilities. Referring clients to housing programs that do not meet their level of need and support can have negative consequences. One of the goals of Montgomery County CoC is to prevent recurring homelessness. Accurately matching clients to the right interventions helps us achieve that goal. For example, during the CES meeting, the Program Manager refers a client to a Rapid Rehousing program but notices that the assessments are two years old. After reviewing the client's information and history in HMIS, the Program Manager proceeds with the referral. The referral email includes all standard information but also features a note at the top of the page, highlighting the outdated assessments, requesting new ones, and explaining that changes in the client's score might alter the necessary intervention.

Upon receipt of the referral e-mail from CES Program Manager, the Housing provider must meet with the client within three business days to offer housing. If the client accepts the housing opportunity, the following items should be verified and uploaded in HMIS as soon as possible:

1. The new completed HMIS Release of Information (ROI) set for a 1 year time period.
2. All of the client's identity, benefit, health, and income documentation (ex. Photo ID, Birth Certificate, Social Security Card, DD-214, Income, SNAP, Medicaid Enrollment, etc.).
3. The documentation of disability should be uploaded in HMIS.

b. Decline Policy

Client Decline Policy

Client choice is a key aspect of Montgomery County CES. Therefore, individuals should only be referred to housing options they are eligible for and interested in living in or participating. People may decline housing matches if program requirements do not align with their needs or preferences. Declining a housing option does not remove the person from the prioritization list, but it may negatively affect how long they remain on the list before being housed. Reasons a client might decline a housing match include:

1. Geographic location of housing: The housing should be located in a neighborhood accessible to the household and where they feel safe.
2. Accessibility of the unit: The housing match must accommodate the client and their mobility needs. For example, a unit on the third floor of a building with no elevators is not accessible to a person who cannot climb stairs.
3. Program participant willingness or ability to share housing (if applicable): The housing match may require clients to share rooms or common areas, and this may not be what a client needs or is interested in.
4. Preferred service provider: A housing match may be offered by a service provider that the client does not wish to work with.

If a client declines a housing match, the housing match provider must obtain the client's signature on the Client Decline form (See Section 3-20: **Appendix**). Once the form is completed, it must be uploaded to the client's profile in HMIS as a file attachment. Next, the provider must complete a "Client Referral Decline" in HMIS as a sub-assessment under the "MC CoC Coordinated Entry Project" entry. It is important that the provider ensure that all notes pertaining to this client are included in the notes section of this sub assessment. When this is complete, the provider must contact the CES Program Manager, who will review the decline in HMIS for accuracy. If no changes or updates need to be made, the CES Program Manager will refer another client.

If a client declines a housing match and is refusing to sign the Client Decline form, the provider needs to document this, either as a Case Note or a Service Transaction in HMIS, as well as including it in the notes section of the Client Referral Decline sub assessment.

Provider Decline Policy

Publicly funded service providers are allowed two declines a year. However, publicly funded service providers, including RRH, TH, and PSH programs, may only decline a referral under limited, specific circumstances such as when:

- The person(s) does not meet eligibility criteria for the program
- The household configuration cannot be accommodated with the space available in the housing program because the household composition has changed

If a program declines a referral, they must issue a program decline decision notification. This should include, at a minimum, the following details, if applicable:

- The reason the referred household cannot enter the program, including the reason for rejection by the client or the program.
- Instructions for appealing the decision, including the contact information for the person to whom and under what time frame the appeal should be submitted.

If the provider has made three documented attempts to contact the person(s) for which no response was received to engage in intake, they must report this to the CES Manager. Providers are encouraged to attempt these three engagements within a 10-day period, to allow for a new match. When the three engagement attempts are documented in HMIS as either case notes or service transactions, the Provider may submit a CES Provider Decline. This decline is submitted

as an “Interim Update” sub assessment under the “MC CoC Coordinated Entry Project in HMIS. After the provider submits the decline, they must send an email including their Contract Monitor the CES Program Manager, and the case workers supporting the client, to notify them that a provider decline has been submitted and is ready for review. This email notification is important because it reduces the amount of time clients must wait to transition back to the CES list for prioritization. To obtain approval from a Contract Monitor, the provider must ensure that they described all attempts to engage with client. This will result in the next qualified person(s) being referred to the program and not count as a program decline. Providers may not exit a referred client out of their program, close out a project in HMIS, or submit a vacancy until the provider decline has received contract monitor approval.

XIII. Coordinated Discharge

All programs must have specified procedures and protocols for handling user discharges, both planned and unplanned. Discharges must be conducted with harm- reduction and trauma-informed practices and every effort to connect the utilizer to additional resources must be made. In the event of an unplanned discharge, all appropriate crisis interventions must be fully exhausted prior to discharge. For the most updated policies regarding coordinated discharge, please reference the Written Standards.

XIV. Program Transfers

a. Purpose

At times, the Coordinated Entry System (CES) requires transfers between program types to better align with a household's preferences and needs. A critical part of the transfer process is the ongoing assessment of the household's needs to determine whether the level of services should be adjusted, either increased or reduced.

In accordance with HUD guidance as well as to ensure continuity of supportive services and remain trauma informed; the CES program transfer policies aim to:

- Provide flexible strategies to structure assistance based on household needs.
- Use ongoing assessments to determine the most suitable level of support.

b. When should program transfer request be initiated?

A household may need to transfer to another program within the CES for various reasons, including:

- Defunding of an agency or program.
- Accommodations due to somatic health issues like mobility.
- Criminal record for state-mandated restrictions-e.g. Convicted Sex offenders.
- Changes in family composition that cannot be served in the current housing.
- Level of support does not match client's needs through ongoing case conferencing.
- Transfer from rapid re-housing to permanent supportive housing can be made as a bridge as long as the household meets the Permanent Supporting Housing project's specific eligibility criteria and program requirements.
- Transfer for individuals experiencing domestic violence, dating violence, sexual assault, or stalking are protected under the Violence Against Women Act (VAWA), housing rules.

Note: no more urgent vs non urgent transfer requests

c. Who Should Request a Program Transfer?

- The Client: If the current housing is not supporting the client's needs, they can request a program transfer.
- The Housing Provider: If the Provider believes that the current housing is not supporting or cannot support the client's needs, they can request a program transfer. The Provider should collaborate with others to prove wraparound services.

d. How to Document and Complete a Transfer: HMIS Workflow

Providers must ensure that the Case Plans, Case Notes, and Service Transaction notes in HMIS are updated and detailed. The following information should be included:

- Frequency of meetings.
- Level of support provided.
- Documented encounters/attempts of engagement.
- Documented efforts to support collaboration with other systems of care.

To start the transfer process, add a project entry for the transfer program in HMIS using "MOCO Program Transfer IND" or "MOCO Program Transfer FAM". This project is important because this is how the CES Transfer List is generated. If a provider does not open a transfer project for their client in HMIS, they cannot be considered for a program transfer. The project assessment with need to be completed with the following information:

- Detailed description of the reason transfer is being requested.
- Explanation on which housing program or intervention would be most appropriate.
- Utilize ongoing assessments to determine suitable level of support.
  - From RRH to PSH, a Full SPDAT and Acuity must be updated.
  - From scattered site to site based PSH, an Acuity must be updated.
- Include documented efforts, interventions, and case conferencing.

After the Provider submits the program transfer, they must email both their Contract Monitor and the CES Program Manager to notify them that a transfer has been submitted and is ready for review. This email notification is important because it reduces the amount of time clients must wait to get on the CES Transfer List for prioritization. To obtain approval from a Contract Monitor, the provider must ensure that all sections of the transfer assessment were completed. Only program transfer requests that have been submitted in HMIS and approved by a Contract Monitor will appear on the report generated for CES Transfer List.

e. CES Prioritization: How & When Will a Household be Prioritized via the CES?

After the transfer is approved, the household will be placed on the CES Transfer List. Households on the approved transfer list will be matched with a vacancy based on the number of total vacancies available during the CES meeting. Vacancies will be assigned 50/50 if there is an even number of vacancies. If there is an odd number of vacancies available, the number of vacancies that go to the by name list clients should be higher than what is offered to the transfers (i.e. 5 vacancies = 2 transfers & 3 CES list).

Transfers remain valid and prioritized on the transfer list only while participants are in their current housing. If a transfer participant enters an Emergency Shelter (ES), Safe Heavens (SH), Transitional Housing (TH), or Outreach program, the transfer process will stop. Their prioritization will then be determined based on the regular CES prioritization process.

If a client loses their housing while awaiting an approved transfer, the current provider will close both transfer and program entry/exit when the client returns to homelessness.

Complex cases will be reviewed individually through case conferencing to determine a housing intervention that addresses the needs of individuals with severe service needs.

Coordinated Entry staff, in collaboration with the Contract Monitoring team, will review transfer requests and update the status. Decisions will be finalized and communicated within 10 business days.

XV. Veteran CES

a. Veteran Definition

Definition

HUD defines a Veteran as "A person who served in the active military, naval, air, or space service, regardless of length of service, and who was discharged or released therefrom," excluding anyone who received a dishonorable discharge from the Armed Forces or was discharged or dismissed from the Armed Forces by reason of the sentence of a general court-martial (38 USC § 2002 (b)). This definition applies to housing programs that are eligible for HUD funding.

Montgomery County defines a Veteran as "Any individual experiencing homelessness who has served on active duty in the U.S. Military, regardless of discharge status." This definition applies to the CES in general due to our prioritization of Veterans. For programs that are HUD funded, clients must meet HUD's definition and eligibility criteria.

There is no time restriction on the active-duty requirement, meaning it applies to any length of service beyond training or boot camp. Individuals with a humanitarian discharge are not considered veterans unless they have completed active duty.

b. Types of Service

Active Duty

According to Veteran Affairs, a person who is active duty is in the military full time. They work for the military full time, may live on a military base, and can be deployed at any time. Active Duty status must meet one of the following criteria:

(A) full-time duty in the Armed Forces, other than active duty for training;

(B) full-time duty (other than for training purposes) as a commissioned officer of the Regular or Reserve Corps 1 of the Public Health Service (i) on or after July 29, 1945, or (ii) before that date under circumstances affording entitlement to "full military benefits" or (iii) at any time, for the purposes of chapter 13 of this title;

(C) full-time duty as a commissioned officer in the commissioned officer corps of the National Oceanic and Atmospheric Administration or its predecessor organization the Coast and Geodetic Survey (i) on or after July 29, 1945, or (ii) before that date (I) while on transfer to one of the Armed Forces, or (II) while, in time of war or national emergency declared by the President, assigned to duty on a project for one of the Armed Forces in an area determined by the Secretary of Defense to be of immediate military hazard, or (III) in the Philippine Islands on December 7, 1941, and continuously in such islands thereafter, or (iii) at any time, for the purposes of chapter 13 of this title;

(D) service as a cadet at the United States Military, Air Force, or Coast Guard Academy, or as a midshipman at the United States Naval Academy; and

(E) authorized travel to or from such duty or service.

Reserves

According to Veteran Affairs, persons in the Reserve are not full-time active duty military personnel. The part-time military personnel who can maintain civilian employment. Each branch of the military has a Reserve component, and the Reserve are under the command of their respective military. The purpose of the Reserve is to provide and maintain trained units and qualified persons to be available for active duty in the armed forces when needed. They can be called into active duty and deployed internationally at any time. The primary job of the Reserve is to fill the gaps in stateside service positions when the active duty forces ship overseas. Members of the Reserve are required to participate in training drills one weekend a month and two weeks per year. After 20 years of service, can retire with modified retirement benefits

National Guard

According to Veteran Affairs, persons in the National Guard are not full-time active duty military personnel, although they can be deployed at any time should the need arise. The National Guard is the Reserve component of the United States Army and Air Force. They are a militia of all 50 states, Guam, US Virgin Islands, Puerto Rico, and District of Columbia who can be activated both by their state's governor or the federal government. However, in times of war, the National Guard can become federalized and deployed. As with the Reserve, the National Guard requires training drills one weekend a month and two weeks per year. National Guard members are given Veteran status if they have served for 30 consecutive days in a war zone. Eligibility requirements for several VA benefits also include a certain length of active service.

c. Veteran Status Verification

Verification of Veteran status begins when a client engages with a program or service within the CoC. This process starts by asking the client the following questions:

1. Do you have your DD214?
2. In what branch did you serve?
3. What was your job in the _____ (branch)?
4. Where were you stationed?
5. Do you know your discharge status?
6. Have you ever been to the VA hospital?
7. What sort of benefits do you enjoy as a veteran?

The next step of verification is obtaining the necessary documentation. The preferred document for veteran status verification is the DD-214: Certificate of Release or Discharge from Active Duty form. However, there are other forms of verification that are also accepted. Those other forms of verification are Veterans Affairs (VA) ID, Veterans Health Administration (VHA) ID Card, Service Connected Disability (SCD) Award Letter, and Veterans Benefits Administration Statement of Service

d. Veteran CES List

As mentioned above, in Section 2.10, a Veteran pre CES list is prepared prior to the meetings. This list is compiled from the CES Singles list, by filtering for Veterans and copying that information over to a new Excel sheet. Before the CES Singles list is finalized, the CES Program Manager checks for Veteran verification. All clients who have identified themselves as a Veteran are listed as such in HMIS. However, not all these clients' Veteran status have been confirmed. Client's whose Veteran status have been confirmed either through a DD-214 form or a VA representative, they are listed as "*Yes*" in the "*Veteran*" column of the CES Singles list. For Veterans who are not eligible for VHA services, CES Veteran services, and HUD VASH, they are manually listed as "*Yes, Not VHAE*". For clients whose Veteran status needs confirmation, they are listed as "*Pending*". When the pre-list is finalized, it will be sent out through email to Veteran mailing list.

e. Veteran Prioritization

Veterans have access to the full range of housing and service intervention options in the CoC, including some specialized resources for Veterans. Many veteran service providers have specific military service requirements for entry. For Veteran housing programs that are provided through CES, active military service is required. Veterans who have only completed active-duty training or were Reservists, are not eligible for Veteran housing programs through CES or Veteran Health Administration (VHA) benefits. HUD VASH may serve Veterans who are not VHA eligible, however those clients would only receive the housing assistance, and not the health benefits. For Veterans who do not meet these specific service requirements for both CES Veteran programs and HUD VASH, they are prioritized for vacancies during the CES Singles meetings.

f. Veteran CES Meeting

As stated in Section 2.10, the Veteran CES meetings are on the 2nd and 4th Monday of every month, for one hour. The meeting begins with updates and announcements, either from the CES Program Manager or the providers attending. Next is the review of clients who have been assigned to a housing provider on the "Assigned- Accepted" tab. As each client is reviewed, the Program Manager is documenting updates regarding their housing process. After all clients have been reviewed, the last task on the agenda is filling program vacancies. Clients will be matched to vacancies based on prioritization scores and program eligibility.

g. Veteran Housing and Intervention Programs

Supportive Services Only (SSO)

Supportive Services for Veteran Families (SSVF) provides supportive services to very low-income Veteran households with and without minors, living in or transitioning to permanent housing. The criteria for this program is:

1. HUD Category 1 and 2
2. Veterans with a discharge other than dishonorable
3. Income below 50% of area median income

Safe Haven (SH)

The Veteran Safe Haven program is managed by The Montgomery County Coalition for the Homeless (MCCH). This is an emergency housing program that serves hard-to-reach Veterans with severe mental illness, who are experiencing street homelessness and have been unwilling or unable to participate in supportive services. Safe Haven is a 24 hour residence with no specified duration period that provide access to needed services in a low demand facility but cannot require program participants to utilize them. The criteria for this program is:

1. HUD Category 1
2. Veteran with severe mental illness
3. History of disengagement with supportive services

Rapid Rehousing (RRH)

There are two Rapid Rehousing programs for Veterans in the Montgomery County CoC. The first RRH housing program is managed by Bethesda Cares and serves Veteran households without minor children. The criteria for this program is:

1. HUD Category 1
2. A score of 4-7 on the VI-SPDAT or a score of 20-34 on the Full SPDAT
3. Veteran with active military service history

The second RRH program is Veterans First, which is managed by Friendship Place to serve Veteran households with minor children. The criteria for this program is:

1. HUD Category 1 and 2
2. Veterans with a discharge other than dishonorable
3. Income below 50% of area median income

Permanent Supportive Housing (PSH)

There are two Veteran PSH housing programs that are managed by Bethesda Cares and the Montgomery County Coalition for the Homeless (MCCH). Bethesda Cares PSH program is for adult-only households. MCCH's PSH program is offered to both adult-only households and households with minor children. Criteria for Veteran PSH is:

1. HUD Category 1
2. For adult-only households: a score of 8+on the VI-SPDAT or a score of 35+ on the Full SPDAT
3. For households with minor children: a score of 9+ on the VI-SPDAT or a score of 54+ on the Full FSPDAT
4. Veteran (Head of household) with active military service history
5. Disability

HUD Veterans Affairs Supportive Housing (VASH) Voucher

The HUD-Veterans Affairs Supportive Housing (HUD-VASH) program combines HUD's Housing Choice Voucher (HCV) rental assistance for homeless Veterans with case management and clinical services provided by the Department of Veterans Affairs (VA). These services aim to help eligible homeless Veterans and their families find permanent housing and access healthcare, mental health treatment, and other supports necessary to improve their quality of life and maintain housing over time. Case management and clinical services may include monthly housing visits, providing housing and financial resources, benefits assistance, helping clients manage medication, scheduling specialty appointments, and support for addiction and substance abuse. VASH program referrals are sent to a representative from the Veterans Affairs Medical Center in Washington, D.C., who partners with the CoC. This representative reviews the client's information and history to determine eligibility. If eligible, they work with the client and their case manager to complete the voucher application and gather necessary documentation to send to the Housing Opportunities Commission (HOC) of Montgomery County, which oversees the VASH vouchers for the county.

It is important to note that clients referred to VASH must be able to live independently or have 24/7 in-home support. Clients who cannot live independently or cannot have 24/7 care, will not be eligible. VASH does not require specific scores from assessments for eligibility.

Eligibility

1. HUD Category 1
2. Veteran with honorable, general, and other specific discharges. (Please visit Veteran Affairs for more information).
3. Ability to live independently or have 24/7 in-home support

XVI. Domestic Violence Placement

Clients in need of temporary accommodations will be referred to the Betty Ann Krahnke Center which is a 60-bed, short-term crisis shelter for women and children who are fleeing domestic violence and/or victims of sexual assault or human trafficking. The Betty Ann Krahnke Center provides crisis intervention, safety planning, victim advocacy services, counseling and therapeutic interpersonal skill-building, with an emphasis on trauma reduction and personal empowerment.

If the Betty Ann Krahnke Center is full or if there is a male victim requiring placement, the CoC works closely with the County's Abused Persons Program to provide motel placement. If a victim of domestic violence requires ongoing CoC housing solutions, they may be placed on transitional housing or permanent housing queues and will be prioritized based on their score as described herein. The CES Manager will maintain a paper-based housing queue for victims of domestic violence.

XVII. Youth CES

a. Governance

ICH Youth Subcommittee

The Youth Subcommittee is purposed with establishing a coordinated entry for young adults in addition to setting the priorities. This workgroup meets monthly to discuss updates in Youth Outreach, YAB meetings, and next steps or goals.

ICH Youth Advisory Board (YAB)

The Youth Advisory Board is comprised of members who are young adults. The purpose is to ensure that policies regarding youth are guided by individuals with lived experience.

b. Coordinated Entry

As of August 1, 2025, a Youth CES has not been finalized.

c. Assessment

The TAY-VI-SPDAT (v.1) is the initial screening tool used to assess individuals between the ages of 18-24, who need housing intervention(s) and is based on client self-report. If a youth is the head of household with minor children, the VI-SPDAT for Families (v.2) (See Section 2.7: **Type, Background, Score Breakdown**) is the appropriate screening tool to use for assessment. CES access points, typically at emergency shelter, use the tool to help prioritize the housing needs of each presenting household. The TAY is utilized by Youth specific providers in the CoC at this time.

XVIII. Case Conferencing

a. Contract Monitoring Meetings

Contract Monitors will meet with the housing providers assigned to them on a monthly basis. These meetings can include program updates, discussions regarding clients, review contract details, and program compliance.

b. CES Joint Leadership Meetings

SEPH and partners meet monthly to discuss various areas of coordinated entry such as CoC announcements or updates, policy, data analysis, and trainings. The purpose is to maintain an open flow of communication between all partnering organizations in the CoC.

c. Outreach Case Conferencing Meeting

The CoC hosts a Homeless Outreach workgroup that meets monthly. The purpose of this meeting is to allow space for different providers to coordinate their outreach efforts within the CoC to, communicate, discuss clients' cases, collaborate on services, and work together towards the same goal. During this meetings, the group reviews clients on a separate list called "*Outreach Case Conferencing*" that is a part of the greater CES list that is sent out to providers. This list allows for updates on clients whose barriers may prevent them from accepting housing and those who may benefit from being added to the list. The housing intervention that is prioritized for these clients is Corporate Lease. Corporate Lease referrals are matched from the "*Outreach Case Conferencing*" portion of the CES List. These are clients that have met the eligibility criteria for Corporate Lease. This separate list is updated during the monthly Outreach subcommittee meetings.

XIX. Coordinated Entry Assistance

a. HMIS Assistance

For question regarding access to HMIS, HMIS training, how to enter data into HMIS, data entry in general, duplicate client profiles, or reports, please contact the HMIS team at hmis@montgomerycountymd.gov. The HMIS team also hosts weekly office hours to answer questions or provide demonstrations. If you do not already have the meeting invitation, please email them.

b. Coordinated Entry Assistance

For questions regarding coordinated entry policy, procedures, prioritization, referrals, vacancies, or grievances, please contact the CES Program Manager at CES.Ind@montgomerycountymd.gov. The CES Program Manager also hosts weekly office hours to answer questions or provide demonstrations. If you do not already have the meeting invitation, please email them.

c. CoC Assistance

For questions regarding CoC governance structure, CoC policy, participation in the CoC, ICH governance structure, ICH committees, Written Standards, and Strategic Planning Goals, please visit the ICH website or contact the CoC/ICH Coordinator at Rozina.Adhanom@montgomerycountymd.gov.

d. Assessment and Mental Health

For questions regarding the VI-SPDAT, Full-SPDAT, Full F-SPDAT, Acuity, trainings, or mental health resources within the CoC, please send an email adding both CES and Social Worker II (VANTAGE) at sarah.moore@montgomerycountymd.gov, CES.Ind@montgomerycountymd.gov as the recipients.

Section III: Additional Resources

XX. Appendix

a. VI-SPDAT for Single Adults (Version 2.0)
b. VI-FSPDAT for Families (Version 2.0)
c. FULL SPDAT for Single Adults (Version 4.0)
d. FULL F-SPDAT for Families (Version 2.0)
e. TAY-VI-SPDAT for Youth (Version 1.0)
f. Montgomery County Acuity Scale for Singles
g. Montgomery County Acuity Scale for Families
h. Client Decline Form

XXI. Glossary

Acuity: Acuity is an assessment of the complex strengths and challenges of our clients. It is used to determine the level and frequency of housing support and case management services required to promote housing stability, personal recovery, and self-sufficiency.

The Acuity Scale should be used in combination with the VI- or Full SPDAT to determine both the type of housing (PSH, RRH, limited case management/emergency services) and the level of support services.

Agency: An organization that is a member of the continuum of care and oversees one or several homeless service projects. For example, Bethesda Cares, Interfaith Works, and MCCH are all agencies.

Case Plan: The Case Plans portion of the Client module allows case managers to assign and track case managers assigned to clients, establish goals and action steps to reach that goal. Service Transactions related to achieving goals can be entered directly in Case Plans. This feature allows case managers and program evaluators to show that goals were or were not achieved, the action steps taken, and the services provided to allow clients to achieve success through case management.

Case Conferencing: A reoccurring meeting with case management staff and other key stakeholders serving households experiencing homelessness, that consists of case coordination and problem solving. In terms of the CES meeting, case conferencing consists of an in depth conversation about the housing process for clients assigned to a housing provider who have the highest length of time on the list.

CES List (Also known as "By Name List"): A real-time, up-to-date list of all people experiencing homelessness in an area. May include categories such as veteran status, chronic status, active/inactive status, homeless/housed status, and more.

Chronically Homeless: HUD defines this population as an unaccompanied homeless individual with a disabling condition or a family with at least one adult member who has a disabling condition who has either been continuously homeless for a year or more OR has had at least four (4) episodes of homelessness in the past three (3) years.

Continuum of Care (CoC): A collaborative funding and planning approach that helps communities plan for and provide, as necessary, a full range of emergency, transitional, and permanent housing and other service resources to address the various needs of homeless persons. HUD also refers to the group of community stakeholders involved in the decision-making processes as the "Continuum of Care."

Continuum of Care Lead Agency: Agency or organization designated by the CoC primary decision-making body to be the entity that submits the CoC application. The CoC lead agency is responsible for the coordination and oversight of the CoC planning efforts and has the authority to certify and submit the CoC homeless assistance funding application. A state governmental entity is the only acceptable organization that may serve as the Lead Agency for multiple CoCs, due to the level of involvement and possible conflict of interest that comes with serving multiple

CoCs. Under no other circumstance should one entity be identified as the Lead Agency for multiple CoCs.

Continuum of Care Primary Decision-Making Group: This group manages the overall planning effort for the CoC, including, but not limited to, the following types of activities: setting agendas for full CoC meetings, project monitoring, determining project priorities, and providing final approval for the CoC application submission. This body is also responsible for the implementation of the CoC's HMIS, either through direct oversight or through the designation of an HMIS implementing agency. This group may be the CoC Lead Agency or may authorize another entity to be the CoC Lead Agency under its direction.

Coordinated Entry (CE) or Coordinated Entry System (CES): A process developed to ensure that all people experiencing a housing crisis have fair and equal access and are quickly identified, assessed, referred and connected to housing and assistance based on their strengths and needs.

Coordinated Entry (CE) Projects in HMIS: These projects are necessary for clients on the CES List. These projects must be opened when a person who is experiencing homelessness connects to a provider or service within our homeless response system. These entries are used to generate the CES List and inform the Coordinated Entry System on who needs resources.

MC CoC Coordinated Entry Project (CES-IND): Households without minor children

MC CoC Coordinated Entry Project (CES-FAM): Households with minor children

Department of Housing and Urban Development (HUD): U.S. federal agency responsible for national policy and programs related to housing, community development, homelessness, and fair housing.

Disability: HUD defines a person with disabilities as (1) a disability as defined in Section 223 of the Social Security Act (42 U.S.C.423), or (2) is determined by HUD regulations to have a physical, mental or emotional impairment that: is expected to be of long, continued, and indefinite duration; substantially impedes his or her ability to live independently; and is of such a nature that such ability could be improved by more suitable housing conditions, or (3) has a developmental disability as defined in the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 15002(8)), or (4) has the disease acquired immunodeficiency syndrome (AIDS) or any conditions arising from the etiologic agent for acquired immunodeficiency syndrome (HIV).

Emergency Shelter: A project that offers temporary shelter (lodging) for people experiencing homelessness in general or for specific populations of people experiencing homelessness.

Emergency Shelter Grants (ESG): The Emergency Shelter Grants program provides homeless persons with basic shelter and essential supportive services. Eligible activities include funding operational costs of the shelter facility, grant administration, and short-term homeless prevention assistance to persons at imminent risk of losing their own housing due to eviction, foreclosure, or utility shutoffs.

Engagement: This is the point at which an interactive client relationship results in a deliberate client assessment or the beginning of a case plan. This is a one-time event that may occur on or after the Project Start date and on or before Project Exit. The engagement is captured in the Date of Engagement field.

Entry Point: An agency or organization that acts as a door to the homeless response system and Coordinated Entry. Entry points are triage points where an enrollment into Coordinated Entry takes place and where referrals can be sent or received.

Family-Vulnerability Index-Service Prioritization Decision Assistance Tool (F-VI-SPDAT): An assessment tool that is designed to help providers determine the most appropriate housing intervention for households that have one or more adults accompanied by children.

Full SPDAT (Service Prioritization Decision Assistance Tool): An assessment tool used to help guide case management and improve housing stability outcomes. The SPDAT is used by frontline staff that work with program participants who are currently homeless to inform decisions on appropriate service interventions and to assist with prioritization and program matching decisions for finite supportive housing resources. It is an in-depth assessment that relies on the assessor's ability to interpret responses and corroborate those with evidence. As a result, this tool may only be used by those who have received proper, up-to-date training provided by OrgCode Consulting, Inc. or an OrgCode certified trainer.

Head of Household (HoH): In a household of a single individual, that person must be identified as the head of the household. In multi-person households, the term "Head of Household" is not intended to mean the "leader" of the house. When a group of persons present together as a household or family unit, one of those persons must be designated as the Head of Household and the rest must have their relationship to the Head of Household recorded. If the group of people is composed of adults and children, an adult must be indicated as the Head of Household. The Head of Household is typically thought of as the "primary client" or the "eligible individual."

HIPAA: Health Insurance Portability and Accountability Act that requires the protection and confidential handling of protected health information. All HMIS end users must attend HIPAA training.

HMIS Lead Agency*:* Agency, organization or government department which manages a CoC's Homeless Management Information System (HMIS) on behalf of the Continuum of Care. While the CoC retains ultimate authority and responsibility for a CoC's HMIS, the HMIS Lead is generally responsible for the administration, management, and operation of the HMIS implementation, in addition to providing end user training and meeting reporting requirements for funders.

Homeless Management Information Systems (HMIS): HMIS is a local information technology system used to collect client-level data and data on the provision of housing and services to individuals and families at risk of and experiencing homelessness. Each CoC is responsible for selecting an HMIS software solution that complies with HUD's data collection, management, and reporting standards.

Household: A single individual or a group of persons who apply together to a continuum project for assistance and who live together in one dwelling unit, or, for persons who are not housed, who would live together in one dwelling unit if they were housed.

Housing First: An approach to ending homelessness that centers on providing people experiencing homelessness with housing as quickly as possible, and then providing services as needed. Key elements are a low threshold for entry and no clinical prerequisites such as completion of a course of treatment or evidence of sobriety.

Housing Move in Date: The date a client leases up/moves into a unit. “Move-in” means a lease arrangement has been made, the client has a key or entry ability to the unit, and that the client has physically slept in the unit.

Interim Update: An assessment completed on an open project record anytime there is a change to the client’s information (ex: income, disability, health insurance, non-cash benefits, etc.) that occurs after project entry. Interim updates are also done to complete acuity assessments, VI-SPDATs, annual assessments, and housing move in date interims.

Length of Stay (LOS): This metric indicates the number of days a client stayed in an emergency shelter bed.

Length of Time (LOT) Persons Remain Homeless: This measure assesses the average duration households experience homelessness, aiming to reduce this period through timely interventions.

Medicaid: A Federally aided, State-operated and administered program that provides medical benefits for certain indigent or low-income persons in need of health care. Subject to broad Federal guidelines, States determine benefits covered, program eligibility, rates of payment for providers, and methods of administering the program.

Other Permanent Housing: For the purpose of this manual, other permanent housing includes programs that help clients achieve housing such as Short-Term Housing and Resolution Program (SHaRP) and vouchers.

Permanent Supportive Housing (PSH): A project that offers permanent housing and supportive services to assist people experiencing homelessness with a disability (individuals with disabilities or families in which one adult or child has a disability) to live independently.

Project End Date: The last day a contact was made, or a service was provided.

Project Start Date: The date the client first began working with the project and generally received the first provision of service.

Protected Personal Information (PPI): Information that can be used to distinguish or trace an individual’s identity, either alone or when combined with other information that is linked or linkable to a specific individual.

Provider: In HMIS, this is the specific project providing services to a client. For example, MCCH Rapid Rehousing RRH-IND. In Coordinated Entry, the provider is the organization or program within our CoC, serving households experiencing homelessness. For example, The Montgomery County Coalition for the Homeless.

Rapid Rehousing (RRH): A project that offers ongoing rental assistance that may or may not be accompanied by financial or other supportive services to participants. A housing project that provides housing relocation and stabilization services and/or short- and/or medium-term rental assistance as necessary to help an individual or family experiencing homelessness move as quickly as possible into permanent housing and achieve stability in that housing.

Referral Date: The date the CES Program Manager sends the e-mail referral to current shelter /outreach case managers and the housing provider.

Release of Information (ROI): Written documentation signed by a participant to release their personal information to authorized partners.

Service Transactions: Service Transactions include identifying the client's needs and the services and providers who can meet the needs. Service transactions are one-and-done services provided to a client that can be done in one day or less.

Street Outreach: A project that offers services necessary to engage people experiencing unsheltered homelessness, connect them with emergency shelter, housing, or critical services, and provide urgent, non-facility-based care. Only persons who are residing on the streets or other places not meant for habitation should be entered into a street outreach project.

Supportive Services Only: Supportive Services Only (SSO) projects allow recipients to provide supportive services—such as conducting outreach to sheltered and unsheltered homeless persons and families and providing referrals to other housing or other necessary services—to families and individuals experiencing homelessness.

Transitional Housing: Provides temporary housing with supportive services to individuals and families experiencing homelessness with the goal of interim stability and support to successfully move to and maintain permanent housing. TH projects can cover housing costs and accompany supportive services for program participants for up to 24 months.

Unsheltered Housing: Someone who is living on the streets or in a vehicle, encampment, abandoned building, garage, or any other place not normally used or meant for human habitation.

Violence Against Women Act (VAWA): The Violence Against Women Act (VAWA) is a federal law that, in part, provides housing protections for people applying for or living in units subsidized by the federal government and who have experienced domestic violence, dating violence, sexual assault, or stalking, to help keep them safe and reduce their likelihood of experiencing homelessness.

Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT): A pre-screening tool that is designed to help providers determine the most appropriate housing intervention for single individuals or families, i.e. households with minor children.