Coordinated Assessment System
Tippecanoe County

Working together to create a system to rapidly connect the most appropriate intervention to households and individuals that are homeless or at risk of homelessness.

July 2018

Coordinated Assessment Policies and Procedures

PURPOSE

The state of Indiana is in the process of implementing a state-wide coordinated assessment (CA) program in its effort to end homelessness. This new system includes one standardized assessment, Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT), for all households entering the homeless services system. This tool will be administered at community entry points throughout Indiana's Balance of State. Using this assessment, Indiana regions will coordinate, prioritize and match available housing interventions to household needs.

The system will roll out in several phases. The first phase includes system pilots in the following cities: Bloomington, Fort Wayne, Evansville and Lafayette. The target (prioritized) population for these pilots is households experiencing chronic homelessness. The primary intervention for this population will be permanent supportive housing. This system will be adapted in later phases to include all households experiencing a housing crisis – homeless or at risk of homelessness, matched to all available housing interventions and services.

These policies and procedures will govern the implementation, governance and evaluation of coordinated assessment for Indiana Balance of State's Continuum of Care. These policies may only be changed by the approval of the Continuum of Care (CoC) Board based on recommendations from the Coordinated Assessment Committee of the CoC.

Vision

For households experiencing a housing crisis or homelessness, we know who everyone is, we know which interventions each needs and our access system aligns our available resources most effectively to end homelessness in Indiana.

Mission Statement

The mission of the Indiana Balance of State Continuum of Care's coordinated assessment system is to rapidly connect the most appropriate need-based interventions to households that are facing or are at risk of facing homelessness.

OVERVIEW

Overview of Coordinated Assessment

Coordinated assessment refers to the process used to assess and assist in meeting the housing needs of people at-risk of homelessness and people experiencing homelessness. Key elements of coordinated assessment include:

- A designated set of coordinated assessment locations and staff members;
- The use of standardized assessment tools to assess consumer needs;
- Referrals, based on the results of the assessment tools, to homelessness assistance programs (and other related programs when appropriate);
- Capturing and managing data related to assessment and referrals in a Homeless Management Information System (HMIS); and
- Prioritization of consumers with the most barriers to returning to housing for the most cost- and service-intensive interventions.

The implementation of coordinated assessment is now a requirement of receiving certain funding (namely Emergency Solutions Grant and Continuum of Care funds) from the Department of Housing and Urban Development (HUD) and is also considered national best practice. When implemented effectively, coordinated assessment can:

- Reduce the amount of research and the number of phone calls people experiencing homelessness must make before finding crisis housing or services;
- Reduce new entries into homelessness through coordinated system wide diversion and prevention efforts;
- Prevent people experiencing homelessness from entering and exiting multiple programs before getting their needs met;
- Reduce or erase entirely the need for individual provider wait lists for services;
- Foster increased collaboration between homelessness assistance providers; and
- Improve a community's ability to perform well on Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act outcomes and make progress on ending homelessness.

This Document

These policies and procedures will govern the implementation, governance, and evaluation of coordinated assessment in Lafayette, Indiana. These policies may only be changed by the approval of the Local Coordinated Assessment Committee.

Basic Definitions

- **Provider –** Organization that provides services or housing to people experiencing or at-risk of homelessness
- **Program –** A specific set of services or a housing intervention offered by a provider
- **Consumer –** Person at-risk of or experiencing homelessness or someone being served by the coordinated assessment process

- **Housing Interventions –** Housing programs and subsidies; these include, emergency shelter, rapid re-housing, and permanent supportive housing programs, as well as permanent housing subsidy programs (e.g. Housing Choice Vouchers).

Target Population

This process is intended to serve people experiencing homelessness and those who believe they are at imminent risk of homelessness. Homelessness will be defined in accordance with the official HUD definition of homelessness.[1] People at imminent risk of homelessness are people who believe they will become homeless, according to the HUD definition, within the next 72 hours. People who think they have a longer period of time before they will become homeless should be referred to other prevention-oriented resources available in the community.

This coordinated assessment process was developed primarily for residents of Tippecanoe County. In cases where it is forbidden by their funders or local, state, or federal law, providers may not be able to serve individuals who do not have adequate proof of residence in Tippecanoe County. Assessment staff will attempt to link consumers that fall into this category with resources that may be available in their area of origin or wherever they are currently staying.

Coordinated Entry Prioritization Policy

The Indiana Balance of State Continuum of Care Board of Directors adopts the following policy and guidance around Coordinated Entry and prioritizing the most vulnerable persons experiencing homelessness.

HOUSING INTERVENTION	TARGET POPULATION	PRIORITIZATION
Diversion	All Persons seeking assistance via Coordinated Entry	
Permanent Supportive Housing **	Persons experiencing chronic homelessness	1. Highest VI-SPDAT Score (8+) **HUD Guidelines/Prioritization** 2. Longest history of homelessness
Rapid Re-Housing **SSVF**	Persons literally homeless Veterans experiencing homelessness	1. VI-SPDAT Score (4+) 2. Length of homelessness 3. *Regional Prioritization

[1] The definition is available here: https://www.onecpd.info/resources/documents/HEARTH_HomelessDefinition_FinalRule.pdf

		Veterans* Youth* Families* Single Adults* 4. Date of Assessment (Only in tie breaker situation)
Emergency Shelter	Persons literally homeless and not diverted	1. First come, first served 2. When person is literally homeless and no permanent housing/rapid rehousing is available
Referrals to Mainstream Resources		1. VI-SPDAT (0 – 3)

As the Coordinated Entry System continues to evolve, regional decision making and prioritization needs should be taken into consideration. Procedures will be developed for regions as the CE implementation progresses to help guide decision making at the regional level.

**** If a person is prioritized for PSH and no PSH is available, that person should be prioritized for other types of assistance such as RRH. In this situation the person does not lose their Chronically Homeless status and can be moved into PSH when a unit becomes available.**

Goals and Guiding Principles

The goal of the coordinated assessment process is to provide each consumer with adequate services and supports to meet their housing needs, with a focus on returning them to housing as quickly as possible. Below are the guiding principles that will help Tippecanoe County meet these goals.

- **Consumer Choice**: Consumers will be given information about the programs available to them and have some degree of choice about which programs they want to participate in. They will also be engaged as key and valued partners in the implementation and evaluation of coordinated assessment through forums, surveys, and other methods designed to obtain their thoughts on the effectiveness of the coordinated assessment process.

- **Collaboration**: Because coordinated assessment is being implemented system wide, it requires a great deal of collaboration between the CoC, providers, mainstream assistance agencies (e.g., Department of Social Services, hospitals, and jails), funders, and other key partners. This spirit of collaboration will be fostered through open communication, transparent work by a strong governing

council (the Coordinated Assessment Committee), consistently scheduled meetings between partners, and consistent reporting on the performance of the coordinated assessment process.

- **Accurate Data:** Data collection on people experiencing homelessness is a key component of the coordinated assessment process. Data from the assessment process that reveals what resources consumers need the most will be used to assist with reallocation of funds and other funding decisions. To capture this data accurately, all assessment staff must enter data into Client Track, HMIS (with the exception of some special populations and other cases, outlined later in this document) in a timely fashion. Consumers' rights around data will always be made explicit to them, and no consumer will be denied services for refusing to share their data.

- **Performance-Driven Decision Making**: Decisions about and modifications to the coordinated assessment process will be driven primarily by the need to improve the performance of the homelessness assistance system on key outcomes. These outcomes include reducing new entries into homelessness, reducing lengths of episodes of homelessness, and reducing repeat entries into homelessness. Changes may also be driven by a desire to improve process-oriented outcomes, including reducing the amount of waiting time for an assessment.

- **Housing First:** Coordinated assessment will support a housing first approach, and will thus work to connect households with the appropriate permanent housing opportunity, as well as any necessary supportive services, as quickly as possible.

- **Prioritizing the Hardest to House:** Coordinated assessment referrals will prioritize those households that appear to be the hardest to house or serve for program beds and services. This approach will ensure an appropriate match between the most intensive services and the people least likely to succeed with a less intensive intervention, while giving people with fewer housing barriers more time to work out a housing solution on their own. This approach is most likely to reduce the average length of episodes of homelessness and result in better housing outcomes for all.

KEY COMPONENTS OF THE COORDINATED ASSESSMENT PROCESS IN LAFAYETTE

This section outlines and defines the key components of coordinated assessment and how the coordinated assessment process will work.

Centralized Coordinated Assessment
The designated coordinated assessment for Tippecanoe County will be located at Lafayette Transitional Housing Center's Homeless Services Program. This will be the only location where people experiencing homelessness will be assessed and referred to homelessness assistance services. All people experiencing homelessness or at imminent risk of homelessness should be directed to LTHC to be assessed **prior to receiving any services or admission to any homelessness assistance program** (with the exception of situations where assessment hours have ended for the day and the person needs emergency shelter).

Assessment Center Staffing
The assessment tool, Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT), will be administered by Case Management staff from Lafayette Transitional Housing Center and is housed within the HMIS system.

Outreach staff through PATH at Wabash Valley Alliance will also assess consumers living on the street or other places not fit for human habitation.

All staff that administer assessments will receive training on the standardized assessment forms to be used, proper referral and prioritization procedures, and priority list management. Staff will also receive training in serving domestic violence survivors and other population-specific topics as needed. It is the responsibility of the CoC to ensure this training for staff is available and to make sure it is offered on a regular basis (at least quarterly).

System Entry
Consumers presenting at agencies other than LTHC seeking homelessness assistance services will be referred to LTHC for assessment. If the consumer is unable to reach the center due to a disability or lack of transportation, an effort should be made by the agency where they present to assist the consumer with transportation needs. If LTHC is closed and the agency provides emergency beds, they may admit the consumer until the coordinated assessment process is available again. These consumers should be directed to LTHC again as soon as they are open. **It is prohibited for any homelessness assistance organizations (unless the designated coordinated assessment centers are closed) to admit or serve consumers without them having first gone through the coordinated assessment process and received a referral to their agency.**

Phone Calls
Staff at LTHC, 2-1-1, or other provider locations that answer the phones may encounter people experiencing or at imminent risk of homelessness who are interested in being assessed or receiving homelessness assistance services. All of these callers should be asked a few pre-screening questions:

- Are you currently homeless or do you think you will become homeless within the next 72 hours? (Homeless means living in a place not meant for human habitation, in emergency shelter, in transitional housing, or exiting an institution where you stayed for up to 90 days and were in shelter or a place not meant for human habitation beforehand)
- Are you interested in receiving homelessness assistance services?

If the consumer answers yes to both questions, staff should let the caller know about the LTHC Homeless Services Program and the hours they are open and encourage them to come in to be assessed.

The Assessment Process
Assessment refers to the process of asking the consumer a set of questions to determine which programs or services are most appropriate to meet their needs and prioritize them for various services. A standardized set of assessment tools will be used to make these determinations. Assessment staff will be trained on administering and scoring these tools, as well as the order in which they should be administered and the average amount of time each assessment should take. Assessments will be administered at LTHC Homeless Services Program, Monday through Friday, 8am-5pm.

While Assessment Staff Are On Duty:

1. Each person walking or call into a homelessness assistance provider agency, or other community agency that works with consumers, will be asked the prescreening questions to determine if they should go through the coordinated assessment process. If it is determined by the pre-screening questions that the consumer does not need homelessness assistance services, they will be referred to other more appropriate resources.

2. If they are eligible according to the pre-screening process, they will be directed to an available coordinated assessment staff member. The assessment staff member will then explain the assessment process and discuss needed verification documents with the consumer including: Release of Information for HMIS, ROI for shelter/PATH/other third party verification, documentation of homelessness, income verification*, identification* (*CM can assist in acquiring needed documents). If the consumer signs the ROI for HMIS, the staff member will begin the assessment in HMIS.

3. The assessment staff member will then administer a prevention/diversion assessment to determine if the consumer has alternative housing options within the community, UNLESS they are clearly homeless (e.g., have engaged with outreach workers on multiple occasions, referred from shelter,…).

4. People who are eligible to be diverted will be assessed by a case manager who will determine what resources are needed to help the person stay in housing, mediate disputes, or do anything else necessary to help them obtain that alternative housing. CM staff will have to use their judgment to gauge if they are able to do a full diversion session with the consumer based on the current wait times/demand for assessments and the depth of diversion services the consumer needs.

5. If the household is successfully diverted, they will end their engagement with the CM and make a note in the assessment form and in HMIS that the consumer was diverted. Household will then be exited from Coordinated Entry program.

6. People who are not diversion eligible will continue with the assessment process. This process will prioritize them for housing interventions, including emergency shelter, rapid re-housing, and permanent supportive housing.

If Assessment Staff Are Off Duty (After Assessment Hours):

1. People presenting with a need for emergency shelter will be offered a bed in the emergency shelter where they arrived (if they are population-appropriate). If they are not population-appropriate, they will be referred to a shelter that is population-appropriate or has available space. If no shelter has available space, they will be sent to any available crisis housing (churches, hotels or motels, etc.). If they do not initially present at an emergency shelter, they will be referred to a population-appropriate one.

2. The next available day that assessment hours are open, they will be asked the pre-screening questions and, if needed, referred to a CM.

Data Collection

Data will be collected on everyone that is assessed through the coordinated assessment process. This section, in addition to instructions embedded within the assessment tool, will detail when and how data about consumers going through coordinated assessment will be collected.

Once a client has been asked the pre-screening questions and is deemed eligible to be assessed, the CM will begin the enrollment into Coordinated Entry within HMIS.

Some consumers should never be entered into HMIS. These include:

- Consumers who want domestic violence-specific services should never have information entered into HMIS. The assessment should be done on a paper form and passed off to the appropriate provider. If they are being served by a domestic violence provider, that agency may enter their information into a HMIS comparable database.

Once the assessment/enrollment process has been completed, the staff member will share the consumer's record in HMIS (when Client Track has this function to share with other agencies) with the program they are being referred to. This way the program will have the consumer's information and can ensure they do not ask the same questions again, potentially re-traumatizing the consumer. Access to parts of each consumer record or assessment form may be restricted for safety reasons or by consumer request.

Basis of Referrals

Referrals to additional services will be made based on the following factors:

- Results of the assessment tool process;
- Bed availability and priority lists;
- Program eligibility admission criteria, including populations served and services offered.

Each of these elements is discussed in more detail below.

Within Coordinated Entry the assessment tool has a built-in scoring mechanism that will prioritize households for access to different housing interventions. This will serve as a jumping-off point for a discussion between the staff member and the consumer about what referral should be made.

All bed availability should be determined, ideally, in real-time through HMIS. Until this happens, bed information should be managed through a Google Doc spreadsheet. Agencies should update the number of available beds or units (specifying which bed or unit the population is for if they serve multiple populations) in real time. Assessment staff will update this information in the spreadsheet. This spreadsheet will be Internet-based and shared through a cloud-based software program (Google Doc) to ensure that it is viewable by all coordinated entry staff. The Housing Prioritization Tool has a built-in element that will work to keep priority lists for each intervention short. There are three different scenarios: short, medium, or long priority lists. Short means less than 2 weeks, medium means 2-4 weeks, and long means 4 weeks or more. When waiting lists are short, then people of any letter prioritization level can be added to the list. When priority lists are medium length, only those with a designation of A through D can be added to the priority list, and when priority lists are long, then only A priority people are assigned to the priority list. Assessment staff will alternate responsibility sharing how long each list is with other assessment staff on a daily basis.

The coordinated entry process will be geared toward prioritizing those households with the most intensive service needs and housing barriers (e.g. chronically homeless households and households with multiple episodes of homelessness). The Indiana Balance of State CoC will have a renewed discussion annually, around the time of CoC application process, about the priority populations for the CoC and the coordinated assessment process. The assessment tools being used at coordinated assessment will be tweaked to reflect any changes to the priority groups. The Indiana BOS Coordinated Assessment Committee will be responsible for making changes to the coordinated assessment tool and re-distributing it to assessment staff.

Referrals will also be based on each program's admissions eligibility criteria, including populations served. For example, programs that serve only families from Tippecanoe County will only receive families from Tippecanoe County as referrals. **Agencies participating in coordinated assessment must submit all of their eligibility criteria to the Local Coordinated Assessment Committee before they can participate in the coordinated assessment process.** Any changes to a program's eligibility criteria or target population must be sent immediately to the Local Coordinated Assessment Committee to make sure referral protocol is updated accordingly. Criteria that agencies may have that are not bound to local law or strict funders' requirements will be reviewed by the Local Coordinated Assessment Committee along with data about people who have remained in emergency shelter for more than 45 days or are living on the street. If the Committee has a concern that a program's requirements may be contributing to "screening out" or excluding households from needed services, the Committee may request to meet with the provider to discuss their criteria. If the Committee can clearly show a link between underserved populations and eligibility criteria from a provider, and the provider is unwilling to modify the criteria, the Committee may recommend to the Indiana Balance of State CoC board that provider be de-prioritized for CoC or other sources of funding.

Family Promise Program Eligibility Requirements

- Adults must pass a criminal history background check which consists of the following:
    1) No sex crimes
    2) No violent crimes against children (battery, etc)
    3) No recent felonies (within the last 5 years)
    4) The adult cannot currently be on house arrest
- Adults must have a minor child in their custody or be pregnant.
- Must be homeless, fleeing domestic violence, or loosing housing within 14 days.
- Must be a resident of Tippecanoe or the surrounding counties (min. 30 days)

Laurie Mann, Executive Director Family Promise of Greater Lafayette, Inc

Making Referrals and Prioritizing Consumers

1. After the assessment/enrollment process is complete, the score will determine which interventions the consumer should be prioritized for, if any.

If the consumer scores as a potential consumer for permanent supportive housing or rapid rehousing, the staff member will administer the Vulnerability Index. The assessment staff member should provide information about the different intervention types the consumer is prioritized for, including general intervention attributes (e.g., length of services, type of housing) and the size of the current priority lists.

2. If the consumer was not prioritized for any interventions, they should explain why and what other services will be available to them (e.g., LTHC case management, connection to mainstream resources, help connecting with family or friends). The consumer should be referred to the appropriate intervention and the assessment process ends for the consumer at this point. And, the consumer should be discharged from Coordinated Entry. If the consumer is experiencing homelessness, but scores between 0-3, that guest is allowed to utilize the Homeless Services Program for a timeframe allowable by the Case Manager. This would allow the guest resources while they are connecting to employment, receiving additional income, or finding housing.

3. For those that did get prioritized for housing interventions, the CM should offer their recommendation of which intervention they think is best (if there is more than one option). The CM should then describe how the referral process will work – the consumer will be able to make a choice between the interventions (if there are multiple ones), and then will be placed on the priority list for whichever they choose. Once on the list, slots will be offered to them based on VI and length of homelessness, although it will account for matching the consumer with a population-appropriate program.

4. The CM should add the consumer to the priority list for their intervention of choice. Consumers should be added by their HMIS identification number only. For the emergency shelter list, people will be arranged on the list based on their vulnerability and housing crisis. For permanent supportive housing list, they will be added based on their Vulnerability Index score.

5. If the consumer is first on the list for a particular intervention and there is an open and available slot in a program they are eligible for, a referral will be made directly to that program.

6. To make the referral, the CM will call or email the program to let them know they are sending them a consumer. They should also ensure the consumer's information is in HMIS and that the HMIS record or their paper assessment is shared with the program in question. The consumer should be given the address and other information for reaching the program. The assessment

worker should then remove the consumer's name from the priority list for that intervention.

7. If there is not currently an opening at an appropriate program within the intervention, the consumer will be referred to the appropriate emergency shelter. The CM should explain that once a spot opens up for them, they and their case manager will be notified. The CM should also make a note in HMIS or on the consumer's paper assessment form of what intervention they are on the priority list for, so the staff at the referred-to program will know. If this information is on the paper assessment, the consumer should be told to give this information to their assigned case manager once they arrive at the emergency shelter. Their case manager at the referred-to program should then contact the CM via email to let them know they will be working with that particular consumer. The assessment staff member should then enter the case manager's name and contact information as a note into HMIS so that they can contact them when a program slot opens up.

8. If a consumer does not show up at the referred-to program within 4 hours of being referred, the referred-to program should notify their assessment staff member. This person should attempt to make contact with the consumer. If the consumer cannot be located 12 hours after being notified that a space was available in a program, the slot will be offered to the next person on the priority list for that intervention.

9. Each guest should be re-assessed every 90 days if they are still actively homeless.

10. If you are unable to locate a guest, when exiting please use "No Exit Interview Completed", for destination. The next field, Exit reason would be "unknown/disappeared".

Priority List Management and Notification of Referral

Priority list management and notification of referrals will be the responsibility of assessment staff. The assessment staff will need to check the priority list several times a day to see if new spots are becoming available and contact the consumer and the case manager if a slot opens up for them. They will also be responsible for managing situations where a consumer does not show up to the referred-to program.

Vulnerability Index

Tippecanoe County is utilizing the VI-SPDAT to prioritize those who qualify for Rapid Re-Housing and Permanent Supportive Housing. The VI provides a score for each person based on their barriers. The highest score is the #1 person on the list for housing. If

there are multiple same scores, we have implemented the following guidelines for tie breakers:

1. Length of homelessness ~ longest are higher priority
2. Date of VI ~ first on the list

For Permanent Supportive Housing placement, there are several factors that are considered.

1. Section 8 eligibility
2. Shelter + Care eligibility
3. Man or Woman (depending on shared restroom facilities at Singles Program)

The VISPDAT need to be updated every 90 days, or when the situation changes

Post-Referral Procedure

Once a consumer has entered a program, the program should make sure the consumer is connected to a case manager. Case managers should make sure they are reachable by assessment staff to receive updates on where their consumer stands on the priority list if they are waiting for a longer-term intervention. If the case manager determines that a consumer is ineligible for their program's services, they should follow the procedure described in the "Program Declines Referral" subsection of the Declined Referrals and Grievance Procedures section below.

DECLINED REFERRALS AND GRIEVANCE PROCEDURES

Program Declines Referral

There may be rare instances where programs decide not to accept a referral from the coordinated assessment process. Refusals are acceptable only in certain situations, including:

- The person does not meet the program's eligibility criteria;
- The person would be a danger to others or themselves if allowed to stay at this particular program; and
- The person has previously caused serious conflicts within the program (e.g. was violent with another consumer or program staff).

If the program determines a consumer is not eligible for their program after they have received the referral from coordinated assessment, the consumer should be sent back to their initial assessment point for assessment staff to determine a place for them to sleep that night (if they do not already have one). If a program is consistently refusing referrals (more than 1 out of every 4) they will need to meet with the Coordinated Assessment Committee to discuss the issue that is causing the refusals.

Consumer Declines Referral
Assessment staff, through the administration of the assessment tools and the assessment process (which includes consumer input), will attempt to do what they can to meet each consumers needs while also respecting community wide prioritization standards. The Local Coordinated Assessment Committee (LCAC) has the right to limit the number of program refusals any consumer can have per episode of homelessness. If a consumer exceeds this number of refusals they forfeit their right to be served by the homelessness assistance system.

Provider Grievances
Providers should address any concerns about the process to the Local Coordinated Assessment Committee, unless they believe a consumer is being put in immediate or life-threatening danger, in which case they should deal with the situation immediately. A summary of concerns should be provided via email to the chair of the LCAC. The chair of the committee should then schedule for that provider's representative to come to the next available LCAC meeting so the issue can be resolved. If it needs more immediate resolution, the chair will be in charge of determining the best course of action to resolve the issue.

Consumer Grievances
The assessment staff member or the assessment staff supervisor should address any complaints by consumers as best as they can in the moment. Complaints that should be addressed directly by the assessment staff member or assessment staff supervisor include complaints about how they were treated by assessment staff, assessment center conditions, or violation of confidentiality agreements. Any other complaints should be referred to the chair of the LCAC to be dealt with in a similar process to the one described above for providers. Any complaints filed by a consumer should note their name and contact information so the chair can contact them and ask them to appear before the committee to discuss them.

GOVERNANCE

Roles and Responsibilities
The coordinated assessment process will be governed by the Local Coordinated Assessment Committee (LCAC) of the Homelessness Prevention and Intervention Network (HPIN) and will report to the Coordinated Assessment Committee of the Indiana Balance of State CoC.

This group will be responsible for:

- Investigating and resolving consumer and provider complaints or concerns about the process, other than declined referrals;

- Providing information and feedback to the Indiana Balance of State Coordinated Assessment Steering Committee, Homeless Prevention and Intervention Network (HPIN), and the community at-large about coordinated assessment;
- Evaluating the efficiency and effectiveness of the coordinated assessment process;
- Reviewing performance data from the coordinated assessment process; and
- Recommending changes or improvements to the process, based on performance data, to the CoC and CoC Board.

Policies and Procedures

Committee Composition

This committee will include the following seats:

- All Emergency Shelters, one staff representative
- A PATH representative
- A RRH provider staff representative;
- A SSVF staff representative;
- A Coordinated Entry staff representative;
- All Permanent Supportive Housing Providers, one staff representative;
- A health care provider representative

Committee Chair

The Committee will have a chair. The chair will be responsible for:

- Putting together an agenda for each meeting, based on communications or agenda items submitted by providers or consumers;
- Serving as the point of contact for anyone seeking more information or having concerns about the coordinated assessment process; and
- Ensuring minutes are taken at each meeting of the committee.

Members will elect the chair from within the LCAC. Each chair will hold the position for one year at a time.

Expectations of Members

To remain in good standing and be allowed to vote and participate as members of the LCAC, all members must attend at least 75 percent of meetings. The chair must attend 90 percent of meetings.

Voting Procedures

Decisions in the LCAC will be made based on a majority vote by Committee members. Any decisions that would lead to a modification of the coordinated assessment process, including changes to the assessment tool or policies and procedures, must be approved by majority vote by the State Coordinated Assessment Committee AND approved by the CoC Board.

EVALUATION

The coordinated assessment process will be evaluated on a regular basis to ensure that it is operating at maximum efficiency. Evaluation will be carried out primarily through the LCAC.