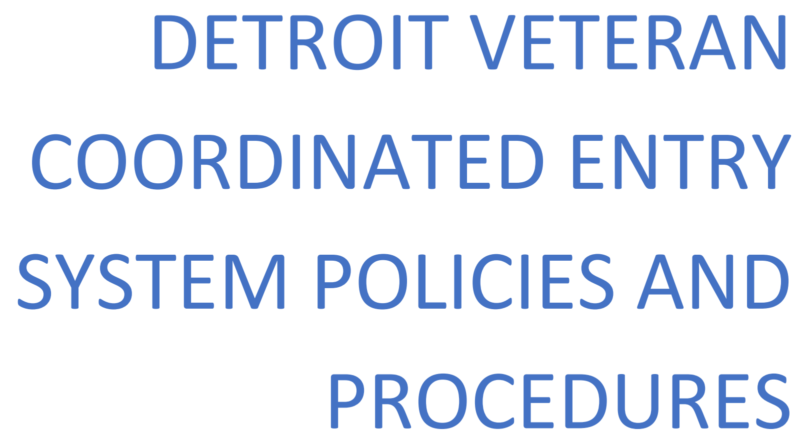

DETROIT VETERAN COORDINATED ENTRY SYSTEM POLICIES AND PROCEDURES

July 8, 2019

"Our Goal is to End Veteran Homelessness by making it rare, brief, and non-recurring".

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Vision Statement

Veterans at risk or experiencing literal homelessness in Detroit will quickly move into permanent housing through a coordinated process that links them with customized interventions based on individual needs.

This homeless response system will:

- Focus on ending Veteran homelessness through diversion with an aim of ensuring homelessness is avoided or as brief as possible when it does occur.
- Focus on early identification of housing needs and prevention of homelessness.
- Provide low-barrier, low-threshold points of entry that take into consideration transit issues, regional preferences, and other barriers to access experienced by Veterans.
- Be person-centered, as evidenced by a consistent respect for Veteran choice, safety, and cultural preferences.
- Be flexible enough to respond to changing needs and evolve as the system standardizes best practices
- Utilize a standardized assessment tool across all points of access. The assessment will be made available via multiple methods, such as over-the-phone and in-person.
- Rely on the Homeless Management Information System (HMIS) as a centralized and accurate database that has real-time availability of resources.
- Reduce barriers by increasing program accessibility, limiting restrictive program criteria and focusing on matching the person in need to the right resources.
- Coordinate with other systems of care, locally and regionally, including but not limited to the health care system, the criminal justice system and the surrounding suburban communities.
- Higher intensity resources are prioritized to serve chronic and long-term homeless Veterans.

Goals and Guiding Principles

The goal of the Coordinated Entry System(CES) is to rapidly connect single Veterans and Veterans with families to appropriate housing interventions based on need and to provide identified entry points to the CES . The following guiding principles are utilized to achieve this goal:

Housing First: The Detroit system will utilize low-barrier housing options that prioritize connecting people to housing first, before focusing on other stability-related goals. The system will also ensure that these households have access to the supports and services they may need to maintain their housing. This strategy ensures that Veterans are housed regardless of presenting barriers, such as zero income, and without needing to complete any particular program or achieve specific outcomes prior to accessing housing.

Collaboration: Moving away from a program-centric to a system-centric solution to ending Veteran homelessness requires a strong commitment to a team approach. All key partners must work together on behalf of Veterans, ensuring our system-wide response meets the needs of people with varying needs and strengths. This requires clear protocols, transparent decision-making processes, and inclusive meetings to work through challenges, review progress, and implement best practices.

Communication: Open communication is key amongst all partners to build and maintain a shared vision and action plan to end Veteran homelessness. Effective communication of ongoing data sharing, will support transparency and provide opportunities to evaluate and improve the Detroit CES.

Driven-Data Practice: System implementation decisions will be data-driven, necessitating the need for ongoing, timely, accurate, and complete HMIS data entry by designated staff. This will allow the community to measure outcomes and make decisions to improve quality and effectively target resources.

Prioritizing the Most Vulnerable: The process of matching Veterans to resources will center on serving the most vulnerable. The Vulnerability Index Service Prioritization Decision Assistance Tool (VI-SPDAT) assessment, provider clinical judgment, and progressive engagement strategies will determine prioritization.

Low Barrier Shelter: Unsheltered Veterans will be immediately offered and provided shelter (i.e., emergency shelter, GPD, Contract Residential or other temporary setting) to those who want it, while assisting the Veteran to swiftly achieve permanent housing. Access to shelter is not contingent on sobriety, minimum income requirements, lack of criminal record, or other conditions.

Rapid Response: The system will respond to the needs of Veterans experiencing homelessness with the sense of urgency, with consideration for the instability faced by Veterans experiencing homelessness. This will involve a timely process for assessing, matching, and housing Veterans.

Coordinated Assessment Model (CAM) Overview

The Coordinated Assessment Model(CAM) is a systematic approach to homelessness that focuses on aligning the needs of individuals and families experiencing homelessness or at imminent risk of becoming homeless to available shelter and housing resources. As the Detroit Continuum of Care (CoC) lead agency, the Homeless Action Network of Detroit (HAND) is responsible for developing a coordinated entry process for the Detroit CoC. Southwest Solutions serves as the lead agency for implementation of the CAM, in partnership with Community and Home Supports (CHS) and Neighborhood Service Organization (NSO).

The process directs households in need of homeless assistance to a common access point where they are assessed using a universal screening and subsequently, a common assessment tool. The CAM is a concerted effort to create a standard and uniform process of assessing, prioritizing, and referring households to emergency shelter and housing resources.

Coordinated Entry System (CES) Overview

The Veteran focused approach to ending Veteran homelessness in Detroit falls within the CAM and is referred to as the Coordinated Entry System (CES). The CES ensures that all people experiencing a housing crisis have fair and equal access and are quickly identified, assessed for, referred, and connected to housing and assistance based on their strengths and needs. Through coordinated entry, a CoC ensures that the highest need, most vulnerable households in the community are prioritized for housing and services first.

The VA Deputy Under Secretary for Health for Operations and Management published a memo in the fall of 2017, issuing guidance to VAMC staff and staff of VA funded homeless assistance programs regarding their roles in supporting local CoC CES, which are required by the U.S. Department of Housing and Urban Development. This guidance from the VA to the VHA medical centers is meant to support community planning and CES efforts within CoCs by clearly outlining the expectations of VAMC involvement.

Key Components

Several key components work together to ensure that housing and homeless resources are prioritized for the most in need, therefore targeting resources to those that need them most.

Centralized Intake/Access Points: Veterans experiencing homelessness can access homeless services through centralized access points which include the VAMC, VCRRC or CAM.

Standardized Assessment: All Veterans will be assessed using the VI-SPDAT to determine appropriate housing intervention. Veterans will be matched to a Housing Track(HT) based on the VI-SPDAT score. A common

assessment tool used across all providers allows seamless determination of needs and prioritization of resources based on need. All Veterans entering the Veteran homeless system who want Veteran Health Administration(VHA) services will also have a biopsychosocial assessment and HOMES assessment completed by HCHV or VCRRC staff.

Homeless Management Information System (HMIS): Per the Department of Housing and Urban Development (HUD), "A Homeless Management Information System (HMIS) is a local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness. Each Continuum of Care is responsible for selecting an HMIS software solution that complies with HUD's data collection, management, and reporting standards." HAND serves as the CoC's designated HMIS Lead Agency. HAND is the lead agency for HMIS for the Detroit CoC and is responsible for managing HMIS and all data points for the Detroit Plan to End Veteran Homelessness(DPEVH). Additionally, HAND leads HMIS trainings related to the Detroit CES.

Leadership and Coordination

"Our Goal is to End Veteran Homelessness by making it rare, brief, and non-recurring".

The Veteran Leadership Team's purpose is to act towards achieving this common goal by providing direction and support for the community at large who serve Veterans experiencing homelessness. This is accomplished by providing resources and trainings to equip the community with the tools and understanding of the decision making process. It allows community partner's views to be expressed and incorporated into future development and planning. This process looks to strengthen the community's capacity to identify opportunities and address crises in innovative way to end Veteran homelessness.

Leadership Team: The Leadership Team that meets regularly and oversees the DPEVH consists of a board range of critical representatives, including the City of Detroit, John D. Dingell Medical Center Medical, HAND, CAM, Detroit CoC Board, Corporation for Supportive Housing(CSH), and representatives from the Grant and Per Diem programs (GPD), Contract Residential (CR), Housing and Urban Development-Veterans Administration Supportive Housing (HUD VASH), and Supportive Services for Veteran Families programs (SSVF). This group sets the course for coordinated assessment implementation; serves as a group of "barrier busters" receiving information about systems barriers that need resolution by collaboration; implements appropriate policies and protocols as needed; and is tasked with communicating key decisions to key stakeholders. Additionally, the team collaborates for the purpose of seamless implementation of appropriate protocol and to oversee any change in course when data supports the need to do so. By tracking what needs to be accomplished and how, the Leadership Team positively impacts system level changes.

The Leadership Team shall communicate their actions and decisions to the Continuum of Care (CoC) Board and CoC general membership on an ongoing basis, and shall share system changes at least once per quarter, either in writing or at an in-person forum.

By-Name List Case Conference Group (BNLCCG): The By-Name List Case Conferencing Group (BNLCCG) is led by the BNLC and Health Care for Homeless Veterans Coordinated Entry Specialist (HCHV CES) and includes representatives of Transitional Housing (TH) providers, Rapid Re-Housing (RRH) providers and Permanent Supportive Housing (PSH) providers including the Department of Veterans Affairs (VA). This team's purpose is to ensure that each Veteran household is appropriately served through CES matching; monitors each Veteran's progress toward housing for efficiency and effectiveness; and assists the providers to provide support and accountability in their work to rapidly house the Veterans experiencing homelessness in Detroit.

Each provider appoints staff to attend who have in-depth knowledge about the status, needs and preferences of each Veteran being reviewed and who are also able to make decisions regarding provision of shelter, services, or housing assistance. This may be a program director, program manager, coordinator, housing specialist, case manager and/or outreach workers. Agencies with multiple programs can have representatives from each project, or identify one or two staff members to share updates and insights on Veterans across their programming.

The work of the BNLCCG is done through bi-weekly meetings which begin with a review of the current data related to Veterans becoming homeless and getting housed followed by a review of a specific sub-population of Veterans experiencing homelessness to assess their progress and work as a team to resolve any barriers to success. Sub-population discussions include:

- Veterans experiencing chronic and long-term homelessness
- Unsheltered Veterans
- Veterans who have been on the BNL for 100+ days
- Veterans enrolled in RRH and not yet housed
- Veterans who are matched to PSH and are not yet housed
- Veterans in TH; Bridge Bed over 90 days
- Veterans who are matched to a Housing Track but need another Track match

Review will be done through case conferencing that works to ensure holistic, coordinated, and integrated assistance across providers for all Veterans experiencing homelessness in the community; provides a forum for reviewing progress and barriers related to each Veteran's housing goal; identifies and tracks systemic barriers and strategizes solutions across providers and to clarify roles and responsibilities to reduce duplication of services. In the event that a program or project is not able to attend, the program is responsible for providing any updates or requests for assistance to the BNL Coordinator in advance of the meeting.

The BNLCCG will bring critical system-barriers that have been identified as affecting Veterans' progress toward housing to the Leadership Team as needed for discussion and potential resolution. The type of information discussed at this meeting includes the following:

- **Current status:** Where the Veteran is currently located and what the homelessness status is, including active in shelter, active unsheltered, missing and whether that status has changed since the last case conference review
- **Veteran Preferences:** Housing plans and next steps guided by the Veteran's preferences.
- **Critical Housing Placement Barriers***:* Review and problem-solving of any barriers to housing placement.
- **Critical Service Barriers:** Review and problem-solving of any challenges with connecting Veterans to critical services.
- **Current Safety:** Ensuring any unsheltered Veteran has a safe place to stay tonight and in near term.
- **Next Steps:** Identification of any immediate or critical action items related to the Veteran, including roles and timelines.

The BNL Coordinator will provide an overview of the Criteria and Benchmark data with the BNLCCG Team at the bi-weekly meetings to ensure staff understand the importance of their role in meeting these goals.

Outreach Coordination: Street outreach is provided within the Detroit CES, and all street outreach staff have received training on assessing Veterans. In addition to community-wide outreach efforts, specific efforts to identify, assess, and connect Veterans exist within the CES. Coordinated efforts focus on Veterans who are unsheltered and Veterans experiencing chronic homelessness to effectively engage them, offer them permanent

housing options and make appropriate resources available. This includes completing assessments, transporting Veterans to the Veterans Community Resource and Referral Center (VCRRC) or John D. Dingell Medical Center to evaluate eligibility for VHA services and benefits, assisting Veterans who have been assessed and matched with accessing services from the identified housing provider, and providing other short term supports as necessary to move Veterans into shelter and housing.

System Facilitation: The CAM was selected to provide support to the DPEVH by managing the BNL (adding Veterans when referral packets are received; completing updates to the BNL when received, etc.), attending BNLCCG meetings, pulling names for BNLCCG and sending the names to all Veteran community homeless providers for review, preparing and presenting data at the Leadership Team meetings and taking notes and distributing them afterward. The CAM also assists in coordinating with the VA in implementation and operation of the CES for Veterans who are experiencing homelessness. The BNLC is responsible for sharing data with the Leadership Team. The Leadership Team reports this data to the Detroit Coc.

Policies and Procedures

A. Policy: Access

All Veterans have access to homeless services. The Detroit CES screens Veterans with moderate to high barriers to housing stability. It is a low barrier, person- centered, easily accessible, and standardized system. Program eligibility will embrace these principles. Housing providers will offer housing first and assist in navigation of long-term supports. Veterans may access homeless services by utilizing the automated Call Center or coming to a physical access point. The CES utilizes a hybrid approach by having an automated Call Center (877-424-3838, Homeless Veterans Helpline) and the operation of five physical access Point locations.

Procedure: When a Veteran calls the Call Center, they can either speak to someone directly or leave a voicemail message and receive a return call within 24 hours. If a Veteran presents at an access point, the Veteran will be assessed and provided homeless services as applicable to his/her needs or homeless circumstances.

Veterans may access any CAM access point:

- Families and Unaccompanied Youth (ages 18-24):
  - Southwest Counseling Solutions Housing Resource Center, 1600 Porter St., Detroit, MI 48216
    - Monday-Friday between 11:00am and 7:00pm.
- Single Adults:
  - Neighborhood Service Organization Tumaini Center
    - 3430 Third St., Detroit, MI 48201
    - Monday-Friday between 11:00am and 7:00pm
  - NOAH Project
    - 23 East Adams, Detroit, MI 48226,
    - Monday - Thursday between 10:00am and 4:00pm
- Veterans:
  - Veteran Community Resource & Referral Center
    - 301 Piquette St., Detroit, MI 48202
    - Sunday - Saturday between 8am and 8pm
  - Healthcare for Homeless Veterans
    - 4646 John R. Street, Detroit, MI 48201 (Second floor, Red Tower)
    - Monday - Friday between 8am to 1:30pm

Veterans who are literally homeless complete an initial assessment (Rapid Resolution and, if necessary, VI-SPDAT) across all access points, Rapid Resolution(RR) is the first strategy. Reasonable Accommodations will be provided as necessary. For example, translation will be provided for Veterans whose first language is not English. Transportation to/from the access point to a shelter is assessed and addressed on a case by case basis.

After-Hours Access

During non-operating hours, Veterans can present at any shelter or warming center and then present at the appropriate access point (CAM or VAMC/VCRRC) the next business day. 100% of Veterans must be referred to the VAMC/VCRRC or CAM access point. It is the shelter's responsibility to connect the Veteran to an access point within 48 hours if the VAMC or CAM did not serve as the initial intake point. This is to ensure Veterans in shelter get access to housing services they may qualify for.

Offers of Permanent Housing Intervention

The practices described here comply with the guidance provided by United States Interagency Council on Homelessness(USICH) Federal Benchmarks and Criteria. https://www.usich.gov/tools-for-action/criteria-for-ending-veteran-homelessness. The offer of permanent housing intervention must be made to all Veterans experiencing homelessness at the time of, or soon after the date of identification. *Please see below for a script that should be used when making the offer*.

OFFER OF PERMANENT HOUSING INTERVENTION SCRIPT

I'm wondering how you are feeling about getting an opportunity to move into permanent housing? In Detroit we have a number of different types of permanent housing options that are available to Veterans who are in your situation. All of the programs have people who would help you with the process of finding housing, negotiating with the landlords and some even have limited or longer term rental assistance. Even if you don't currently have any income, we can connect you to an appropriate program. If you would like to begin the process of getting into housing, we can make that connection for you within a couple of days depending on what you may be eligible for and what is available. If you want to explore this, you can still access shelter, transitional housing, and/or other services while you are working on getting into housing with the assistance of one of the housing programs. Would you like me to make that connection for you?

B. Policy: By-Name List Management

A registry called the By-Name List(BNL) is managed by the BNL Coordinator. This list is used to track the progress of Veterans as they move through the system from homelessness to housed. By using this list, we know how many Veteran households are experiencing literal homelessness in Detroit, the programs in which they are currently enrolled (e.g., emergency shelters, transitional housing, outreach affiliations), the Housing Track to which they have been matched, and their progress towards permanent housing.

This registry includes both an active list of all Veterans in the process of moving towards permanent housing as well as an inactive list of Veterans. Inactive defined Veterans are those who are permanently housed or have lost contact with our system. This is a way of maintaining data on Veterans in the event they are found again.

Procedure:
Veterans who are assessed will appear on the BNL within 48 hours of receiving the referral packet. The BNL Coordinator will be responsible for placing Veterans on the BNL. The Veteran's Housing Track will be noted on the BNL and assigned Lead Case Managers and Housing Program Case Managers (SSVF, HUD VASH) are responsible for providing updates on the status of where the Veteran is during their housing search.

The BNL will be sent out to the community the Monday after the BNLCCG for updates. The BNL updates are due back to the BNL Coordinator by that Friday. The Monday of the BNLCCG, a list will be sent out of the Veterans who will be reviewed. Lead Case Manager(LCM)s and Housing Program Staff are expected to provide updates on Veteran's progress towards permanent housing at least every two weeks. Veterans will only be added to the list by the BNL Coordinator if all information is completed on the referral packet. Missing information will delay this process.

Veterans are moved from the active to inactive list after providers have searched for 90 days without finding the household or Veteran is permanently housed.

BNL Lead Case Manager Role:

1. Assist Veterans in obtaining necessary documents for their identified Housing Track
2. Support Veteran in housing searches
3. Ensure Veterans attend necessary housing meetings based on their identified Housing Track
4. Update the BNL at least bi-weekly
5. Connect Veteran with community resources as needed such as security deposit assistance, furniture needs, etc.

Cross-County Identification

If a Veteran reports wanting to reside in an out-county, but is currently residing in temporary housing in Detroit, then the Veteran will remain on Detroit's BNL.

However, if a homeless Veteran has been assigned to an out-county provider and wants to live in an out-county, but his/her only temporary housing option is in Detroit, the Veteran will remain on the out-county's BNL. The Veteran will continue receiving assistance from the out-county staff. The HCHV Coordinated Entry Specialists are available to navigate any concerns that may arise and the LCM's will provide the daily supports necessary to ensure the Veteran is housed efficiently and not lost in the system between counties. BNL Leads will double check the BNL to ensure the Veteran is not counted on two BNL's.

The BNLC will track out-county Veterans who are temporarily residing at a Detroit TH site because of lack of shelter in the out-county on the BNL. This will be noted in a separate tab in the spreadsheet so as not to affect Detroit Criteria and Benchmark data.

C. Policy: Unit and Voucher Availability Tracking

All providers will track their availability (PSH Units, HUD VASH Vouchers, Landlord availability) through various measures in order to provide up to date data as needed to Leadership and within the continuum.

Procedure:

1. *CoC Permanent Supportive Housing:* Permanent Supportive Housing Providers complete an online survey *each time a new unit or set of units become available* in order for CAM staff to send them a referral from the PSH prioritization list.
2. *HUD VASH:* Data of available vouchers is tracked by the HUD VASH team at the John D Dingell Medical Center and the information is reported to the community during Leadership, BNLCCG and

CoC meetings. VHA eligible Veterans needing PSH will be prioritized for HUD VASH first and if there are no HUD VASH units available, the Veteran will be referred to CoC PSH.

3. *Rapid Rehousing Providers:* SSVF programs maintain a centralized list of landlords that work with RRH programs. This list is accessible to all SSVF case managers for use as a resource for RRH placement.

D. Policy: Veteran Status Confirmations

All Veterans will be verified for VHA eligibility to determine the highest level of services available to them. The John D Dingell Medical Center has staff available at the VCRRC to respond to requests for VHA eligibility. VA-funded programs must verify that the Veteran meets eligibility criteria by reviewing the Veteran's DD214 paperwork. This can be obtained in person at the VA Regional office or through the mail. For Non-VA funded resources, Veterans may have any discharge status and any length of active military service.

Procedure:
When conducting assessments, Outreach Staff or CAM staff will contact the VAMC VCRRC Staff at 313-576-1580 during regular business hours (Monday through Sunday 8:00am-8:00pm) to determine the following information about the Veteran's status:

- Discharge status
- Date of active military duty
- Eligibility for various Veterans' programs including CR, GPD, VASH, SSVF, VA Medical Care
- HOMES (VA database) Chronic Status and date of that status

The CAM or Outreach Staff will follow the CAM P&P if a Veteran does not agree to go through the full VAMC assessment but has agreed (by signing the HMIS ROI) to have his/her information shared into HMIS. Veteran status verification will be indicated in the "Veteran Status" section of the Assessment.

To Obtain a copy of the DD214 for Detroit veterans:

VA Regional office address:
McNamara Federal Building
477 Michigan Ave 12th Floor, Detroit, MI 48226
1-800-827-1000
Hours: Monday-Friday, 8am-4pm

- Veterans must go in person to request this assistance AND bring a picture I.D.

Michigan Veterans Affairs Agency (MVAA)
222 N Washington Square, Lansing, MI 48933
(800) 642-4838

- For any Veteran that enlisted in Michigan, MVAA can send DD214's same day via email or fax with the request document signed by the Veteran
- https://www.michiganveterans.com/a/DD-214-Requests

Requesting a DD-214 through the mail:
Please complete the following steps:

1. Obtain Release of Information
2. Fill out Standard Form 180 http://www.archives.gov/research/order/standard-form-180.pdf
3. Write **"HOMELESS VETERAN"** on the form.

- If the DD-214 is to be returned directly to the provider, write the fax# on the form or the address

4. Fax the completed form to **314-801-9201.**

E. POLICY: BNL Inactive - Loss of Contact: Follow-up Policy

A Veteran is considered to be Inactive Unknown/Missing when s/he is no longer in contact with our system and HMIS reflects no active engagement or a change in status. The *Inactive* designation indicates that there has been no documented contact over 90 consecutive days after continual attempts by the LCM to contact the Veteran. Veterans remain on the Inactive List indefinitely.

PROCEDURE:
The LCM will attempt to make contact with the Veteran using the following procedures:

1. *1 week out of contact*: at least one call is made to the Veteran
2. *2 weeks out of contact*: at least 2 calls ***and*** the staff responsible for the Veteran reaches out to the BNL Coordinator to determine whether the Veteran is connected somewhere else in the non-VA system and will contact HCHV Coordinated Entry Specialist to determine if the Veteran is connected to a VA service. If the Veteran is connected to the VAMC, the staff will contact the VCRRC for assistance with outreach and engagement. If the Veteran is matched to a SSFV, the staff will notify SSVF that the Veteran has not been in contact and request support to search for the Veteran.
3. *3 weeks out of contact*: in addition to calling the Veteran, a call or letter to the Veteran's emergency contact shall be made, outreach efforts are continued, and the staff person will bring up the Veteran for review at the BNLCCG Meeting to inform the community of the need to locate the Veteran.
4. *4 weeks out of contact*: same as above (3rd week)
5. *After 4 weeks*: there should be 3 distinct attempts to contact made every thirty days.
6. *8 weeks out of contact*: Staff person will reach out to the VCRRC if they can be found anywhere in the VA
   system and reengage outreach efforts.
7. *8-12 weeks out of contact*: 3 distinct attempts to contact made including outreach to emergency contact again.
8. The Veteran will return to active status on the BNL once any provider reengages with the Veteran.
9. This list will be reviewed during the BNLCCG meeting and housing providers will be reminded of protocols around engagement.

Once a Veteran in the Inactive Status is found or re-engaged, and they are still experiencing homelessness, the Veteran is immediately reactivated on the BNL to receive supports in pursuing permanent housing. If the Veteran had been matched to a Housing Track prior to becoming inactive, the last assigned LCM will be notified of the recent activity, and will proceed with engaging the Veteran so long as that provider has capacity to do so; otherwise, the Veteran will be matched to another Case Manager by the BNL Coordinator based on eligibility and availability.

F. POLICY: BNL Inactive – Housed

A Veteran is considered to be housed when s/he has obtained a permanent residence and HMIS reflects the location of the permanent housing placement. Veterans remain on the Inactive List indefinitely.

PROCEDURE:
When a Veteran is permanently housed:

1. LCM notifies the BNL Coordinator within 48 hours of housing placement

2. If Veteran is housed via HUD VASH it is the responsibility of the HUD VASH Social Worker to notify the BNL Coordinator within 48 hours of lease signing.
3. The BNL Coordinator updates the BNL indicating Veteran as permanently housed and status is changed to inactive.

G. POLICY: BNL Updates

The BNL must be updated at least bi-weekly. All providers must notify the BNL Coordinator within 48 hours when a Veteran is permanently housed. This will successfully place the Veteran as Inactive on the BNL and will help Detroit track housing outcomes.

PROCEDURE:
An offer of permanent housing must be offered and updated on the BNL:

1. Every two weeks until the offer is accepted
2. Once the offer is accepted staff does **NOT** need to update the offer unless circumstances change and the Veteran decides to decline permanent housing at this time (such as: going to substance use treatment, having surgery with a long recovery period, or the Veteran wants to focus on income stability first)
3. Once a Veteran is permanently housed, the LCM notifies the BNLC within 48 hours of housing placement
4. The BNLC updates the BNL to reflect Veteran as being permanently housed and is noted as Inactive.

H. POLICY: Homeless Identification

All Veterans experiencing literal homelessness in Detroit will be immediately identified.

PROCEDURE: Street Outreach and engagement to Veterans who are unsheltered or in community shelters.

1. Street Outreach will be conducted by outreach partners, CAM (Coordinated Assessment Model), PATH, VCRRC, SSVF grantees, and other community outreach teams, on a daily basis or as appropriate, for the purposes of identifying unsheltered Veterans experiencing homelessness.
2. Specific geographic areas are identified to ensure comprehensive coverage and efficient provision of resources.
3. All street outreach teams will engage Veterans who are unsheltered and who are not yet enrolled in a housing program to ensure that they are identified and assessed.
4. After a Veteran who is experiencing homelessness is assessed, he or she will be directed to an access point. If a Veteran declines a Veteran specific access point, s/he will be directed to a CoC access point.

PROCEDURE: Requesting outreach support to assess a Veteran

1. In the case where Community Outreach Staff is in communication with a Veteran who is experiencing homelessness, the VCRRC can be contacted to engage the Veteran and complete an assessment. The phone number for the VCRRC is 313-576-1580 and the VCRRC is staffed every day from 8am – 8pm. VCRRC staff may be available on the day requested if it is before 5:00pm, pending staff availability. Transports to shelters stop at 7pm.
2. In the event that the VCRRC is unavailable to engage the Veteran, the Veteran may walk-in to the VAMC hospital Red Tower, 2nd Floor before 1:30pm and ask to meet with HCHV staff for an assessment. Walk-in cases are triaged and screened based on urgency. The average VA Homeless

Assessment is 3 hours which includes Biopsychosocial Assessment, HOMES Assessment, VI-SPDAT, BNL Packet and necessary Release of Information(ROI)s.

I. POLICY: Unsheltered Veterans

All Unsheltered Veterans will be provided immediate access to a community shelter if available. Unsheltered is defined as those Veterans who do not use shelters and are typically found on the streets, in abandoned buildings, or in other places not meant for human habitation.

PROCEDURE:

1. When first encountered, an unsheltered Veteran experiencing homelessness will be asked if they would like to have a bed in a shelter today.
2. Anyone encountering an unsheltered Veteran will offer to assist that Veteran to go to a local emergency shelter. If the Veteran accepts this offer, Outreach will transport Veteran to a shelter (depending on time of day) or will transport to an access point.
3. If local shelters are full, SSVF providers may pay for a temporary stay in a local hotel/motel for the unsheltered Veteran, where the Veteran is eligible and following SSVF requirements. The Veteran has to have housing identified and there are time restrictions based on household makeup.
4. If unsheltered Veterans decline the shelter offer because of challenges to entry, program staff working with the Veteran will work to resolve the challenges.
5. If the issues with local shelter challenges to entry cannot be immediately resolved, SSVF grantees may pay for a temporary stay in a local hotel/motel for the unsheltered homeless Veteran, where the Veteran is eligible and following SSVF requirements including having housing identified. This resource is used in rare instances most often for families who are unable to find shelter.
6. If an unsheltered Veteran declines a shelter offer for reasons other than challenges to entry, outreach providers will continue to make offers of shelter on no less than a biweekly basis. In extreme weather situations, shelter offers must be made no less than every three days.

J. POLICY: Refusal of Assessment

A Veteran has the right to refuse to complete a VA assessment and still receive permanent housing services. Veterans can be connected to a community agency outside of the VA system when necessary.

PROCEDURE:

1. Veteran declines opportunity to complete a VA assessment
2. Staff refers Veteran to a local community access point or shelter so that alternate plans can be made.
3. CAM staff will complete VI-SPDAT and send BNL Packet to BNL Coordinator.
4. Veteran will follow protocol for CAM CoC permanent housing placement.

K. POLICY: Assessment

All Veterans experiencing homelessness will be assessed by specifically trained CAM/HCHV/ VCRRC, in order for that Veteran to be added to the BNL. All staff have been trained on the Veteran-specific questions within the assessment.

Entering emergency shelter can be a traumatic experience for Veterans, especially for families with children. The CES is committed to preventing Veterans from entering the homeless system whenever possible by first utilizing Rapid Resolution.

PROCEDURE:

RAPID RESOLUTION: RR is an intervention designed to prevent immediate entry into homelessness or immediately resolve a household's homelessness once they enter shelter, transitional housing or an unsheltered situation.

1. RR includes both Diversion and Rapid Exit strategies with the aim of ensuring that homelessness is avoided or is as brief as possible when it does occur.
2. RR will be attempted with every Veteran regardless of their perceived barriers. RR is utilized by assisting households find an alternative to shelter, which prevents stress associated with shelter stays and entering into homelessness.
3. To that end, all Veterans seeking to access homeless services are first engaged in RR. Staff may use the OrgCode Diversion Interview Guide and motivational interviewing to identify diversion opportunities with Veterans. The RR compliance guide can be found at: https://www.va.gov/HOMELESS/ssvf/docs/SSVF_Rapid_Resolution_Compliance_Guide.pdf

PERMANENT HOUSING PLACMENT: For those that are not able to be diverted, they are administered the VI-SPDAT. The VI-SPDAT is used with all Veterans entering the CES. Additionally, the Leadership Team determined that the VI-SPDAT is used as part of the CES to determine Veteran vulnerability as it relates to needing Permanent Supportive Housing and possible access to HUD VASH. This assessment provides separate tools for households of varying ages and sizes. There are three VI-SPDATS:

1. For single adults over the age of twenty-five; https://d3n8a8pro7vhmx.cloudfront.net/orgcode/pages/313/attachments/original/1479851108/VI-SPDAT-v2.01-Single-US-Fillable.pdf?1479851108
2. For families with minor children; https://d3n8a8pro7vhmx.cloudfront.net/orgcode/pages/313/attachments/original/1479851219/VI-SPDAT-v2.01-Family-US-Fillable.pdf?1479851219
3. For single youth between the ages of eighteen and twenty-five. https://d3n8a8pro7vhmx.cloudfront.net/orgcode/pages/313/attachments/original/1479851282/TAY-VI-SPDAT-v1.0-US-Fillable-Amended-July-13-2015.pdf?1479851282

Depending on the Veteran's vulnerability and needs; an appropriate referral will be given. The CES obtains and tracks real time bed/unit availability for emergency shelter. The VA tracks real time bed/unit availability for TH and HUD-VASH.

Best Practice for Prevention of Return to Homelessness: Detroit Providers offer support, information, and targeted assistance to previously assisted Veterans to help minimize returns to homelessness.

TH, PSH, SSVF and other RRH grantees, have policies and procedures that allow for Veterans who were previously assisted with housing services to access additional information and resources designed to ensure long-term housing stability. This includes providing contact information and resources to Veterans as it relates to diversion and homelessness prevention.

** See Resources Section for Fiduciary and Guardianship in Appendix p. 46**

L. POLICY: Housing Tracks

Initial VI-SPDAT scores will indicate prioritization for referrals to identified Housing Tracks. VI-SPDAT scores will indicate prioritization for referrals to:

1. Self-Funded Housing Track: Veteran is likely to self-resolve homeless situation with minimal support needed.
2. Rapid Rehousing Track: An intervention that rapidly connects families and individuals experiencing homelessness to permanent housing through a tailored package of assistance that may include the use of time-limited financial assistance and targeted supportive services. Referrals may be referred to Housing Choice Voucher(HCV) for ongoing rental subsidy if appropriate.
3. Permanent Supportive Housing Track: Permanent housing assistance with indefinite leasing or rental assistance paired with supportive services to assist homeless persons with a disability or families with an adult or child member with a disability achieve housing stability. Highest level of case management supports needed.

Veterans who have been assigned a Housing Track may face multiple barriers to navigating their path to housing. To ensure Veterans with the greatest barriers to housing remain connected within the system, a LCM is assigned once a Housing Track is identified. This is especially important to Veterans experiencing chronic homelessness who need support with attending appointments related to their housing placement goals and/or collecting their needed documents.

Case Management engagement can take many forms. Most often the focus of CM includes obtaining documentation necessary for housing placement, transporting or providing transportation assistance to attend all housing-related appointments, providing emotional support, serving as a point of contact for both the Veteran and navigating the Housing Track they have been assigned. If there are multiple case managers involved with the Veteran, the LCM is the CM where the Veteran is residing or has the most contact. LCM are expected to coordinate care throughout the housing process.

PROCEDURE:

If Rapid Resolution is not successful:

VCRRC/HCHV/CAM verifies VHA eligibility

1. If VHA eligible, VCRRC/HCHV will complete the VI-SPDAT.
2. If not VHA eligible, CAM staff will complete VI-SPDAT and send BNL Packet to BNL Coordinator.

Self-Funded Housing: Veterans who score in the “No Housing Supports” range on the VI-SPDAT are least likely to require intensive services, are most likely to self-resolve and/or are over income and therefore are not prioritized for any CoC-funded resources. Veterans in this category are still referred to SSVF by the BNLC for further screening and will be evaluated on eligibility and/or level of need. If SSVF determines Veteran does not need any support from SSVF, TH Site Case Managers or Shelter case managers will assist this population in developing strategies to resolve their homelessness.

1. The VA/CAM referral packet is provided to the BNLC within 48 hours.
2. The BNLC will place Veteran the on BNL indicating Veteran is homeless within 48 hours.
3. It is the responsibility of the assigned LCM to provide updates to the BNL on at least a bi-weekly basis.

Rapid Rehousing Track: Veterans are offered RRH referrals if they score between 0-7 on the VI-SPDAT for singles and 0-8 for families. The Veteran will be screened by SSVF to determine the level of services needed.

1. BNL Coordinator receives referral packet within 48 hours, places Veteran on the BNL and assigns Veteran to an SSVF provider on a rotating basis based on grant numbers.
2. The Veteran is referred to a community shelter or Bridge Bed.

3. SSVF becomes the Veteran's LCM throughout the housing process.
4. SSVF LCM ensures Veteran completes a HCV application for all Veterans in the RRH Track if Veteran meets the income guidelines.
5. It is the responsibility of the SSVF LCM to provide updates to the BNL Coordinator on at least a bi-weekly basis.

Permanent Supportive Housing Track: If a Veteran scores above an 8 or above on the VI-SPDAT indicating a need for intensive case management services then the Veteran would be placed on the Permanent Supportive Housing Track. Chronically homeless Veterans will also be placed on the PSH Track regardless of VI-SPDAT score.

1. The VA Assessment packet is provided to the BNLC within 48 hours.
2. The BNLC will place Veteran the on BNL with prioritization based on VI scores within 48 hours.
3. If PSH and VHA eligible, BNLC will send email to Engagement Team for Veteran to be screened for VASH.
4. If Veteran is determined as PSH but Non VHA-Eligible the BNLC will refer Veteran to CAM staff to complete full VI-SPDAT to determine eligibility for community PSH.
5. The Veteran is assigned a LCM based on where she/he resides during the housing placement process.
6. It is the responsibility of the assigned LCM to provide updates to the BNL on at least a bi-weekly basis.

**See Detroit CES Flow Chart in Appendix Page 32 **

M. POLICY: Providing Transitional Housing to Veterans Experiencing Homelessness Only in Limited Instances

The VA will prioritize Veterans for the use of TH including VA GPD and/or CR as a short term link to permanent housing.

Detroit TH programs have the following Bed Type Models:

• Bridge Housing — short-term stay in transitional housing for homeless Veterans with pre-identified permanent housing destinations, when that housing is not immediately available.
• Low Demand — to accommodate homeless Veterans experiencing chronic homelessness, who were unsuccessful in traditional housing/residential programs.
• Hospital to Housing — addresses the housing and recuperative-care needs of homeless Veterans who have been hospitalized and/or evaluated in an emergency room.
• Clinical Treatment — provides residential substance use and/or mental health treatment in conjunction with services to help homeless Veterans secure permanent housing and increase income through benefits and/or employment.
• Service-intensive Transitional Housing — residential services that facilitate stabilization and transition to permanent housing.

Veterans experiencing homelessness are only assisted with TH in the following situations:

1. If a Veteran scores for RRH Track then Veteran could be placed in either a Bridge Bed or community shelter.
2. If a Veteran's VI-SPDAT score identifies Veteran for the PSH Track then Veteran could be placed in a Bridge Bed.

3. The Veteran has declined an offer of permanent housing assistance because Veteran is experiencing some challenges that could be addressed and resolved by a particular VA TH program. This is reported to the BNLC via the LCM and noted in the BNL notes section.
4. The Veteran accepted an offer of permanent housing, either PSH or RRH, but the permanent housing unit is not immediately available.
   - In this situation, a Veteran may be moved into a TH unit while waiting for the permanent housing unit to become available, rather than remaining in the emergency shelter or in an unsheltered location. The Veteran would be identified as a Bridge Bed.
5. Once an offer of permanent housing has been made, accepted, and documented on the BNL by the appropriate provider, additional offers of permanent housing do not need to made or documented.

PROCEDURE:

1. HCHV or VCRRC completes an assessment and the level of need is determined (Bridge, Clinical Bed, Low Demand, etc.).
2. HCHV/VCRRC staff reviews the available beds via the daily census and/or has consultation with the site/liaison.
3. If preferred/required bed is available, HCHV/VCRRC staff executes a referral and release with the Veteran present and faxes or emails information to TH site.
4. Transportation is then arranged to facilitate Veteran's entry to TH site.

Once at Veteran is residing at the TH site:
When a Veteran moves into a TH program and declines a permanent housing intervention, the TH program must make new offers of permanent housing on a bi-weekly basis.

1. The TH program's LCM are responsible for offering permanent housing and providing updates to the BNLC on at least a biweekly basis.
2. The Veteran will be assigned a Bed Type upon entering a TH program. The Veteran is responsible for following the criteria and expectations of that Bed Type. The goal is to move Veterans to permanent housing as swiftly as possible. However, if there are mitigating circumstances that arise such as an unexpected illness, emergency etc. the Veteran may determine that s/he is unable to pursue permanent housing for a period of time. This will be discussed and address by TH staff. The LCM will notify the BNLC to update the BNL as not having accepted a permanent housing offer.
3. The TH program does not need to wait until the bi-weekly check in to record an offer of permanent housing on the BNL.

N. Policy: Transitional Housing Review

The transitional housing review team (THRT) is an interdisciplinary team in VA homeless programming that reviews all Veterans requesting a VA-funded transitional housing placement who have already had two VA-funded transitional housing placements. The team include GPD and CR Liaisons, Supervisors, and other VAMC homeless staff members. For the purposes of the Detroit community, VA-funded transitional housing placements are: CR and GPD.

The THRT meets as follows:

Tuesdays – Location: HCHV – B2South – 4646 John Street, Detroit, MI
Thursdays – Location: VCRRC – Conference Room – 301 Piquette, Detroit, MI

PROCEDURE

1. Veterans must present to a HCHV or VCRRC social worker to be referred to THRT for review.

2. The meeting lasts 30-45 minutes with each Veteran. During the meeting, the THRT works with the Veteran to determine if VA-funded transitional housing is a suitable option
3. If the Veteran is approved for an additional TH stay, staff will forward the referral packet to the BNLC
4. The BNLC will record the Veteran on the BNL
5. The LCM will provide bi-weekly updates to the BNLC on Veteran's permanent housing progress
6. If VA-funded transitional housing is not suitable, the THRT will provide Veteran and referring social worker with other treatment/service recommendations.

O. POLICY: Request for Re-VI-SPDAT

If a LCM believes that a Veteran's VI-SPDAT Score does not accurately reflect Veteran's current need for case management then that staff person can submit a request for new scoring.

PROCEDURE

1. Staff requesting a second VI-SPDAT would complete the Request for VI-SPDAT Reassessment form.
    a. Include detailed information on what has changed or was not discussed at the time of the original VI-SPDAT.
    b. Be sure to fill out each section of the form or it will be rejected. If you do not have the information, please put N/A or Unknown.
2. Submit the Request for VI-SPDAT Reassessment form to the BNLC.
3. The BNLC will send the request to the Leadership Sub-Committee within 48 hours of receipt of the request.
4. The Leadership Sub-Committee will review the submitted request and any supporting documents provided to make a determination within 48 hours of submission.
5. Once the determination is made, the Sub-Committee will notify the requesting staff of the outcome via email and attach the Request for VI-SPDAT Reassessment Form with comments.
6. The Sub-Committee will also notify the BNLC, HCHV CES, VA Director of Homeless Programming, Chief of Veterans Community Resource & Referral Center and HCHV, Transitional Housing, Prevention, & Veterans Justice Outreach Supervisor
7. Submitting staff should request a VCRRC or HCHV staff person to complete a new VI-SPDAT.
8. VCRRC or HCHV staff will notify the submitting staff of the outcome.
9. VCRRC or HCHV staff completing the updated VI-SPDAT will email the new scores to BNLC within 48 hours of completion.
10. The BNLC will updated the BNL within 48 hours.

See Appendix for Request for Re-VI-SPDAT form Page 32

P. POLICY: Domiciliary Residential Rehabilitation Treatment Program

This 50 bed co-ed residential treatment facility is available to assist Veterans who may be homeless and in need of structured treatment to assist them in preparing for a move into permanent housing. Each Veteran works with a multidisciplinary team of staff to develop their own personal treatment plan, addressing the issues and concerns unique to that Veteran.

If a literally homeless Veteran will be admitted to the DOM, a complete VA assessment needs to be completed by HCHV or VCRRC staff prior to admission to the DOM for purposes of maintaining their homeless status. A Veteran maintains his/her homeless status for 90 days while at the DOM. After 90 days, the Veteran will no longer be considered homeless or eligible for homeless services.

PROCEDURE:

1. Veteran's experiencing homelessness will meet with HCHV or VCRRC staff for a complete assessment prior to admission to the DOM
2. BNL Coordinator receives BNL referral packet within 48 hours and places Veteran on the BNL
3. The Veteran is referred to the DOM for admission
4. The Program Director at the DOM becomes the Veteran's LCM throughout the housing process and provides bi-weekly updates to the BNLC
5. Veterans who exceed his/her 90 days will be placed as inactive on the BNL due to no longer qualifying as homeless

Q. POLICY: HUD VASH Protocols

The HUD-VASH Program is reserved for Veterans experiencing chronic homelessness and a disability who have few resources and require long-term case management to either obtain or maintain permanent housing. The goal of this protocol is to create transparency and coordination in the process of assisting eligible Veterans to access available HUD-VASH vouchers through the CES and to ensure that all Veterans served by the HUD-VASH program are appropriately represented and tracked on the BNL. These policies and procedures should assist homelessness service providers, the VA, the Leadership Team, and others by providing a clear explanation of the process by which Veterans are matched to the HUD VASH Program.

The John D Dingell Medical Center is committed to taking referrals for HUD-VASH vouchers through the CES process. The HUD VASH team makes the final determinations on the appropriateness of any referrals that come from CES based on their clinical judgement and Veteran eligibility as it relates to discharge status.

If a Veteran scores an 8 or above on the VI-SPDAT, they will be considered for a HUD-VASH voucher. Priority referral for HUD-VASH vouchers will follow the CES targeting prioritization process in this order:

1. Chronic Homelessness regardless of VI-SPDAT score
2. Long Term regardless of VI-SPDAT
3. VI Score
4. Number of days homeless
5. Date Identified for BNL

PROCEDURE:

1. Once the VA assessment is completed and referral is sent to the BNL Coordinator, the Veteran will be added to the BNL within 48 hours.
2. If Veteran appears to qualify for HUD VASH, Veteran will be referred to the Engagement Team for final determination.
3. The HUD-VASH Engagement Team will attempt to contact the Veteran to arrange an initial meeting with the HUD-VASH staff within 2 business days of receiving the referral from the BNLC. The HUD VASH team will update the BNL bi-weekly of attempted contact.
4. If accepted, a HUD VASH Case Manager is assigned to Veteran to navigate the HUD VASH process.
5. The HUD VASH team will notify the BNL Coordinator by email within 48 hours of HUD VASH acceptance. This email will include the Veteran's LCM if at a TH Site or Community Outreach Staff, as appropriate, to help facilitate engagement between the Veteran and the HUD VASH program. The HUD VASH Case Manager is responsible for notifying the Veteran of the HUD VASH acceptance.
6. If the Engagement Team has experienced 3 unsuccessful attempts at engaging the Veteran in the vouchering process, they will notify the BNLC of these unsuccessful attempts.
7. The BNLC will updated the BNL and the Veteran will go back on the BNL to be pulled in the future.

Project-Based VASH Programs

If a Veteran is referred to one of the Project-Based HUD-VASH projects from CES and the Veteran meets all of the stated entry requirements of that housing provider, they are expected to serve the Veteran. If the PSH provider believes that the referred Veteran does not meet their stated eligibility requirements, the HUD VASH Engagement Team will be notified.

A Veteran assigned to one project-based program cannot transfer to another project-based program without being issued a new voucher.

R. POLICY: Piquette Square Project-Based HUD VASH Vouchers

Piquette Square has 25 HUD VASH Project-Based units and 125 Project-Based Voucher units and is managed by Southwest Housing Solutions. The Piquette Square building serves Veterans who are homeless and have a disability. Piquette Square has a preference to utilize the CES process to ensure HUD VASH units are filled from the BNL as quickly as possible.

PROCEDURE: At the time of assessment, if a Veteran is identified for the PSH Housing Track, staff will inquire if a Veteran would be interested in project-based housing vs. tenant based housing. The Veteran's answer will be noted on the BNL coversheet and the BNLC will indicate this on the BNL.

HUD VASH PSH Identified Veterans:

1. The Property Manager will notify the BNLC, HCHV CES, HUD VASH Engagement Team Lead via email of upcoming unit availability.
2. BNLC will pull the next Veteran who indicated interest in a project-based unit from the BNL
3. The LCM and HUD VASH Engagement Team Lead will be notified via email of the Veteran being pulled from the list for a Piquette Square opening.
4. To expedite the process in filling vacancies and getting Veterans housed, the Veteran will be given a Piquette Square application to start the process at the same time the Veteran will be referred to HUD VASH for an application screening.

When the Veteran obtains the project-based HUD VASH voucher:

HUD VASH Engagement Team will:

1. Assist veteran with completing the application process for both the project-based building and the MSHDA application for the housing agent's office, RPI Management
2. Appeal Process: If the Engagement Team assisted with the initial application then the Engagement Team will assist with the appeal; however if the Veteran's initial application was submitted by a LCM at a TH or shelter site then the Leasing Manager at Piquette will follow up with the Veteran and the LCM.
3. Following approval by both the project-based building and the housing agent's office, schedule Veteran for Project-Based Briefing
4. Transport Veteran following briefing to leasing office of project-based housing to complete lease signing process.
5. Assist Veteran with completing and submitting request for security deposit from other agencies.
6. Initiate warm hand off with social worker assigned to case manage those Veterans in project-based housing.

Piquette Square does not accept*:

- Criminal Sexual Conduct Charge
- Criminal charges
- Past Evictions
- Arson
- Methamphetamine Manufacturing
- Outstanding DTE bills

Documents needed to process Piquette Square Application:

- DD214
- State Picture ID
- Homeless Verification by professional
- Income verification
- Completed application

*Veteran may appeal a denial in writing within 7 days with a letter explaining history behind reason for denial. If appeal is granted Veteran's application will move to MSHDA. If denied, Veteran can appeal the denial with an in-person conference. Support staff are encouraged to attend as advocates.

S. POLICY: Bell Building Project-Based HUD VASH Vouchers

Bell has 10 HUD VASH Project-Based units and 145 CoC PSH units. The building serves persons who are homeless and have a disability. The Bell Building will utilize the CES process to ensure HUD VASH units are filled from the BNL as quickly as possible.

PROCEDURE: At the time of assessment, if a Veteran is identified to the Permanent Supportive Housing Track, staff will inquire if a Veteran would be interested in project-based housing vs. tenant based housing. The Veteran's answer will be noted on the BNL coversheet and the BNLC will indicate this on the BNL.

HUD VASH PSH Identified Veterans:

1. The Property Manager will notify the BNLC, HCHV CES, HUD VASH Engagement Team Lead as via email soon as they are aware of an upcoming available unit
2. BNLC will pull the next Veteran who indicated interest in a project-based unit from the BNL within 48 hours
3. The LCM and HUD VASH Engagement Team Lead will be notified via email of the Veteran being pulled from the list for a Bell Building opening within 48 hours
4. To expedite the process in filling vacancies and getting Veterans housed, the Veteran will be directed to the Bell Building to start the application process at the same time the Veteran will be referred to HUD VASH for an application screening.

When the Veteran obtains their project-based HUD VASH voucher

Engagement Team will:

1. Assist veteran with completing the application process for both the project-based building and the MSHDA application for the housing agent's office, RPI Management
2. Appeal Process: If the Engagement Team assisted with the initial application, then the Engagement Team will assist with the appeal; however if the Veteran's initial application was submitted by a LCM at a TH or shelter site then the Leasing Manager at Bell will follow up with the Veteran and the LCM.

3. Following approval by both the project-based building and the housing agent's office, schedule Veteran for Project-based Briefing
4. Initiate Warm hand off with social worker assigned to case manage those Veterans in project-based housing.
5. Transport Veteran following briefing to leasing office of project-based housing to complete lease signing process.
6. Assist Veteran with completing and submitting request for security deposit from other agencies.
7. Initiate warm hand off with social worker assigned to case manage those Veterans in project-based housing.

CoC PSH Identified Veterans: Will follow CoC PSH protocol as noted in the Detroit CoC Permanent Supportive Housing Policies and Procedures Document found here: http://www.handetroit.org/coc-psh-policy-procedure

The Bell Building does not accept:

- Criminal Sexual Conduct Charge
- Arson
- Methamphetamine Manufacturing
- Criminal charge within the past 3 years

The Bell Building is flexible in accepting:

- Past evictions
- Poor credit history

Documents needed to process Bell Building Application:

- DD214
- State Picture ID
- Income verification (if Veteran only has a Direct Express Card they will need to do an inquiry at an ATM and choose balance only printout. Bell will accept this as proof of income)
- Completed application

T. POLICY: Veterans Porting a VASH voucher into the Detroit Area

The HUD-VASH tenant-based vouchers are portable. Portability allows Veterans to live in the community of their choice (with some limitations) by taking a previously issued voucher with them. HUD-VASH participants may only port their voucher into those jurisdictional areas that have available HUD VASH Case Management services. The John D Dingell Medical Center is responsible for determining the appropriateness of accepting a porting request by a Veteran.

PROCEDURE:

1. When the HUD-VASH Program considers a port request from another catchment area, the treatment team will use its clinical judgment to approve or disapprove the Port request. *At this time all port request are being approved*.
2. It is the responsibility of the VA staff to notify the BNLC of a porting Veteran.
3. Availability of vouchers and needs within the continuum will be taken into consideration if vouchers become limited.
4. VA staff will consult with CoC CES Veteran Leadership Team to determine a criteria for accepting or denying ports if vouchers become limited.

U. POLICY: SSVF

As part of community-wide outreach efforts, and in line with SSVF program outcomes, Detroit SSVF grantees will work together to coordinate targeted outreach plans to locate and assess Veterans who are experiencing homelessness. At a minimum, all grantees will conduct targeted outreach once a week. If a Veteran does not qualify for SSVF due to income or other requirements, then the Veteran will be connected with a PATH team.

PROCEDURE

SSVF staff members will qualify Veterans to their SSVF program by using the following conditions:

- The Veteran meets SSVF eligibility criteria.
- The Veteran meets the definition of literal homelessness.
- For all SSVF grantees, Veteran households must have a discharge other than dishonorable, and must be below 50% of the AMI.
- The single Veteran has a VI score of 0 to 7 and the family has a score of 0 to 8 and appears to be an appropriate fit for a RRH intervention.

PROCEDURE: VOA and SWS SSVF Process:

Non-HUD VASH

1. Veteran and SSVF Case Manager meets face to face to complete enrollment packet and HMIS entry
2. Discussion of expectations, cost-sharing, time frames, barriers, needs, legal, etc...
3. Begin to seek and discuss housing options if Veteran does not have any housing leads prior to enrollment.
4. Once housing has been identified, begin housing application and provide Temporary Financial Assistance(TFA) for application fee, if needed
5. Collaborate with Landlord and obtain W9/Lease. (Lease does not need to be signed. Lease does need to include Veteran's name, address, Landlords name, address, amount of Security Deposit and monthly rent)
6. Identify moving date and schedule housing inspection prior to signing of the lease
7. Discuss any other needs that would require TFA such as allowable household items, utility assistance, moving cost, etc.
8. Once Veteran has been housed, discuss other needs and services that Veteran may require.
9. SSVF Case Manager completes referrals as needed.
10. SSVF Case Manager completes exit survey and provides a VA link to complete online survey
11. SSVF Case Manger exits Veteran from HMIS

There is no limit to how long a veteran can be enrolled in SSVF as long as there is a need for extended case management and there is a recertification completed every 90 days. If there is no longer a need for continued SSVF service, the case is usually closed at the 90 day period. SSVF needs an updated income statement to confirm the Veteran still meets income requirements every 90 days.

PROCEDURE: Blue Water Center for Independent Living (BWCIL)

Non-HUD VASH

1. SSVF CM meets with veteran to complete application and assessment (which involves a discussion on needs and barriers, along with the development of a housing plan)
2. SSVF CM submits application to Program Manager for approval and to HMIS agency administrator to enter Veteran data into HMIS
3. SSVF CM works with the veteran to seek housing options that best meets his/her needs
4. Assist Veteran in applying to rental units
5. Once application is approved:
    - SSVF CM coordinates with the landlord to complete Rental Unit Information form and W-9
    - Once all documentation is completed an inspection is scheduled
6. Inspection is completed
    - If unit passes inspection, SSVF CM submits Request for TFA to Program Manager, lease signing is scheduled.
7. Note: Some landlords will accept a commitment letter of payment. This allows the Veterans to move in prior to receiving payment in hand.
8. SSVF CM will request other TFA as needed (Household items, utility assistance, etc)
9. Once Veterans are housed, SSVF CM updates a monthly housing plan and completes the monthly recertification with Veteran. During this time, referrals are made for outside services as needed to assist Veterans in maintaining their housing
10. When Veteran's housing is stable, SSVF CM completes exit forms with the Veteran
11. SSVF CM submits Exit forms to the HMIS agency administrator, exits are completed in HMIS and the Veteran is signed up to receive the VA Satisfaction Survey.

BWCIL (DNOM) completes recertification packets monthly with Veterans that have been housed. Not more than 1 month of assistance is paid out at a time. This ensures BWCIL does not pay out more TFA than what is needed.

HUD-VASH:

1. Based on need of Veteran, the TFA request is completed for Security Deposit, Utility assistance, and/or allowable household goods as needed by the Lead HUD VASH Case Manager
2. VA submits completed HUD-VASH referral packet to SSVF
3. SSVF completes an HMIS entry
4. Once Veteran has moved in, SSVF completes an exit in HMIS

If SSVF Staff finds that a Veteran is not an appropriate fit for RRH (has a more intensive need for case management) or is not eligible for SSVF, Veteran will be directed to VCRRC for a full VA assessment and the BNL will be updated by the referring SSVF CM.

PROCEDURE: VASH referrals for SSVF Security Deposit Assistance

1. Once a Veteran has located and been approved for a unit, the HUD VASH CM will complete the SSVF Security Deposit assistance referral packet -
   located at: http://www.va.gov/homeless/ssvf/index.asp?page=/official_guide/forms
2. The following information will need to be provided to the SSVF Team with the Packet:
    - SSVF Basic Eligibility Form

- SSVF HUD-VASH Referral Form
- HOMES Assessment
- SSVF Temporary Financial Assistance Request Form
- Eligibility Waiver Form: (only if not meeting the CH or income criteria)
- SSVF Client Participation Agreement
- Combined SSVF/HMIS/VA ROI
- Documentation for utility deposit and Arrearages (if SSVF assistance is requested)
- Copy of Landlord W9
- Copy of Tenant Lease with Veteran's name (does not have to be signed)

PROCEDURE: CoC Subsidized Housing SSVF Security Deposit Assistance

Refer to CAM Detroit CoC PSH P&P for process:
http://www.camdetroit.org/wp-content/uploads/2018/11/CAM-Policies-and-Procedures-Manual.pdf

V. POLICY: SSVF BNL Protocol

VA Referrals:

1. Veteran is identified for the RRH Track based on VI-SPDAT Score at the time of assessment
2. Identified Housing Track is noted on the BNL referral packet by the assessing social worker and faxed over to the BNLC within 48 hours of assessment
3. BNLC places Veteran on BNL with RRH Track indicated within 48 hours
4. BNLC assigns Veteran to one of the SSVF programs based on the referral system
    a. Unsheltered Veterans: SSVF provider has one business day to connect with Veteran
    b. Sheltered Veterans: SSVF provider has 2 business days to connect with Veteran
5. BNLC updates BNL list of assigned SSVF providers
6. SSVF Case Managers are responsible for providing updates to the BNLC within 48 hours of program acceptance.

W. POLICY: Provider Follow up Protocol

If the Veteran is currently working with an SSVF provider at the time of assessment, that provider will remain Veteran's SSVF Contact. The assigned SSVF provider will engage contact with the Veteran and assist Veteran in becoming Rapidly Rehoused.

If a Veteran is identified as PSH HUD VASH, RRH cannot be used in conjunction with HUD VASH except for security deposit, basic household goods, and utility bill assistance or if a Veteran is imminently at risk of homelessness/eviction.

For HUD-VASH Veterans needing a security deposit/funds through the SSVF/HUD-VASH referral packet.
http://www.va.gov/homeless/ssvf/index.asp?page=/official_guide/forms

- SSVF staff do not need to meet with the Veteran
- SSVF should NOT be requiring a treatment or housing stability plan
- The packet FAQ's and the instructions on the packet itself clarify what is and isn't needed.

1. For HUD-VASH Veterans imminently at risk of homelessness/eviction
    - Veterans must meet eligibility like any other non-HUD-VASH Veteran including meeting the prevention threshold score

- The HUD-VASH social worker should be assisting and leading the referral process. If HUD VASH is not involved, SSVF staff should engage the Veteran's HUD-VASH social worker during screening/enrollment
- In these cases, SSVF are not required but encouraged to seek a housing stability plan and together with the HUD-VASH social worker and Veteran, determine why the Veteran is facing eviction (what went wrong despite subsidy and case management support) and what action steps can be created to avoid this in the future.
- If a Veteran has been exited from HUD VASH Case Management, has maintained the voucher but is imminently at risk of homelessness/eviction and SSVF is assisting Veteran to avoid losing the voucher, SSVF Case Manager needs to notify the Engagement Team Lead immediately.

X. POLICY: Progressive Engagement

If a Veteran moves into housing that is currently being paid for by RRH, the Veteran maintains their homeless status solely for the purpose of maintaining eligibility for PSH and HCV. While the person is inactive on the BNL, if SSVF finds that this person should be considered for PSH as part of the process of attempting to prevent future homelessness, Progressive Engagement will be utilized. SSVF providers must indicate the reason the initial program was not sustainable in the notes section in the referral form.

* See Progressive Engagement Referral Form in Appendix p. 34*

PROCEDURE:

1. The SSVF Team will review a case for Progressive Engagement.
2. A referral form will be completed by the SSVF Team and sent to the Leadership Subcommittee for review within 48 hours.
3. The Leadership Subcommittee will review the case and determine if the Veteran meets the criteria for additional intensive case management support within 48 hours.
    a. If yes, the Leadership Subcommittee will indicate this on the form and provide direction to the SSVF Team on the next steps for pursuing PSH with recommendations.
    b. If no, the Leadership Subcommittee will direct the SSVF Team to explore additional financial resources to assist the Veteran as it has been determined that the Veteran does not require intensive case management, only financial assistance/support.
        i. Possible resources could include: Garnishment reductions, Debt Management Training, Financial Literacy, Child Support reduction, Guardianship, Payee, etc.
4. The SSVF Case Manager will updated the BNL of the change in Housing Track within 48 hours.
5. If applicable, SSVF must assist Veteran in scheduling a full VA Assessment.
6. The LCM will update the BNL on at least a bi-weekly basis until Veteran is permanently housed.

See SSVF Progressive Engagement Process in Appendix p. 33

Evaluation

Feedback from Veterans

The DPEVH values the feedback and input of the Veterans being served by the CES system and all of the providers. This feedback will be used to strengthen the system response and inform planning efforts to deliver better services and align appropriate housing resources based on Veterans' needs. The same model used for the Detroit CoC will be utilized for Veteran programs.

*See page 15 of the Detroit CAM http://www.camdetroit.org/wp-content/uploads/2018/11/CAM-Policies-and-Procedures-Manual.pdf

Y. POLICY: Grievance Policy and Nondiscrimination

All participating agencies have their own internal process. For VA funded programs both the internal agency structures and VA policies will be utilized. If those do not accommodate a Veteran's needs then the CAM process will be utilized. Members of the Veteran Leadership Team will make themselves available for review. Veterans have the right to file a non-discrimination complaint. Veterans can file a grievance at any point throughout the CES process based on the CoC-wide Grievance Policies and Procedures located: https://static1.squarespace.com/static/5344557fe4b0323896c3c519/t/5ab910a3758d460c88a0005c/1522077860197/Detroit+CoC+Client+Grievance+Procedure+2018.pdf If a Veteran feels they have been discriminated against and their complaint is not adequately addressed through the CoC's established grievance process, they are directed to file a complaint with HUD's Fair Housing and Equal Opportunity Office: https://www.hud.gov/program_offices/fair_housing_equal_opp/complaint-process

System Evaluation

The Leadership and Community teams shall meet together quarterly, or more frequently as necessary to review data, evaluate progress, and brainstorm solutions on the topics of operationalizing coordinated entry and achieving the Federal Criteria and Benchmarks for ending Veteran homelessness.

Data

Veteran and program level data shall be shared at least monthly with the Leadership by way of the BNL maintained by BNL Coordinator. Additional data may be provided via HMIS through HAND. This will assist with transparency of data at the program and agency level. This will also assist all parties in reviewing patterns and will help with the facilitation of discussions about how resources should be used based on current needs. The Leadership Team will also use the data to track progress towards achieving the Federal Benchmarks and Criteria. Additionally, the data is accessible to all current members of the CoC via the HAND website. www.handetroit.org

Dissemination of CES Information to the Community

The Veteran CES is marketed to Veterans and to the general public through various outlets. The CAM maintains a website http://www.camdetroit.org/ and newsletter meant to provide homeless service providers and the general public with timely updates on process changes, training meetings, and data on progress toward the shared goal of ending homelessness. The Veteran Leadership staff presents regularly at the CoC general membership meetings as a way to keep Veteran homeless service providers and mainstream service providers who attend those meetings informed of current activities. Veteran homeless resources are communicated to the Veteran community via Ad campaigns, CAM Flyers and the VA homeless hotline. It is the responsibility of the CAM, VA and Veteran Leadership for providing information to Veterans and the community.

Z. POLICY: Safety, Privacy, and Confidentiality

The VAMC and CAM staff meet Veterans in a safe, private, and trauma-informed environments. Detroit has its own HMIS P&P guide posted located at www.handetroit.org/hmis

The VAMC and CAM staff adhere to requirements set forth by Michigan's HMIS Policies and Procedures which ensure protections of Veteran data and is compliant with HIPAA, and all Federal and State laws and codes. Veteran consent will be obtained in order to share and store participant information as evident by a completed Release of Information. All hard copy Veteran data is stored in locked filing cabinets.

AA.POLICY: Conflict of Interest

A conflict of interest occurs when a staff's services to or relationship with a client is compromised, or might be compromised, because of decisions or actions in relation to another client, colleague, him or herself, or some other third party

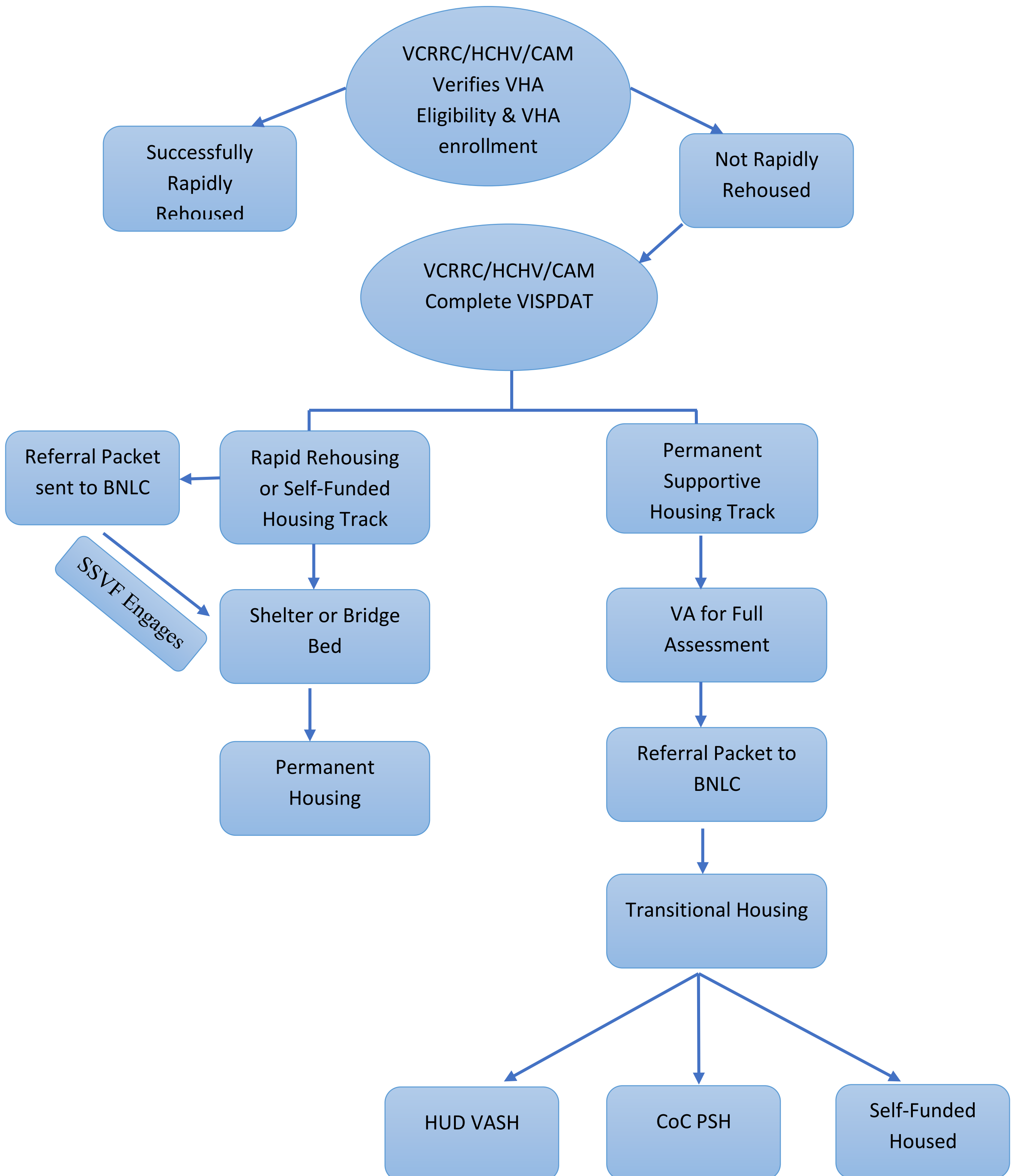
PROCEDURE:

1. In the event that a conflict of interest occurs between a household and CAM staff, emergency shelter staff, or VA provider, the staff must inform their supervisor, who will assign another staff to work with the household as appropriate.
2. Members of the CoC Board, VA Housing Programs, CAM Governance Committee, and CAM implementing agencies are mandated to recuse themselves when a decision is being made at any level that could potentially impact their program or organization.

The Veterans Coordinated Entry Policies and Procedures Manual will be reviewed and revised at least annually by the Leadership Team or a designated entity.

Appendix Documents

Detroit Veteran Coordinated Entry Flow Chart



REQUEST for VISPDAT REASSESSMENT

Date	
Veteran's Name	
Veteran's HMIS #	
Veteran's Last Four	
Initial Assessment Date	
Requested by?	
Organization	
Requester's Email Address	
Requester's Phone #	

Status change: Check the appropriate box to indicate Veteran's current change in status.

	Improved	Same	Deteriorated
Mental Health	☐	☐	☐
Physical Health	☐	☐	☐
Substance Use	☐	☐	☐
Legal Involvement	☐	☐	☐

Please enter new information/observations that warrant a re-assessment to be considered.

Leadership Committee Determination

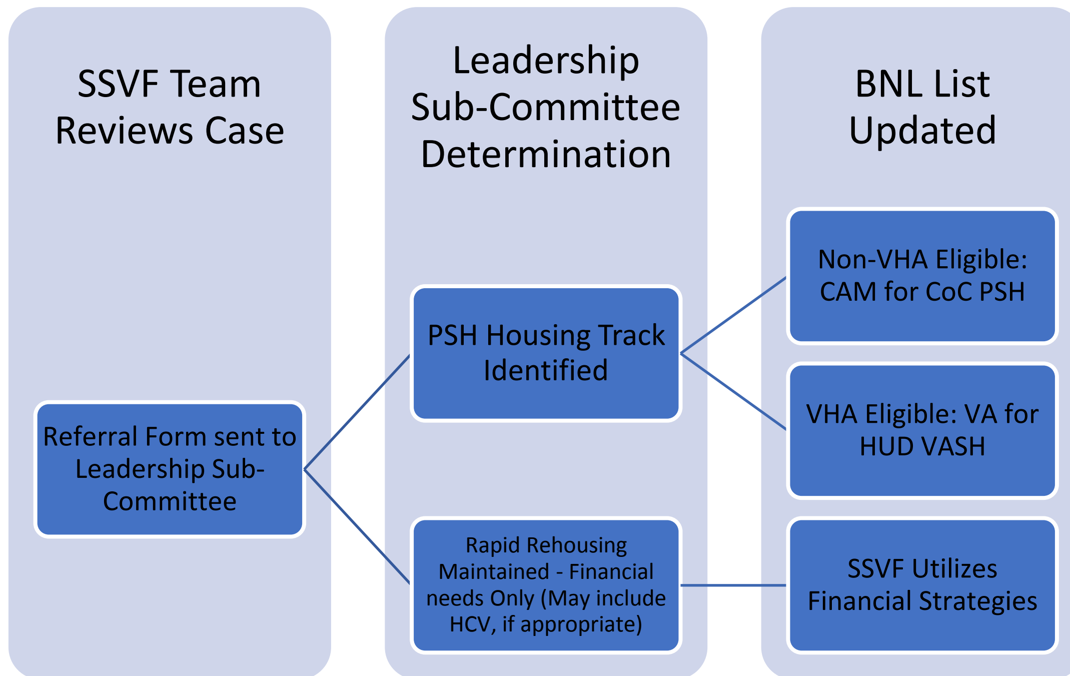
***Approval Status*:**

Determination Date	Yes	No	More Information Needed
	☐	☐	☐

Reason for Determination:

Endorsement: ____

SSVF Progressive Engagement Flow Chart



Progressive Engagement Referral Form

Date: ____________
Veteran Name: ____
SSN: ________________________ **HMIS#:** _________________________________
D.O.B.: ______________________ **Contact Number:** _________________________
Address: ____
Move in Date: ____________________

Summary:

SSVF Staff Name: ____
SSVF Program: ____

VA Referral to Detroit BNL: Referral Packet with HOMES Data for HMIS

Date: ____________________

PLEASE PRINT CLEARLY

Veteran's Name		**Veteran's SS#**	
Phone Number		**HOMES ID**	
Date of Birth		**Gender**	□ Male □ Female □ Transgender male to female □ Transgender female to male □ Other
Monthly Income		**Income Source(s)**	
Disability?	□ Yes □ No	**Race** **Ethnicity**	____________ □ Hispanic □ Non-Hispanic

VA Full Assessment Completed By (For VHA and GPD Only Eligible)	
VA Staff Contact Information	

1. **VHA Services Eligibility:** (Select one)
   ☐ Fully Eligible for Healthcare ☐ GPD Only (not eligible for VASH) ☐ Not VHA Eligible
2. **Program Referred To** (If applicable) : ____________________
   ☐Shelter ☐SA Tx ☐GPD ☐Contract Residential
3. **Unsheltered** ☐Yes ☐No
   a. If Unsheltered, where is Veteran staying? ____________________
4. **Transitional Housing Bed Type**: (Select one, if applicable)
   ☐Bridge Housing ☐Clinical Treatment ☐Hospital 2 Housed ☐Low Demand ☐Service Intensive
5. **Veteran's Identified Housing Track?** (Select one)
   ☐ Self-Funded Housing (over income for SSVF, Housing Choice Voucher, and PSH)
   ☐ Rapid Re-Housing (Score 0-7)
   ☐ Permanent Supportive Housing (Score 8+) or Chronically Homeless
   **Permanent Supportive Housing Preference*: ☐Tenant Based ☐Project Based ☐No Preference

Attachments:

☐ Completed VA Release of Information Authorization with Detroit CoC Client Release of Information and Sharing Plan
☐ HOMES data from questions 3, 4, 20, 22, 25, 26, 26a with date homelessness started or comparable information if not VHA eligible
☐ VI-SPDAT, Family VI-SPDAT, TAY-VI-SPDAT (full document) Score: __________

Submission Instructions: *Document to be emailed with Virtru encryption to BNL Coordinator within 48 hours of assessment completion. VA staff to log on Disclosure Tracking Form.*

Date received by BNL Coordinator		HMIS Number	

HUD VASH Document Checklist

Veteran Name	Phone Number	HOMES ID	HMIS ID
Other Household Members:			

Type of Document	Yes	No	N/A
State ID/Driver's License - for each household member over 18			
Birth Certificate - for each household member			
Social Security Card - for each household member			
DD214			
• VA Benefit Statement			
• Social Security Benefits			
• Other Income (CWT, Employment, Etc.)			
• Bank Statement			
• Food Assistance Printout			
VRAP/Educational Enrollment Letter			
Financial Aid Letter			
Homeless Verification Letter			
VA Medical Card			

- *Income verification*: If a household member receives VA Benefits and/or Social Security Benefits, the letter must be dated within the last 30 days (VA Letters can be obtained from the Federal Building or through EBenefits.Gov and Social Security Award Letters can be obtained from any local branch)
- *If a household member receives child support*: please provide documentation regarding child support as well dated within the last 30 days.
- *If a household member is employed:* present with the last 3 consecutive paystubs or provide a letter from the employer dated within the last 30 days indicating the wages per hour and the hours worked per week.
- *Verification of benefits through Department of Human Services (food stamps)*: if applicable, and letter must be dated within the last 30 days.
- Last Bank Statement from each household member over 18 Income for each household member must be reported during the application process and while a past criminal history of a misdemeanor or felony does not prohibit entry into the program, individuals that are listed as lifetime registered sex offenders are not eligible for HUD/VASH.

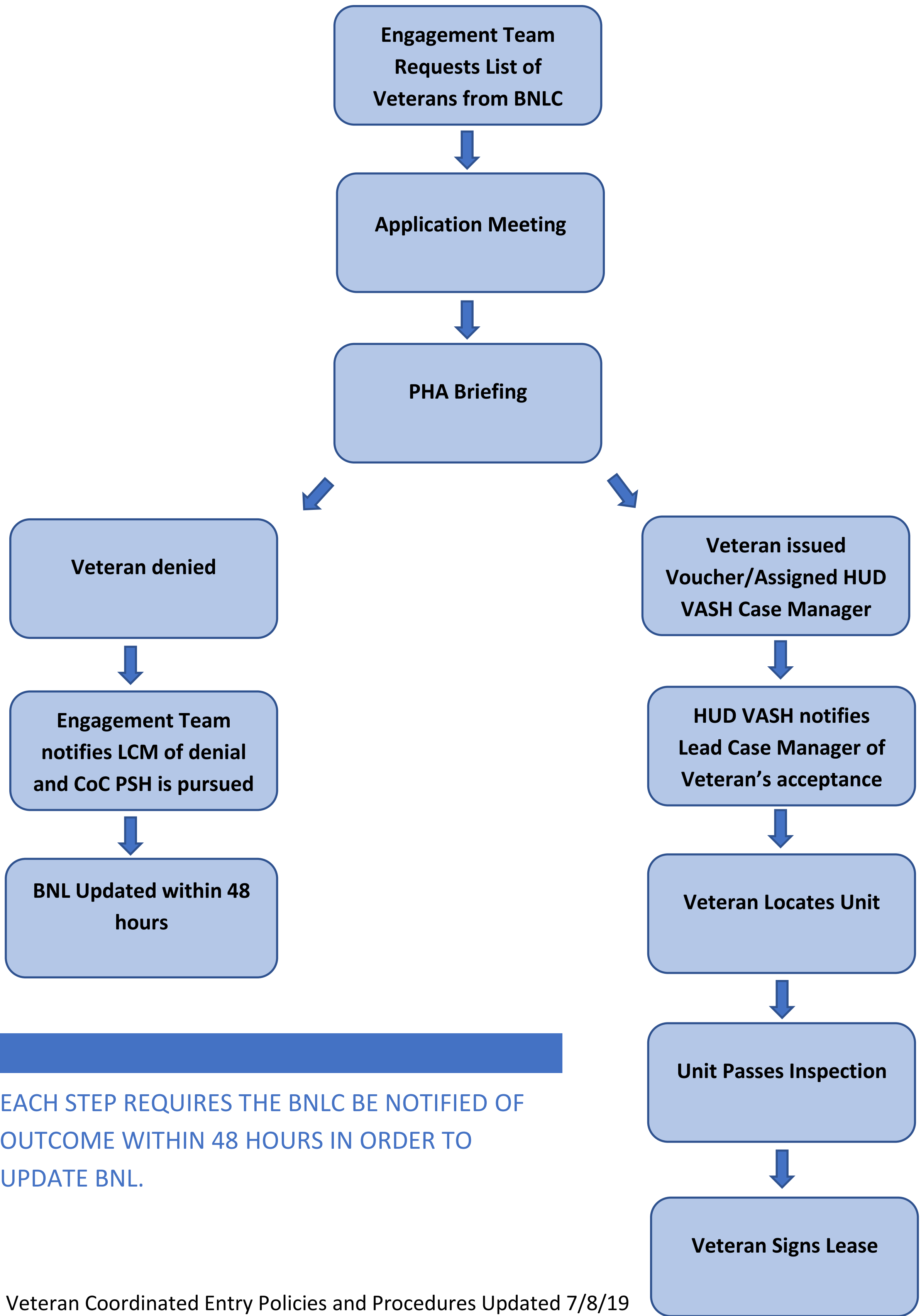
____

Signature of Veteran acknowledging receipt of above checklist Date

____

Staff Signature Date

HUD VASH Process Flow Chart



SSVF Documentation Checklist

Veteran Name	Phone Number	HOMES ID	HMIS ID
Other Household Members:			

Type of Document	Yes	No	N/A
State ID/Driver's License - for each household member over 18			
Birth Certificate - for each household member			
Social Security Card - for each household member			
DD214			
• VA Benefit Statement			
• Social Security Benefits			
• Employment – Last two pays stubs			
Homeless Verification letter			

- *Income verification*: If a household member receives VA Benefits and/or Social Security Benefits, the letter must be dated within the last 30 days (VA Letters can be obtained from the Federal Building or through EBenefits.Gov and Social Security Award Letters can be obtained from any local branch)
- *If a household member receives child support*: please provide documentation regarding child support as well dated within the last 30 days.
- *If a household member is employed:* present with the last 3 consecutive paystubs or provide a letter from the employer dated within the last 30 days indicating the wages per hour and the hours worked per week.
- Last Bank Statement from each household member over 18 Income for each household member must be reported during the application process and while a past criminal history of a misdemeanor or felony does not prohibit entry into the program, individuals that are listed as lifetime registered sex offenders are not eligible for HUD/VASH.

____

Signature of Veteran acknowledging receipt of above checklist   Date

____

Staff Signature   Date

Detroit and Out-County Contact List

BNL Leads, SSVF, VA Coordinated Entry Specialist Contact Information

Wayne County

Detroit CoC (Detroit, Hamtramck, Highland Park)

HCHV Coordinated Entry Specialist	Email	Phone
Jennifer Tuzinsky	Jennifer.tuzinsky@va.gov	(313) 702-3735
BNL Lead		
Lauren Licata	llicata@swsol.org	(313) 963-6601 x 4202
Catherine Distelrath	cdistelrath@swsol.org	(313) 963-6601 x 4157
SSVF Contact		
VOA: Patrick Lothamer	plothamer@voami.org	(269) 447-1462
Southwest Solutions: Kenneth Cobb	kcobb@swsol.org	(313) 963-6601 x 4139
Disability Network: Linda Staley	lstaley@dnom.org	(586) 268-4160 x 6615

Outer Counties

VHA

HCHV Coordinated Entry Specialist	Email	Phone
Janet Smith	janet.smith4@va.gov	(313) 657-8479

Macomb CoC

BNL Lead	Email	Phone
Ricky Garcia	rgarcia@macombhomelesscoalition.com	(5860) 213-5757
SSVF Contact		
TTI: Alysa Wamsler	awamsler@ttiinc.org	(248) 524-8801 x 1237
Disability Network: Sian Washington	swashington@dnom.org	(586) 268-4160 x 6618

Oakland CoC

BNL Lead	Email	Phone
Angela Gougherty	agougherty@chninc.net	(248) 824-7300
Charlotte Blackwell	cblackwell@chninc.net	(248) 824-7303
SSVF Contact		
TTI: Alysa Wamsler	awamsler@ttiinc.org	(248) 524-8801 x 1237
Disability Network: Sian Washington	swashington@dnom.org	(586) 268-4160 x 6618
OLHSA: Lisa Tumbarello	lisat4@olhsa.org	(517) 546-8500 x 4114

Out-Wayne CoC

BNL Lead	Email	Phone
Martha Esquivel-Leon	mesquivel-leon@waynemetro.org	(313) 324-7916
Francesca Vitale	fvitale@waynemetro.org	(313) 463-5525
SSVF Contact		
Wayne Metro: Martha Esquivel-Leon	mesquivel-leon@waynemetro.org	(313) 324-7916
Disability Network: Linda Staley	lstaley@dnom.org	lstaley@dnom.org

St. Clair CoC (part of Balance of State)

BNL/HMIS Lead	Email	Phone
Angela Shand	angelashand@bwcil.org	(810) 987-9337
SSVF Contact		
Brianna Kammer	Brianna.kammer-walsh@bwcil.org	(810) 987-9337

Updated: 4/29/19

Acronyms

BNL: By-Name List
This list is used to track the progress of Veterans as they move through the homelessness response system from homeless to housed and track progress against USICH Benchmarks.

BNLCCG: By-Name List Case Conference Group
This BNLCCG is led by the Co-chairs of the Leadership Team and includes representatives of Transitional Housing (TH), Rapid Re-Housing (RRH) and Permanent Supportive Housing (PSH) providers, including the VA.

CES: Coordinated Entry System or **(CAM)** Coordinated Assessment Model
Coordinated entry (Locally referred to also as CAM) is a process developed to ensure that all people experiencing a housing crisis are prioritize from the most vulnerable to have fair and equal access and are quickly identified, assessed for, referred, and connected to housing and assistance based on their strengths and needs.

CoC: Continuum of Care
A regional or local planning body that coordinates housing and services funding for homeless families and individuals.

CR: Contract Residential
Transitional Housing Program provides Veterans with shorter term transitional housing with case management assistance for up to 6 months and also has the goal of moving the Veteran into safe, affordable permanent housing.

CSH: Corporation for Supportive Housing
CSH utilizes research-backed tools, trainings and knowledge sharing, galvanizes supportive housing solutions with capital funds, specialty loan products and development expertise, collaborates on custom community planning and innovations and engages government leaders and public agencies through systems reform, policy collaboration and advocacy.

DPEVH: Detroit Plan to End Veteran Homelessness
Detroit's 10-Year Plan to End Homelessness.

GPD: Grant and Per Diem
Provides transitional housing for Veterans experiencing homelessness in a community program for up to 24 months while the Veteran receives case management services through the community program staff.

Bed Types:

- *Bridge Housing* — Short-term stay in transitional housing for homeless Veterans with pre-identified permanent housing destinations, when that housing is not immediately available. The allowance is locally made for those who don't have a pre-identified housing destination but have high income, no/few barriers, and report the desire to move into housing immediately.
- *Low Demand* — Accommodates homeless Veterans experiencing homelessness, who were unsuccessful in traditional housing/residential programs. Chronic and a certain percentage of non-chronic homelessness is allowed. Poly-morbid issues are required and it is clear that Veteran is pre-contemplative re: treatment.
- *Hospital to Housing* — addresses the housing and recuperative-care needs of homeless Veterans who have been hospitalized and/or evaluated in an emergency room. Veterans assigned to this bed type MUST have a pre-coordinated discharge plan where it is determined who/which entities will

provide the additional supports for the Veteran who is transitioning from hospital, emergency room, or residential placement.

- *Clinical Treatment* — Ensures coordination and compliance with residential substance use and/or mental health treatment in conjunction with services to help homeless Veterans secure permanent housing and increase income through benefits and/or employment.
- *Service-intensive Transitional Housing* — Residential services that facilitate stabilization and transition to permanent housing. In Detroit, this bed type is used minimally, when no other bed type which is more appropriate is available.

HCHV: Health Care for Homeless Veterans
The Health Care for Homeless Veterans (HCHV) program provides a gateway to VA and community-based supportive services for eligible Veterans who are homeless.

HCV: Housing Choice Voucher
This federal program provides rent subsidies for very low income people who find their own housing in private homes and apartment buildings.

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

HOMES: Homeless Operations Management and Evaluation System
An online data collection system that tracks homeless Veterans as they move through VA's Homeless Programs.

HPACT: Homeless-Patient Aligned Care Teams
(H-PACT) provides accessible, coordinated, comprehensive, patient-centered care, and are managed by primary care providers with the active involvement of other clinical and non-clinical staff.

HTI: Housing Track Identification
Veterans are identified at initial housing assessment with a Housing Track which includes either Rapid Rehousing or Permanent Supportive Housing.

HUD: Department of Housing and Urban Development
HUD's Office of Special Needs Assistance Programs (SNAPS) supports the nationwide commitment to ending homelessness by providing funding opportunities to nonprofit organizations and State and local governments to quickly rehouse homeless individuals and families. Through these opportunities, SNAPS advocates self-sufficiency and promotes the effective utilization of mainstream resources available to individuals and families experiencing homelessness.

HUD VASH: Housing and Urban Development-Veterans Administration Supportive Housing
HUD-VASH is a collaborative program between HUD and VA which combines HUD housing vouchers with VA supportive services to help Veterans who are homeless and their families find and sustain permanent housing.

- *Application Meeting:* Held at VA with Engagement Team to verify initial HUD VASH eligibility
- *Housing Voucher Briefing*: Held at RPI for final HUD VASH screening and obtaining voucher

LCM: Lead Case Manager
The designated case manager assigned to a Veteran who takes primary responsibility in navigating Veterans to permanent housing. The LCM is identified on the BNL and has the primary responsibility of updating the BNL at least every 2 weeks.

MSHDA: Michigan State Housing Development Authority
MSHDA is just one of many Public Housing Agencies (PHA) located in Michigan that oversees and administers a variety of rental housing programs including HUD VASH and the HCV program.

PBV: Project-based Voucher
A component of the Housing Choice Voucher program that targets very low income supportive housing populations and attaches rental assistance to specific housing units.

PHA: Public Housing Authority – *See MSHDA*

PSH: Permanent Supportive Housing
Permanent supportive housing is a subsidized housing intervention that combines affordable housing assistance with voluntary support services to address the needs of homeless people with priority given to chronic homelessness. PSH is the highest level of intervention for those that need permanent (as in not time limited) rental assistance and voluntary support services to remain stably housed.

ROI: Release of Information
A release of information is a statement signed by the Veteran authorizing one entity to give another entity information about the Veteran.

RR: Rapid Resolution
Rapid Resolution (RR) is an intervention designed to prevent immediate entry into homelessness or immediately resolve a household's homelessness once they enter shelter, transitional housing or an unsheltered situation. RR includes both Diversion and Rapid Exit strategies with the aim of ensuring that homelessness is avoided or is as brief as possible when it does occur. RR and other diversion approaches are system-wide interventions that can be used for all populations, not just Veterans.

RRH: Rapid Re-housing
Provides short-term rental assistance and services. The goals are to help people obtain housing quickly, increase self- sufficiency, and stay housed. It is offered without preconditions (such as employment, income, absence of criminal record, or sobriety) and the resources and services provided are typically tailored to the needs of the person.

SSVF: Supportive Services for Veteran Families
Provides supportive services grants to private non-profit organizations and consumer cooperatives to coordinate and provide supportive services to very low-income Veteran families who are homeless and scheduled to become residents of permanent housing within a specified time period; or after exiting permanent housing within a specified time period, are seeking other housing that is responsive to such very low-income Veteran families' needs and preferences.

TFA: Temporary Financial Assistance
SSVF provides a short, intensive period of case management to link families to benefits and offers limited TFA with housing or moving expenses. These include: rental assistance, security deposit, utility deposit, utilities (gas,

electric, water, sewer, and trash), moving expense, emergency housing, general housing stability (bed, household goods), eviction prevention

TH: Transitional Housing
A project that is designed to provide housing and appropriate supportive services to homeless persons to facilitate movement to independent living. When referring to transitional Housing, the Detroit CES also includes Contract Residential under this term.

THRT: Transitional Housing Review Team
An interdisciplinary team in homeless programming that reviews all Veterans requesting a VA-funded transitional housing placement who have already had two VA-funded transitional housing placements.

USICH: United States Interagency Council on Homelessness
USICH coordinates and directs the federal response to homelessness, working in close partnership with senior leaders across 19 federal member agencies. UISICH organizes and supports leaders such as Governors, Mayors, Continuum of Care leaders, and other local officials, to drive action to achieve the goals of the federal strategic plan to prevent and end homelessness.

VA: U.S. Department of Veterans Affairs
Is responsible for providing vital services to America's veterans. VA provides health care services, benefits programs and access to national cemeteries to former military personnel and their dependents.

VCRRC: Veterans Community Resource and Referral Center
The Detroit VAMC's VCRRC is an outpatient program located in the community that is designed to be a one-stop service center for Veterans experiencing homelessness or at risk of homelessness.

VHA: Veterans Health Administration
The Veterans Health Administration (VHA) is the component of the United States Department of Veterans Affairs (VA) led by the Under Secretary of Veterans Affairs for Health[2] that implements the healthcare program of the VA through the administration and operation of numerous VA Medical Centers (VAMC), Outpatient Clinics (OPC), Community Based Outpatient Clinics (CBOC), and VA Community Living Centers (VA Nursing Home) Programs.

VAMC: Veteran Affairs Medical Center
Health care benefits and services from the Veterans Health Administration, part of the U.S. Department of Veterans Affairs.

VI-SPDAT: Vulnerability Index and Service Prioritization Decision Assistance Tool
A pre-screening, or triage tool designed to be used as a common assessment tool by all providers within a community to quickly assess the health and social needs and vulnerabilities of homeless persons and match them with the most appropriate support and housing interventions available.

W-9: Request for Taxpayer Identification Number and Certification—is a commonly used IRS form
Individuals and entities use the form to provide their taxpayer identification number to entities that will pay them income during the tax year.

Definitions

Chronically Homeless To be considered chronically homeless, an individual or head of household must meet the definition of "homeless individual with a disability" from the McKinney-Vento Act, as amended by the HEARTH Act and have been living in a place not meant for human habitation, in an emergency shelter, or in a safe haven

1. For the last 12 months continuously
2. or on at least four occasions in the last three years where those occasions cumulatively total at least 12 months.
3. An in-depth definition is available in the Final Rule "Chronically Homeless."

Disability is a Physical, Mental or Emotional Impairment, including impairment caused by alcohol or drug use, post-traumatic stress disorder, or brain injury that is expected to be long-continuing or of indefinite duration, sustainably impeded the individual's ability to live independently, and could be improved by the provision of more suitable housing conditions. An in-depth definition is available in the Final Rule "Chronically Homeless."

Emergency Shelter is low barrier, site based, temporary shelter to take care of an individual's or family's immediate housing crisis.

Household: A household includes, but is not limited to, the following, regardless of actual or perceived sexual orientation, gender identity, or marital status:
(1) A single person, who may be an elderly person, displaced person, disabled person, near-elderly person, or any other single person; or
(2) A group of persons residing together, and such group includes, but is not limited to: (i) A family with or without children (a child who is temporarily away from the home because of placement in foster care is considered a member of the family). 24 CFR 5.403

HUD Homeless: The definition of "homeless" under the HEARTH Act consists of four categories:
Category 1 - Literally Homeless

- Individuals and families who lack a fixed, regular, and adequate nighttime residence and includes a subset for an individual who resided in an emergency shelter or a place not meant for human habitation and who is exiting an institution where he or she temporarily resided

Category 2 - Imminent Risk of Homelessness

- Individuals and families who will imminently lose their primary nighttime residence

Category 3 - Homeless under other Federal Statutes

- Unaccompanied youth and families with children and youth who are defined as homeless under other federal statutes who do not otherwise qualify as homeless under this definition

Category 4 - Fleeing/Attempting to Flee Domestic Violence

- Individuals and families who are fleeing, or are attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member.2

  A more in-depth definition is available within the HEARTH "Homeless" Final Rule.
  http://ctagroup.org/wp-content/uploads/2015/10/Homeless-Definition-and-documentation.pdf

Housing First is an approach to homeless assistance that prioritizes rapid placement and stabilization in permanent housing and does not have service participation requirements or preconditions such as sobriety or a minimum income threshold. Projects using a Housing First approach often have supportive services; however, participation in those services is based on the needs and desires of the program participant. The Detroit CoC

should review system- and project-level eligibility criteria to identify and remove barriers to accessing services and housing that are experienced by homeless individuals and families.

Street Outreach are programs that work to develop trust and relationships with homeless individuals to connect these individuals with resources, including shelter and/or permanent housing.

Veteran: An adult who served on active duty in the armed forces of the United States, including persons who served on active duty from the military reserves or the National Guard. For the purposes of these criteria, a Veteran is any person who served in the armed forces, regardless of how long they served or the type of discharge they received.
https://www.usich.gov/resources/uploads/asset_library/Vet_Criteria_Benchmarks_V3_February2017.pdf

Veteran family: A Veteran who is a single person or a family in which the head of household, or the spouse of the head of household, is a Veteran.

W-9: **R**equest for Taxpayer Identification Number and Certification—is a commonly used IRS form. Individuals and entities use the form to provide their taxpayer identification number to entities that will pay them income during the tax year.

RESOURCES

VBA Fiduciary Information

If there are concerns about a Veteran not being able to manage VBA financial benefits and could be a need for a fiduciary, Call: 888.407.0144 option 2

- Anyone in the community can alert VBA that a Veteran seems to be having trouble managing his/her money and that this has contributed to homelessness.
- First, try to encourage the Veteran to look at their pattern of money management. At times, the Veteran will willingly agree to contact VBA or Social Security to ask for a fiduciary to be sure their necessary bills for housing are paid and then the remainder of money is theirs to spend.
- If the Veteran does not agree and staff sees a pattern that contributes to homelessness, staff can ask VBA to access the case for possible fiduciary.
    - * This is not done to be punitive but to assist with getting and maintaining stable housing.

Social Security Fiduciary Appointment

The appointment of a fiduciary or representative payee for Social Security Benefits, SSI, or SSDI is generally able to be accomplished in two to three months' time. The process begins by having the Veteran's physician fill out SSA-784 Physician's/Medical Officers' Statement of Patient's Capability to Manage Benefits Form out.

Representative Payee

Social Security's Representative Payment Program provides benefit payment management for beneficiaries who are incapable of managing their Social Security or Supplemental Security Income (SSI) payments. Social Security appoints a suitable representative payee (payee) who manages the payments on behalf of the beneficiaries. Generally, they look for family or friends to serve as payees. When friends or family members are not able to serve as payees, they look for qualified organizations. If a Veteran is incapable of managing or directing the management of his or her benefits, call 1-800-772-1213 (TTY 1-800-325-0778) to request an appointment.

See www.ssa.gov/payee/fagrep.html

Efforts to Engage Landlords

All Stakeholders in the Plan to End Veteran Homelessness can direct potential partner landlords to Michigan Housing Locator http://www.michiganhousinglocator.com/Portals/mshda/Default.aspx. All providers are directed to this site as part of the Plan's commitment to identifying safe, affordable housing for Veterans.