Gulf Coast Partnership
Together We Can
One Charlotte

# ONE CHARLOTTE COORDINATED ENTRY: RECEIVING AGENCY USER GUIDE

## Assessment Key

**VI-SPDAT** = *Single person household*

**VI-FSPDAT** = *Household with minor children and unaccompanied youth with minor children*

**TAY-VI-SPDAT =** *Unaccompanied youth under 25 years old*

## Definition(s)

### *Literally Homeless*

- ✓ Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:
  - Has a primary nighttime residence that is a public or private place not meant for human habitation;
  - Is living in a publicly or privately-operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or
  - Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution

### *Chronically Homeless*

- ✓ An individual who is either:
  - An unaccompanied homeless individual with a disabling condition who has been continuously homeless for a year or more, OR
  - An unaccompanied individual with a disabling condition who has had at least **four** episodes of homelessness in the past **three** years totaling ***at least*** 12 months or more."

## Immediate Crisis Response Procedures

*If a client presents to your agency and appears to be experiencing a mental health or medical emergency, contact 9-1-1 immediately. If the crisis appears to be related to mental health issues, remember to request that a CIT trained officer respond to the call. If your agency has a staff person who is trained in Mental Health First Aid or standard CPR/First Aid, you may want to ask for their assistance while you wait for emergency services to arrive.*

## Immediate Direct Referral Procedures

- If client reports that they are fleeing domestic violence or human trafficking:
  - Ensure client's immediate safety and contact C.A.R.E. at 941-627-6000
- If client reports that they are an unaccompanied youth under the age of 18:

- Ensure client's immediate safety and contact OASIS at 239-278-1030

- If client reports that they are a United States Veteran:
  - Ensure client's immediate safety and contact VA Liaison at 239-470-1729 or 239-560-1800 x 20334

## Coordinated Entry Referral Process

*Once a potential participant has been referred to the GCP One Charlotte Coordinated Entry Process (CEP) for assistance with housing and supportive services, the Director of Coordinated Services will review the participant information and will make an appropriate referral to a participating agency, based on the availability of space in the program, funding, and appropriateness for the client, to begin receiving case management and housing assistance.*

*Once a referral is made, the Receiving Agency has **24** business hours to acknowledge receipt of referral. Once referral has been acknowledged, Receiving Agency has **24** business hours to attempt contact with participant. If contact cannot be established within that **24**-hour period, a case note should be added in CIS documenting the attempt, outcome and plan for follow up. The Receiving Agency must then enroll the participant within **7** business days. A Receiving Agency should only deny a participant's enrollment in their housing project if they have been unable to establish contact with the participant within the **7** business days. If the participant comes into the Receiving Agency after the **7** days has expired, the case manager will assist the participant in re-entering the CEP and will document this information in CIS.*

## Receiving Agency Roles and Responsibilities:

### Step 1: Initial Engagement

Once an agency has received the new participant referral from the Director of Coordinated Services; the agency should assign a case worker to the participant who should then work to contact the household to schedule a face to face appointment either at agency office or other preferred location to begin the CEP housing/case management process.

- If participant is unable to come to the agency's location due to lack of transportation or other issues, the agency should work to arrange meeting place that is more accessible to the participant.
  - A face to face meeting with the participant should occur within 7 business days from the date your agency received referral.
- If case worker is unable to establish contact with the participant or they are a no show for a scheduled appointment, case worker should document this in participant's CIS case notes to show due diligence.

### Step 2: Initial Face to Face Contact with Participant

***Introduction to CEP and Documentation***

- Provide participant with an overview of the Coordinated Entry Process, remembering to never guarantee housing, financial assistance, or services.

  - ***This would be a good time to discuss housing preferences and participant choice, as well as to encourage active engagement in services to ensure that participant has the best possible housing stability outcome.***

- Review and have participant sign the ***Participant's Rights*** and ***Grievance Policy Forms*** which can be found in the Documentation Packet provided to you by the GCP. (Include a copy of these two signed documents when submitting completed documentation to Director of Coordinated Services.)

- Complete appropriate Documentation Packet for participant's population with participant. i.e. Veteran, Chronic, Youth, etc.

    - Complete the appropriate packet in its entirety before submitting copy to Director of Coordinated Services.

    - Copy of completed packet should be provided to Director of Coordinated Services within **45 days** from project start date. This documentation should also be uploaded into CIS and a hard copy kept in participant file for the Receiving Agency's Records.

    - Remember, when third party verification is needed for chronicity and disability, the GCP requires that these documents be received no later than **45 days** from project state date.

## Step 3: On-Going Case Management and Housing Services

- Case managers should work with their assigned participant(s) to determine a housing plan, discuss preferences, identify needs and barriers, set goals and work toward enhancing self-sufficiency.

    - Once a participant's strengths, needs, abilities and preferences have been determined, case managers should work to coordinate and link the participant to appropriate community resources, services and mainstream service providers to improve their ability to live independently and to reduce the chances of re-entering the homeless system.

    - The frequency of contact with a participant should be determined by the participant and case manager and should be individualized to meet the needs of the household. (*This should not be a one-size fits all approach to services*).

        - If a participant works and is unable to meet with case manager during business hours, agencies will need to plan to accommodate the needs of the participant to ensure that they are receiving the supports they need.

        - If a participant stops engaging for any reason, case manager should work to provide case notes showing case manager's attempts to contact and due diligence. Case manager should bring this information to the OC Coordinated Entry Case Conferencing Meetings to be discussed during case conferencing. It may be necessary for another case worker or agency to attempt contact with the participant in order to maintain stability and achieve housing goals.

    - Once a participant is housed, case managers should meet the participant for monthly home visits to monitor the participant's stability, needs, and to provide assistance, and advocacy, as needed.

        - A minimum of one home visit per household, per month, is **required** by participating agencies. Home visits should be based on participant's strengths, needs, abilities, and preferences and should be individualized to meet the participant where they are. Some participants may require more than one home visit per month to start. Home visits should last approximately 1 hour per visit. OC best

practices encourage case managers to engage with unsheltered clients at least one time per week or more until housing is obtained. All efforts to contact and engage clients should be documented in CIS case notes.

## Step 4: Updates and Follow-Ups

- Once a participant has obtained housing, case manager should update Director of Coordinated Services and the OC Coordinated Entry Committee of participant's housing status, move-in date, funding source or if the participant self-resolved. In addition, case manager should report regularly on the participant's progress, needs, and setbacks so that the OC Coordinated Entry Team can intervene as needed to keep the participant stable and housed.

***Encourage clients to keep in contact with service providers and to update their contact information when and if it should change to ensure that they are able to be contacted by Receiving Agency/Case Manager and linked to appropriate services to meet their current unmet housing needs.***