Hudson County Alliance to End Homelessness
Coordinated Entry Policies and Procedures
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Vision Statement

The goal of the Hudson County Alliance to End Homelessness and the Coordinated Entry System is for individuals and families facing homelessness in Hudson County to quickly receive housing assistance through a coordinated process that links them with the most appropriate intervention based on their individual needs.

The system will provide people who are literally homeless, or at imminent risk, with streamlined access to services designed to help them achieve and maintain housing stability. Having this system in place will reduce referrals to supported or subsidized housing programs so that they are reserved for those most in need.

Background and Need

Having a system of care for homeless individuals and families that provides a coordinated entry process has always been the goal of the Hudson County Alliance to End Homelessness. Prior to the implementation of the Coordinated Entry System, when a household (individual or family) became homeless, there were many doors through which they could enter the homeless service system (i.e. emergency shelters, drop in centers, Division of Welfare, NJ 2-1-1 etc.). Households would receive different services and housing options depending on which agency they first sought assistance. Households were often referred from one provider to another resulting in a delay in assistance, or in some cases households may never actually receive the proper assistance. The same was true for households who were at risk of homelessness as many agencies provide homeless prevention assistance with different eligibility criteria. Furthermore, staff at the same agency may be providing conflicting and/or varying information and resources to different families. Moreover, a system which requires households to jump from one agency to another, receiving some help from each and providing inconsistent or incomplete information prevents the County from being able to assess the CoC’s effectiveness as well as the current gaps in services.

Implementing a system with a thorough screening and assessment process allows the HCAEH to assist households with the resources they truly need. By taking the time to evaluate the entirety of a household’s needs up front, rather than focusing solely on where there is space for them at the moment, provides a much clearer picture of the types of housing needs, how much is needed beyond what is currently in place, who is not being served, and how many people could have been served through a more effective allocation of resources.

Implementation of a coordinated entry system is a requirement of Continuum of Care and Emergency Solutions Grant funding from the Department of Housing and Urban Development (HUD), and is considered a national best practice. When implemented effectively, coordinated entry can:

- Reduce the amount of research and the number of phone calls and/or visits people experiencing homelessness must make before finding crisis housing or services;
- Prevent people experiencing homelessness from entering and exiting multiple programs before getting their needs met;
- Reduce or erase entirely the need for individual provider wait list for services;
• Foster increased collaboration between homelessness assistance providers; and
• Improve a community’s ability to achieve positive outcomes for clients and make progress
towards ending homelessness
• Reduce overall amount of time individuals and households spend homeless

Coordinated entry can come in many forms including a physical single point of entry or a
virtual/phone-based system. After much research and input from the homeless services providers,
it was determined that the best model for Hudson County would be a single responsible
coordinated entry agency that coordinates the assessment and referral process for the full Hudson
County Continuum of Care. Garden State Episcopal Community Development Corporation (GSECDC)
has been selected as this coordinated entry agency for Hudson County.

Goals and Guiding Principles

The goal of the coordinated entry system is to provide each consumer with adequate services and
supports to meet their housing needs, with a focus on returning them to housing as quickly as
possible. Below are the guiding principles that will help Hudson County meet this goal:

**Collaboration:** Because coordinated entry is system wide, it requires a great deal of
 collaboration between the CoC, providers, mainstream assistance agencies, funders, and
other key partners. This spirit of collaboration will be fostered through open
communication, transparent work by a strong governing council, consistently scheduled
meetings between partners, and consistent reporting on the performance of the
coordinated entry system.

**Accurate Data:** Data collection on persons experiencing homelessness is a key component of
the coordinated entry system. Data from the assessment process that reveals what
resources consumers need the most will be used to assist with the allocation of funds and
local initiatives. To capture this data accurately, all coordinated entry staff and providers
must enter data into the local Homeless Management Information System (HMIS) in a
timely fashion. Consumer’s rights around data will always be made explicit to them, and no
consumer will be denied services for refusing to share their data.

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

**Prioritizing the Most Vulnerable:** Coordinated entry referrals prioritize households that
have the highest housing barriers for program beds and services. This approach will ensure
an appropriate match between the most intensive services and the people least likely to
succeed with less intensive intervention, while connecting clients with few housing barriers
with lower level services. The goal of this approach is to reduce the average length of time
and number of episodes of homelessness and result in better housing outcomes for all.
Definitions

**Imminent Risk of Homelessness** – An individual or family who will imminently lose their primary nighttime residence, provided that:

i. The primary nighttime residence will be lost within 14 days of the date of application for homeless assistance;

ii. No subsequent residence has been identified; and

iii. The individual or family lacks the resources or support networks, e.g. family, friends, faith-based or other social networks, needed to obtain other permanent housing

**Literally Homeless** – An individual or family who lack a fixed, regular, and adequate nighttime residence, meaning:

i. An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;

ii. An individual or family living in a supervised 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, or local government programs for low-income individuals); or

iii. An individual who is exiting an institution where he or she 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

**Unaccompanied Youth** – An individual or family where the head of household is under the age of 25 and who meet the definition of literally homeless, at risk of homelessness, or a victim of domestic violence.

**Victim of Domestic Violence** – An individual or family who:

i. Is fleeing, or is 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, including a child, that has either taken place within the individual’s or family’s primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence;

ii. Has no other residence; and

iii. Lacks the resources or support networks, e.g., family, friends, and faith-based or other social networks, to obtain other permanent housing

Coordinated Entry System Overview

**Lead Organization**

Garden State Episcopal Community Development Corporation (GSECDC) is the lead entity for the Hudson County Coordinated Entry System. GSECDC is a proven nonprofit serving Hudson County since 1986. With offices and programs throughout Hudson County, GSECDC is a regional leader in affordable housing development, social services and supportive housing. With the goal of “Building Strong Communities”, GSECDC’s approach is structured to meet the multi-faceted and ever-changing needs of specific neighborhoods and populations. The Coordinated Entry System will be run through GSECDC’s Hudson CASA Coordinated Entry Program (HCCEP).
Target Population
The Hudson County Coordinated Entry System was designed to serve persons who are literally homeless, at imminent risk of homelessness, and victims of domestic violence as defined by HUD and outlined in the Definitions section of these policies and procedures.

The Coordinated Entry System was developed primarily to serve residents of Hudson County or those seeking to make Hudson County their permanent residence. In cases where clients do not want to remain in Hudson County, Coordinated Entry staff will attempt to link clients with resources that may be available in their County of origin or where they would like to make their permanent residence.

Accessing Coordinated Entry
All clients seeking services to address their homelessness, should access the Coordinated Entry System for assessment and referral. Below are the access points, and referral agencies and programs that connect clients to Coordinated Entry automatically. Any agency that receives a request for assistance can also refer clients to the Coordinated Entry System directly. In the event that clients are seeking services outside of coordinated entry hours, all individuals should be referred to the homeless hotline 1-800-624-0287 or directly to a homeless shelter (a list of all shelters are available on the HCAEH Homeless Services Navigator website at www.hudsoncountyhomeless.com and on the HCAEH Resource Guide attached in Appendix A). Any family with children seeking assistance outside of coordinated entry hours should be referred to the Hudson County Division of Welfare Homeless Hotline for Families by calling 1-800-624-0287.

Access Points
GSECDC CASA Coordinated Entry Program has two physical access points for clients seeking services through coordinated entry:

**Hudson CASA Coordinated Entry Main Location**
514 Newark Avenue, Jersey City, NJ 07306
**Hours:** Weekdays 9am – 4pm
**Phone:** 201-604-2600 ext. 0

**CASA Coordinated Entry at PERC Drop-In Center**
111 37th Street, Union City, NJ 07087
**Hours:** Weekdays 7am – 3pm
**Phone:** 201-348-8150

In addition to the two drop in locations, an additional access agency has been added to specifically address the needs of unaccompanied youth, as defined in the definitions section of these policies and procedures. Any unaccompanied youth who is seeking homeless services can connect directly with GSECDC or may enter the Coordinated Entry Process through Covenant House, a local youth provider. Covenant House staff have been trained to properly conduct the Coordinated Entry Process and collaborate with GSECDC to integrate youth into the Coordinated Entry and referral system. Unaccompanied youth seeking services can access Coordinated Entry through:

**Covenant House Drop-In Center**
797 West Side Avenue, Jersey City, NJ 07306
**Hours:** Weekdays 9am – 5pm
**Phone:** 609-513-7373

Clients seeking services through the main location, the PERC location, or Covenant House, will receive the same assessment and go through the same referral process regardless of their access point.
Mobile Assessment Team
To remove barriers and ensure all in need are accessing the coordinated entry system, GSECDC also has a mobile assessment team that will conduct assessments at the local shelters in the community and hotspots that may be identified. This mobile aspect enables GSECDC to connect with clients who may not be able to get to a drop in location, or those who may be more reluctant. The mobile team conducts assessments at The Hoboken Shelter and St. Lucy’s Shelter at least once a week. The remaining shelters schedule assessment days with the mobile team directly based on whether they have new intakes that need to be completed in their programs. The mobile team’s schedule is flexible to accommodate the needs of the shelters and other programs in the community. The mobile team determines their schedule on a weekly basis to address the needs of the community at that time, and based on the requests for assessments that they receive.

Street Outreach
All street outreach that is conducted within Hudson County works with the goal of connecting clients to both emergency services and the coordinated entry program. The primary provider of street outreach for Hudson County is GSECDC. GSECDC outreach works to engage service resistant individuals and those with the longest histories of homelessness. All clients that are engaged by outreach are encouraged to connect with coordinated entry. When clients are willing to engage, outreach staff will bring clients directly to a coordinated entry drop in center to be assessed or will connect them with a shelter where they can be assessed. The outreach team will follow up with coordinated entry staff to evaluate whether clients followed through with the assessment process and will reengage clients continuously to ensure they are able to access permanent housing, when it becomes available. GSECDC conducts outreach 7 days a week during the winter months and 5 days a week the rest of the year. Outreach is focused on hotspots and known locations but the team will also canvas areas that are brought to their attention by service providers, local officials or government and community members.

Emergency Shelters
As outlined above, the mobile assessment team of the Coordinated Entry Program conducts assessments on site at the emergency shelters throughout the County on a weekly basis. Emergency Shelters coordinate directly with the mobile assessment team to schedules dates and times that assessments will take place. In addition to the mobile assessment team, it is the responsibility of the local emergency shelters to continue to encourage their clients to connect with the coordinated entry program to be prioritized for permanent housing opportunities. Information regarding the drop in centers is provided to shelter residents and shelter staff must follow up with clients to ensure they are being connected.

The connection of emergency shelter clients to coordinated entry must happen immediately upon shelter admission and programs should not wait until a client is about to be discharged to connect them to coordinated entry. Coordinated entry is not a replacement for shelter, and placements may take time, requiring shelters to connect clients to coordinated entry services as close to engagement as possible.

To determine the effectiveness of emergency shelters connecting clients to coordinated entry, the CoC Lead, the Hudson County Division of Housing and Community Development, evaluates monthly the percentage of clients in each shelter that have been assessed by coordinated entry. If numbers seem low for any one shelter, the Division will reach out to the shelter to target clients for connection to the assessment system.
Assessment Process

Once clients are connected to the Coordinated Entry Program, coordinated entry staff focus on evaluating each household’s need. Client need is determined through two steps, a pre-screen and full vulnerability assessment.

Pre-Screen
Immediately upon connection to coordinated entry, coordinated entry front line staff will conduct a pre-screen for each household. This pre-screen focuses on identifying whether the household meets the eligibility criteria for assessment of being literally homeless, at imminent risk, or a victim of domestic violence, and the need for emergency services and shelter. The pre-screen also asks questions related to diversion and prevention to determine if the household can be diverted out of the system or served in a better way that enables them to avoid entering the homeless system entirely. A copy of the pre-screen tool used is attached in Appendix B.

For clients that are not eligible for coordinated entry services as they are not at risk or currently homeless, staff will provide referrals to local programs or mainstream benefits that may be able to better assist the household. If the household would qualify for prevention funding, GSECDC will make a referral to the appropriate prevention provider based on the client’s eligibility.

For clients that are in need of emergency services and shelter, as identified through the pre-screen, GSECDC will make a connection to a shelter in the community that they know has availability. GSECDC will not send a client to a shelter that does not have a vacancy or they know the client will not be eligible for. If at any point there are no shelter placements available, GSECDC will reach out to the County’s hotline or hotel placement providers, specifically for families. GSECDC will make all efforts to place families and individuals in safe, emergency shelter placements. As a note, engagement with coordinated entry is not a requirement for access to emergency shelter in Hudson County. While staff are able to assess and determine what shelter programs may be available, clients are always able to reach out to emergency shelters directly.

In addition to the placement in shelter, GSECDC will identify referrals for any other emergency needs the family or individual may have, such as food, legal services, etc. After the emergency needs are addressed, the coordinated entry staff will set up an appointment for the client to meet with a case manager and have the full assessment for housing completed. All appointments are made within 7 days of the client first accessing coordinated entry.

Vulnerability Assessment
The Hudson County Continuum of Care uses a Vulnerability Matrix as the assessment tool for the Coordinated Entry Program. The tool assesses households on a variety of factors, each of which have a score associated with them. Factors that are assessed in the matrix include:

- Income
- Employment
- Shelter
- Food
- Education
- Legal Needs
- Health Care
- Life Skills
- Mental Health*
- Substance Use*
- Family Relations
- Transportation/Mobility
- Community Involvement
- Safety
- Unaccompanied youth

In addition to the factors that are assessed for all households, additional areas are assessed for families and/or unaccompanied youth. These factors include:
Family Factors:
- Childcare
- Children’s Education
- Parenting Skills

Youth Factors:
- LGBTQ Status
- DCP&P Involvement
- Trafficking Risk Factors

Additional vulnerability questions that are asked, but not scored, include:
- History of Incarcerations
- Hospital Interactions
- Chronic Homelessness

*While clients are asked about mental health and substance use, questions focus on these behaviors being a risk or putting the client or their family in danger and its interference in their daily functioning. Clients are not required to disclose a disability through the assessment process and are not prioritized based on a disability. Disability information is only collected as needed to determine program eligibility.

Intake workers complete the assessment tool as part of a larger conversation regarding the client’s history and needs. Clients do not fill the tool out themselves, and most questions are not asked directly. Instead, the intake worker will determine the most appropriate response based on information provided.

All factors assessed through the assessment process are scored and totaled to create an overall vulnerability score for each household. The lower the score the household receives the higher the vulnerability that household has.

Clients may refuse to answer any of the questions, or discuss a certain area in the vulnerability assessment. Clients that refuse to answer specific questions will still be assessed and will still be served through the Coordinated Entry Process.

Case managers will update a client’s vulnerability matrix as new information becomes available from the client directly or from partner providers, or every 6 months, whichever comes first.

All households are entered into the CASA Coordinated Entry Program in HMIS at the time of assessment. All vulnerability assessments are completed and maintained in HMIS, where the prioritization list is generated.

The Hudson County Vulnerability Matrix is attached is Appendix C.

**Prioritization and Housing Referral Process**

**Prioritization List**
The Hudson County Continuum of Care has adopted and abides by the HUD Notice CPD-16-11: Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing for the prioritization of homeless clients throughout Hudson County. GSEDCDC utilizes the vulnerability scores and homeless history information of all clients in the system to maintain the Housing Prioritization List for the Continuum of Care. The list of clients is organized and prioritized first based on chronic homeless status and then by the vulnerability score for the household.

**Notification of Housing Vacancies**
All CoC and ESG funded permanent supportive housing, rapid rehousing and joint transitional housing/rapid rehousing programs must fill program vacancies through the coordinated entry program. In addition, there are a number of low-income housing tax credit and multi-family programs that have agreed to take referrals from coordinated entry.

When a housing program is aware that there will be a vacancy in their program, they must notify GSE CDC’s Director of Supportive Housing and Social Service Programs of the anticipated vacancy within 7 days of the vacancy becoming known. With this notification, the program must provide the household type the vacancy is for, as well as any specific eligibility criteria for the program including chronic homelessness, specific disability or subpopulation requirement as well as an anticipated time frame the vacancy will be available.

Once a vacancy is identified, the Coordinated Entry Director will include this program vacancy as part of the discussion in GSE CDC’s next case conferencing session, as described below.

**Case Conferencing**
To make decisions regarding housing referrals and placements, GSE CDC utilizes the household’s position on the prioritization list as well as a case conferencing approach. GSE CDC conducts case conferencing on a weekly basis with all coordinated entry case managers and the program’s Director. In these case conferencing sessions, staff discuss prioritized households and appropriate referrals for clients based on their level of need. Referrals include not only vacancies for long term programs such as permanent supportive housing and CoC rapid rehousing programs, but also referrals that should be made for families and individuals that are lower on the prioritization list that may be appropriate for shorter term rapid rehousing and general affordable housing opportunities in the community. Referrals for programs are made based on the client’s vulnerability and eligibility for the programs that are available in the community, as well as any additional information or insight that can be provided by the client’s case manager. Generally referrals for permanent supportive housing are made for clients with a vulnerability score of 24 or under, while referrals for rapid rehousing and other less service intensive programs are made for clients with a score of 25 or higher.

**Referral Process**
Once decisions are made in the case conferencing session regarding an appropriate housing referral for a client, the case manager will set up a meeting with the client to notify them of the opportunity and begin working on the appropriate housing application. It is at this time that a client may choose to deny a housing referral if they do not feel it will meet their needs. Clients who deny a placement, will remain on the prioritization list and will continue to be evaluated for other opportunities as they become available.

For clients that accept a referral, their case manager work with them to ensure all backup documentation, including disability forms, identification, homeless certifications, etc. are complete and accurate. Once the client’s housing application is complete, the full application is reviewed by the Program’s Director and is sent, along with the coordinated entry referral form (attached as Appendix D) to the contact for the housing program for review and final determination of eligibility. It is the goal of the coordinated entry program to provide a referral within 14 to 30 days of notification of the vacancy. The length of time a referral takes is dependent on the documentation requirements of the program and funding sources. In general, it typically takes a bit longer to complete housing applications for programs requiring chronic homeless status due to the strict documentation requirements for chronic homelessness.
Upon receipt of the housing referral, the agency has 21 days to review the application packet and when necessary, conduct an interview, to determine appropriateness for the housing program. Within 21 days, the program must make a determination of whether the client will be accepted into the housing program and must notify the Coordinated Entry Director of their decision. All agencies have the ability to deny a housing referral from coordinated entry, but if a client is denied an appropriate reason must be provided to the Coordinated Entry Director. All programs must also have an appeals process in place to allow the clients the ability to appeal the denial of their application. GSECDC case managers are able to assist clients in submitting an appeal to the housing provider to help advocate for the housing placement.

Clients that are denied a housing referral maintain their position on the prioritization list and continue to be evaluated for housing opportunities as they become available. Client’s that are approved for housing remain on the case worker’s caseload until the household successfully moves into a housing unit. At that point they are no longer considered a coordinated entry client and are discharged from HMIS.

**Ongoing Case Management**

Throughout the assessment, prioritization and referral process, GSECDC case managers work with clients to provide ongoing case management to assist in the homeless system navigation. Case management focuses on connecting clients to resources in the community that will help them address their barriers to housing and put them in a better position to maintain their housing once it is obtained. Case management staff work to connect clients to mainstream benefits including SSI, SSDI, TANF, Food Stamps, etc. Connections are also made to mental health counseling, substance abuse treatment, employment services, education, legal services, etc. All referrals for services are based on the client’s needs and work to address housing barriers. Case management staff also work to help clients obtain documentation that may be needed when a housing opportunity becomes available including identification, birth certificates and social security cards.

**Special Populations**

There are certain subpopulations of homeless individuals and families that may have special needs that need to be addressed through the coordinated entry system. While any of these subpopulations are able to access the system the same way as the general population, special considerations have been put in place to best accommodate them.

**Victims of Domestic Violence**

If, through the pre-screen of coordinated entry or through the vulnerability assessment, a household identifies as fleeing domestic violence, coordinated entry staff will immediately connect the client with WomenRising, the local domestic violence provider for Hudson County. WomenRising will determine whether the client is appropriate for residential emergency shelter services with WomenRising or if they should be served by the general homeless system. If the client will be served by WomenRising, they are immediately placed in the domestic violence shelter program and an assessment will be conducted by GSECDC staff once the client’s safety is established.

If WomenRising does not feel the client is appropriate for DV specific shelter, GSECDC staff will assess the client’s safety issues and will work to find a shelter placement that will be able to provide
the safety the client needs. This can include them staying in a hotel placement if necessary.

Victims of domestic violence will be assessed and prioritized for permanent housing opportunities in the same method as non-domestic violence clients. WomenRising can schedule mobile assessment to connect with their clients or clients will access coordinated entry drop-in centers. WomenRising works directly with GSECDC to ensure clients are connected to coordinated entry for possible housing options.

All housing opportunities that are made available to victims of domestic violence are done so with consideration of the client’s safety. The client maintains the ability to deny a housing referral if they feel it is not in their best interest. Clients will not lose their place on the prioritization list or their access to case management and services if they deny a housing referral.

**Unaccompanied Youth**
As described in the Accessing Coordinated Entry section of these policies and procedures, unaccompanied youth have the ability to access coordinated entry through either GSECDC or Covenant House directly. Assessments that are conducted by Covenant House are done so outside of the HMIS system and are sent to the Coordinated Entry Director. Once received, the client and assessment are entered into GSECDC’s HMIS program and are included for prioritization and referral with the rest of the population. The ongoing case management for that client is maintained by Covenant House directly.

If a youth that was originally engaged by Covenant House is eligible for a housing program, GSECDC staff will notify Covenant House, and Covenant House will work with the client to complete the housing application, as GSECDC would. Unaccompanied youth are eligible for all housing opportunities that non-youth would be, as long as they meet the eligibility criteria for that specific program.

All youth who are not engaged with Covenant House upon entry to coordinated entry, are connected to Covenant House for services, including emergency shelter if needed.

**Veterans**
Homeless veterans seeking services throughout coordinated entry must immediately be connected with one of the County’s SSVF providers upon completion of the vulnerability assessment. SSVF providers for Hudson County are responsible for determining eligibility and connecting clients with VA specific housing programs, including HUD VASH, when appropriate. All veterans are first assessed for VA specific housing before any non-VA housing referral will be made. GSECDC case managers work closely with the client’s SSVF case manager to determine eligible veteran specific resources, and when not eligible, GSECDC will prioritize them for CoC and non-CoC funded programs. GSECDC staff will also continue to provide case management for non-VA or SSVF eligible veterans.

**Equal Access and Fair Housing**

**Anti-Discrimination Policy**
The Hudson County Coordinated Entry Program was designed and is implemented with the goal of furthering fair housing and equal access to housing by all persons. Housing referrals and placements are based strictly on the vulnerability and eligibility of the client. Housing will not be
determined or impacted based on race, color, religion, sex, national origin, familial status, disability, gender identity, sexual orientation, etc.

GSECDC staff work to ensure clients are not discriminated against when seeking housing in the community and that all client’s understand their right to fair housing. If discrimination is experienced, GSECDC will provide clients with the information necessary to report the discrimination. If discrimination is experienced by an agency that receives funding through the Continuum of Care, GSECDC will reach out to the CoC Lead immediately upon notification to address the concern.

**Service Accommodations**

When needed, GSECDC makes accommodations to ensure all clients can access services provided through the coordinated entry program. To accommodate clients that have disabilities, both GSECDC drop in centers are handicap accessible. GSECDC staff, if needed will also use the mobile assessment team to meet a client where they are if they are not able to go to a drop in center. When necessary, GSECDC will also connect with local agencies, and will use technology to accommodate clients with hearing or vision impairments.

GSECDC has a number of bilingual staff for persons that do not speak English and they have access to the City of Jersey City’s language line. The language line is able to provide translation for a variety of languages that GSECDC staff may not be fluent.

**Data Collection**

All information regarding clients that are served in the coordinated entry program will be maintained in the CoC’s Homeless Management Information System. The Coordinated Entry program must abide by the following HMIS expectations:

- All clients must be entered into HMIS within 24 hours of their vulnerability assessment meeting
- Interim updates regarding client information must be completed as soon as the information is collected
- Vulnerability assessments must be updated every 6 months, or more frequently if additional information is collected
- All clients should be discharged once permanent housing has been obtained
- Clients should be discharged from the Coordinated Entry program in HMIS if they have not been engaged and have not been seen by coordinated entry at any point over the prior 12 months

GSECDC must maintain the appropriate client consent forms for all clients entered into the HMIS and for all referrals made. Clients will not be denied services if they refuse to sign a client consent form or refuse to have their information shared in HMIS. In addition to these consent forms, the Hudson County Alliance to End Homelessness has developed and HCAEH Consent Form allowing for data sharing and case conferencing among agencies, when sharing will lead to better service provision for the clients. This consent form is signed along with the HMIS consent form and entered into HMIS. Clients do not have to sign the HCAEH Consent Form to be served.

Data quality must be evaluated by GSECDC staff regularly. Formal evaluations of GSECDC data will
be conducted by the CoC Lead as outlined below.

**Training**

All GSECDC staff receive training annually to ensure they are up to date on the Coordinated Entry policies, procedures and best practices. Annual trainings include a review of the program’s code of ethics, system flow, homeless definitions, HMIS data entry, program outcomes, and best practices for working with hard-to-serve clients. The CoC Lead will participate in this annual training to ensure staff are equipped with appropriate knowledge to conduct assessments for the Continuum of Care. All new staff receive this information immediately upon starting in addition to the annual training.

In addition to internal trainings, coordinated entry staff must attend local Continuum of Care meetings and trainings to maintain an understanding of the full homeless system, new initiatives and best practices. Staff are required to attend annual LGBT trainings that are provided by the Continuum of Care as well as any trainings that are required by the CoC Lead.

GSECDC is responsible for ensuring all staff attend training as needed to maintain appropriate HMIS data quality and program implementation.

Covenant House staff have been, and are trained annually, by coordinated entry staff to ensure consistent implementation of the coordinated assessment vulnerability matrix.

**Evaluation**

The coordinated entry program is evaluated on a regular basis to ensure that it is operating at the maximum efficiency. Evaluations will be conducted both internally by GSECD and formally through the Hudson County Division of Housing and Community Development as the CoC Lead and the Hudson County Alliance to End Homelessness Performance and Evaluation Committee.

The following evaluations will be completed by Garden State Episcopal CDC:
- GSECDC will conduct focus groups on a weekly basis at its main drop-in center for clients who are interested to provide feedback regarding GSECDC directly or the system as a whole
- Twice a year GSECDC will conduct a general satisfaction survey

The following evaluations will be completed by the Hudson County Division of Housing and Community Development Data Analyst:
- A monthly review of HMIS program data quality highlighting problem areas
- A monthly review of percentage of clients that are connected to coordinated entry from emergency shelters in the system
- A monthly review of discharge destinations

The following evaluations will be completed by the HCAEH Performance and Evaluation Committee:
- Annual review of HMIS program data quality (sample report attached as Appendix E)
- Annual performance evaluation (performance measures attached as Appendix F)
In addition to these structured evaluations, the CoC will utilize coordinated entry data throughout the year to complete grant applications as well as in HCAEH subcommittee meetings to determine outcomes and needs of clients. Coordinated Entry data will also be used to conduct gaps analysis and services needs for the Hudson County Alliance to End Homelessness. Through these uses any issues with the data, process, or system as a whole will be identified and addressed.

**Complaints or Issues**

Any issues or complaints related to Coordinated Entry should be submitted to the CoC Lead for the Hudson County Continuum of Care. The contact information for the CoC Lead can be found at [www.hudsoncountynj.org/homeless-initiatives/hudson-county-alliance-to-end-homelessness-hcaeh/](http://www.hudsoncountynj.org/homeless-initiatives/hudson-county-alliance-to-end-homelessness-hcaeh/)

All complaints submitted will be responded to within 7 days, and complaints that require further attention will be handled by the Hudson County Alliance to End Homelessness Executive Board.

**Adjustments and Modifications**

Because the Coordinated Entry Program is an integral piece to the CoC’s homeless service system, the program will be updated as needed by the community. These policies will be reviewed annually, and adjustments or updates can be made as needed.

If GSE CDC feels the vulnerability matrix needs to be updated to better address the needs of a specific subpopulation or to better collect information from clients, all updates must be submitted to the Hudson County CoC Lead for consideration and adjustment.