

**Hudson County  
Division of Housing and  
Community Development**



**Hudson County  
Coordinated Assessment Framework**



# Hudson County Coordinated Assessment Framework

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## **I. Vision Statement**

Individuals and families facing homelessness in Hudson County will 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.

## **II. Background and Need**

Reforming the system of care for homeless individuals and families to create a more coordinated entry process has been a primary goal of the HCAEH as well as the County's Ten Year Plan to End Homelessness. Within the current system in Hudson County when a household (individual or family) becomes homeless there are many doors through which they could enter the homeless service system (i.e. emergency shelters, drop in centers, Division of Welfare, 211 etc.). Households may receive different services and housing options depending on which agency they first seek assistance. Households are 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 is true for households who are currently housed but 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.

A thorough screening and assessment will allow the HCAEH to assist households with the resources they truly need. Moreover, the current system, which often requires households to jump from one agency to another, receiving some help from each and providing inconsistent or incomplete information to all, prevents the County from being able to assess the CoC's effectiveness as well as the current gaps in services. By taking the time to evaluate the entirety of a household's need up front, rather than focusing solely on where there is space for them at the moment, the coordinated entry system will be able to provide a much clearer picture of what other types of services not currently provided by the community may be needed, 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 assessment system is now a requirement of receiving certain funding from the Department of Housing and Urban Development (HUD) and is also considered national best practice. When implemented effectively, coordinated assessment can:

- Reduce the amount of research and the number of phone calls 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 lists for services;
- Foster increased collaboration between homelessness assistance providers; and
- Improve a community's ability to perform well on Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act outcomes and make progress on ending homelessness.

Coordinated assessment 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 service providers, it was determined that the best model for Hudson County would be a single responsible coordinated assessment agency that coordinates

the assessment and referral process. Garden State Episcopal Community Development Corporation (GSECDC) has been selected as this coordinated assessment agency for Hudson County.

Implementation of a coordinated assessment system requires a shift in the assessment of clients and the delivery of services by all of the agencies currently providing housing and homeless assistance. Such a change can be challenging for consumers, funders, and agency staff. However, the reality is that resources continue to be cut as the need continues to grow. Therefore, it is critical that the HCAEH is increasingly thoughtful and targeted about using available resources.

### III. Goals and Guiding Principals

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

**Collaboration:** Because coordinated assessment is being implemented 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 assessment process.

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

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

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

### IV. Coordinated Assessment Overview

#### *Lead Organization*

Garden State Episcopal Community Development Corporation (GSECDC) will serve as the lead entity for the Coordinated Entry Process. GSECDC is a proven nonprofit serving Hudson County since 1986. Based in Jersey City, 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 and assessment program will be run through GSECDC's Hudson CASA Coordinated Entry Program (HCCEP). Previously serving as a drop in center and case management program, HCCEP has restructured to focus on intake and assessment. Though implementation will be phased in due to limited funding, HCCEP will ultimately be responsible for performing a detailed assessment on all homeless individuals and families in Hudson County utilizing a standardized assessment tool. In the interim, until all required funding is identified, HCCEP staff will train intake staff at specified agencies to administer the assessment tool and refer appropriately.

### ***Target Population***

This process is intended to serve people currently experiencing homelessness and those who believe they are at imminent risk of homelessness. Homelessness will be defined in accordance with the official HUD definition of homelessness.<sup>1</sup> People at imminent risk of homelessness are those who believe they will become homeless, according to the HUD definition, within the next 14 days. Households who think they have a longer period of time before they will become homeless should be referred to other prevention-oriented resources available in the community.

This coordinated assessment process was developed primarily for residents of Hudson County. In certain cases funding or program policy may prohibit an agency from serving individuals who do not have adequate proof of residence in Hudson County. Assessment staff will attempt to link consumers that fall into this category with resources that may be available in their area of origin or wherever they are currently staying.

### ***Assessment Tool***

A coordinated assessment tool was developed by the Division and GSECDC with input and feedback from the HCAEH. The tool can be done either on paper or directly in HMIS. The tool will assess each household on a variety of factors and will ultimately result in a numerical score that will determine the type of housing or intervention that is best suited to the household's needs.

A copy of the assessment tool is available in Appendix A.

### ***System Flow***

Effective July 1, 2015 all Continuum of Care (CoC) funded programs will only take referrals through the coordinated assessment process. Prior to entering any CoC funded Permanent, Transitional or Rapid Re-housing program, each homeless household will be assessed using the assessment tool. Each CoC funded housing program will accept households that score within a pre-determined range and HCCEP will place individuals and families into those programs as openings become available and eligible households are identified.

Individual CoC funded programs can no longer accept clients into their program that self-refer, walk-in, or come from pre-existing waiting lists or other community referral process. HCCEP will work closely with all providers to ensure that appropriate and eligible referrals are made. Providers will also be given a certain amount of discretion in accepting clients should they feel that a certain household is not suitable for their program.

The assessment and referral process is explained in further detail below.

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<sup>1</sup> The definition is available here: [https://www.onecpd.info/resources/documents/HEARTH\\_HomelessDefinition\\_FinalRule.pdf](https://www.onecpd.info/resources/documents/HEARTH_HomelessDefinition_FinalRule.pdf)

## **V. Screening and Assessment Process**

### ***Emergency Shelters***

For the most part all emergency shelters will continue to function as is. Households seeking emergency shelter at one of the County's five homeless shelters will be screened by shelter staff for program eligibility as well as diversion potential. An optional pre-screening tool (Appendix B) has been developed and shelters are encouraged to incorporate the tool into their existing intake process. The ultimate goal of the pre-screening tool is to divert households from entering the shelter system whenever possible if another more permanent option exists. Diversion strategies could include family reunification and/or mediation if possible, and prevention assistance with landlords.

If diversion is not possible, the shelter has space and the household is deemed eligible, that household will be admitted into a shelter and those providers will make basic services available to households until a more detailed assessment is completed. Current data suggests that a quarter of the individuals who enter the shelter system in Hudson County leave within 7 days and do not return, suggesting that many households experience short-term housing crises, are able to stabilize their crises quickly with minimal interventions, or are able to obtain other means of support. As resources and time are limited, a full, in-depth assessment will only be completed on households who remain in the system for more than seven days or who return multiple times.

After a household remains for seven days or more, they will be assessed using the Coordinated Assessment tool to determine needs, identify the best short-term placement, and develop a long-term strategy for housing stability. The tool can be administered on paper, but must be entered into HMIS within 24 hours.

Since Coordinated Assessment cannot guarantee immediate housing to anyone, shelters are urged to provide sufficient supportive services relating to housing placement prior to discharging a resident. Cooperation on this front is particularly crucial for programs assisting homeless families with children. Coordinated Assessment cannot replace emergency housing, therefore due to the lack of additional emergency housing options for families, family shelters are urged to provide appropriate discharge planning for residents. No homeless family should be referred to Coordinated Assessment from a shelter without first speaking with coordinated assessment staff. Staff will request information relating to the family shelter's efforts around housing placement in order to determine how they may be able to proceed.

### ***Street Outreach Team***

When homeless outreach teams engage with unsheltered homeless individuals, the first priority is linking them with shelter and case management through Hudson HCCEP. Typically, the assessment will be completed when the client visits HCCEP or a shelter. In the event that an individual does not accept either of these referrals, outreach staff should conduct the assessment tool on the individual.

### ***GSECDC Hudson CASA Coordinated Entry Program (HCCEP)***

GSECDC HCCEP drop in center is open Monday – Friday 9am -4pm for walk in clients. When a household presents at GSECDC HCCEP for assistance a pre-screening tool is administered to determine if household is homeless or imminently homeless. Once an individual is determined to be homeless or imminently homeless, they are scheduled for intake. Generally within two days, all households will receive a full assessment, which includes completion of the coordinated assessment tool, to determine needs, identify the best short-term placement, and develop a long-term strategy for housing stability.

HCCEP staff will first work to address the immediate needs of homeless households, and will work to link each with a shelter placement as needed.

### *Community Inquiries*

All households who contact nonprofit service and housing providers, religious organizations, 211, government agencies who are homeless should be referred to GSECDC for assessment. If individuals are seeking assistance after 4pm or on the weekends, they should be referred to a homeless shelter. If families are seeking assistance after 4pm or on the weekends, they should be referred to the Hudson County Division of Welfare Homeless Hotline for Families by calling 1-800-624-0287. All information on shelters can be found on the Hudson County Homeless Resource Guide.(Appendix C)

## **VI. Housing Referral Process**

All CoC funded permanent, transitional and rapid re-housing programs can only fill vacancies with referrals from HCCEP. All bed availability should be determined, ideally, in real-time through HMIS. However, because of data entry delays, programs must alert GSECDC and the Division of any vacancies as soon as they become available via email. In addition, as soon as a provider knows of an upcoming vacancy, they must notify [Susan Milan](#) at GSECDC and [Carol Sainthilaire](#) at the Division.

Referrals will be based on each program's admissions eligibility criteria. Any changes to a program's existing eligibility criteria or target population must be sent immediately to the CoC Lead. If the CoC Lead has a concern that a program's requirements may be contributing to "screening out" or excluding households from needed services, they may request to meet with the provider to discuss their criteria. Existing eligibility criteria and target population is listed in Appendix D.

### *Households with Children*

GSECDC will first perform an initial screening for TANF eligibility on all households with children. Assessment staff will refer TANF eligible families to the Hudson County Division of Welfare to complete TANF and Emergency Assistance (EA) applications. If deemed eligible for EA, the household will receive services and case management from the Division of Welfare. This may include the provision of a Temporary Rental Assistance (TRA) voucher. Welfare Homeless Navigators will assist homeless households that are provided a TRA voucher with assistance obtaining and maintaining this housing.

If ineligible for EA, the household will remain with GSECDC for services until placement into another program. All families will be referred to a Rapid Re-housing or Permanent housing program based on identified needs and assessment score.

Families with the most severe needs and those living on the street should always be prioritized for assistance.

### *Households without Children*

#### Permanent Supportive Housing

Openings in all permanent supportive housing (PSH) units for the Chronically Homeless will be prioritized for those households with the most intensive service needs and housing barriers. GSECDC will follow the order of priority established in CPD Notice CPD-14-012 when making referrals:

1. Chronically Homeless individuals with longest history of homelessness and with the most severe service needs;
2. Chronically Homeless individuals with the longest history of homelessness;
3. Chronically Homeless individuals with the most severe service needs; and
4. All other Chronically Homeless individuals.

Through the use of the coordinated assessment tool, data collected at intake and administrative records from the Hudson County Jail and local hospitals, GSEDC will be able to determine which clients have been homeless the longest and have the most severe needs.

### Transitional and Rapid Re-housing

Individuals with less intensive service needs will be referred to rapid rehousing or transitional housing programs.

### *Process for Making Referrals*

1. GSEDC staff will work with each client to collect the required application and eligibility documentation prior to making a referral.
2. All referrals will be made via email, with a follow up phone call to ensure the program received the required items. All application materials and eligibility paperwork will be forwarded to the housing program.
3. The housing program will have one week to schedule an appointment with the referred client.
4. HCCEP staff will work with the client to ensure they make all scheduled appointments and to assist in making a smooth transition into the housing program.
5. If a client does not show up at the referred-to program, the referred-to program should notify their assessment staff member. This person should attempt to make contact with the client. If the client cannot be located after being notified that a space was available in a program, the slot will be offered to the next person on the priority list for that intervention.
6. Housing programs are expected to accept all referrals from HCCEP unless it is determined that the household does not meet the eligibility criteria. From time to time housing programs and HCCEP staff may disagree on whether a household was an appropriate referral for the program. (Appendix E)

### *Post-Placement Procedure*

Once a client has entered a housing program they should be discharged from the HCCEP HMIS program and considered successfully housed. HCCEP staff may continue to assist with transitioning the household once housed.

## **VII. Special Populations**

There are a certain subpopulations of homeless individuals that may have special needs that may be better served by a specific organization or agency. While any of the subpopulations below are eligible for regular homeless assistance programs, additional programs and resources exist which are targeted to meet their unique needs.

### *Victims of Domestic Violence*

If a household identifies that they are fleeing a domestic violence situation or a situation that meets the HUD definition of a household fleeing domestic violence, the Coordinated Assessment staff will contact WomenRising to check for DV openings.

### *Homeless Veterans*

If a household reports having served in the armed forces, the individual will be referred to the Homeless Veterans Committee of the HCAEH to determine eligibility for veteran specific programs.

### *Homeless Youth*

Individuals between the ages of 18 and 25 will be referred to Covenant House for assistance.

### *Mental Health*

Individuals who have a history of serious mental illness and are homeless or at serious risk of becoming homeless should be referred to the PATH Program (Projects for Assistance in Transition from Homelessness)

## **VIII. Data Collection**

Data collection is essential, because although the new system will be able to determine what intervention would be most appropriate for each household, it will not be able to provide for all of the identified needs, at least initially. As in many communities, resources are limited and there is not enough housing and services to meet the need. Accordingly, detailed data will be collected and analyzed on the scores that each homeless household receives to determine the types of housing and services that are most needed. This data will be used to guide future funding for new housing programs, or for the reallocation of existing resources. Data will be collected on everyone that is assessed through the coordinated assessment process.

Once a client has been accepted into any homeless program, the appropriate staff member will show the client the HCAEH Consent Form (Appendix D). They will go over it with them and explain what data will be requested, how it will be shared, who it will be shared with, and what the client's rights are regarding the use of their data. Agency staff will be responsible for ensuring clients understand their rights as far as release of information and data confidentiality. If they sign the form, the staff member can complete the intake and assessment process in HMIS.

## **IX. Evaluation**

The coordinated assessment process will be evaluated on a regular basis to ensure that it is operating at maximum efficiency. Evaluation will be carried out primarily through the Coordinated Assessment Sub-Committee of the HCAEH. Evaluation mechanisms will include the following:

- A monthly review of metrics from the coordinated assessment process will be performed by the Division and shared with the Coordinated Assessment Agency.
- A report issued to the community every six months on coordinated assessment and homelessness assistance system outcomes. This report will include trends from the month-to-month analysis of coordinated assessment data, as well as the total number of assessments and referrals made, and successes to be shared. Major findings from this report should be presented at the CoC meetings.

- An annual report on the homelessness assistance system with a section devoted to coordinated assessment. Major findings from this annual report should be presented at the CoC meeting.

## **X. CONTACT INFORMATION**

Questions about these policies and procedures should be directed to:

Carol Sainthilaire, Program Director and Continuum of Care Lead

Hudson County Division of Housing and Community Development

201-369-4520

[csainthilaire@hcnj.us](mailto:csainthilaire@hcnj.us)

## **APPENDIX A: Assessment Tool**



# Saint Joseph - York St RRH Phase 2 - Hudson



## Hudson County Assessment Matrix

**\* Indicates required fields.**

**\*Client Name**

**Pin #**

**Program Name**

**Admission Date**

**Household ID**

**Client ID**

**\*Assessment Date**

**\*Assessment**

- Admission
- Interim
- Exit

Update Hudson County Assessment Matrix Section

### **\*1. Income**

- 2
- 1
- 1
- 2
- 3

Income Threshold

- 2. No Income
- 1. Inadequate income and/or spontaneous or inappropriate spending
  - 1. Can meet basic needs with subsidy/ appropriate spending
  - 2. Can meet basic needs and manage debt without assistance
  - 3. Income is sufficient, well managed/ has discretionary income and is able to save

### **\*2. Employment**

- 1
- 2
- 3
- 4
- 5

Employment Thresholds

- 1. No Job
- 2. Able to work, but has criminal history or other barriers to achieving employment
- 3. Temporary, part-time and/or sporadic employment
- 4. Employed full-time/ inadequate pay/ few or no benefits
- 5. Employed full-time with adequate pay and benefits

### **3. Shelter**

- 1
- 2
- 3
- 4
- 5

Shelter Thresholds

1. Homeless, in shelter, or imminently facing eviction
2. In transitional, temporary or substandard housing; and/or current rent/mortgage payment is unaffordable
3. In marginally adequate housing
4. Household is in safe, adequate, subsidized housing
5. Household is in safe, adequate, unsubsidized housing

#### \*4. Food

1  2  3  4  5

##### Food Threshold

1. Insufficient food or means to prepare it; relies on sources of free or low-cost food
2. Household is on Food Stamps; and/or able to purchase food but lacks means to prepare it
3. Can meet basic food needs, but requires some assistance, (Food Stamps or other)
4. Can meet basic food needs without any assistance
5. Can choose to purchase any food household desires

#### \*5. Adult Education

1  2  3  4  5

##### Adult Education Threshold

1. Unable to Read and/or Write
2. Currently engaged in literacy, ESL, adult education or GED program; and/or not fluent in English.
3. Currently engaged in specific skills development program
4. Completed high school, or GED, or skilled trades training
5. Educational level, literacy and English language are adequate for good income and fulfilling employment

#### \*6. Legal

-2  -1  1  2  3

##### Legal Threshold

- 2. Current outstanding warrants or serious charges/trial pending; or noncompliance with probation/parole
- 1. Has criminal history which may negatively impact housing and employment opportunities (ex: sex offence conviction, arson, etc.)
1. Fully compliant with current probation/parole
  2. No active criminal justice involvement in more than 12 months
  3. No felony criminal history

#### \*7. Health Care

1  2  3  4  5

##### Health Care Threshold

1. No medical coverage, with serious, immediate need
2. Has difficulty accessing adequate medical care when needed; and/or no access to public programs; and/ or ignoring medical needs.
3. Household members attend to their medical needs, but may strain budget, and/or only use Emergency Room or walk-in clinics
4. Some household members (e.g. children) on Medicaid, Medicare, NJ Family Care, VA, ACA, etc.
5. All members are covered by affordable, adequate health insurance

### \*8. Life Skills

1    2    3    4    5

#### Life Skills Threshold

1. Unable to meet basic needs, such as hygiene, food, activities of daily living
2. Can meet a few but not all needs of daily living without assistance
3. Can meet most but not all daily living needs without assistance
4. Able to meet all basic needs of daily living without assistance
5. Able to provide beyond basic needs of daily living for self and family

### \*9. Mental Health

-2    -1    1    2    3

#### Mental Health Threshold

- 2. Experiencing acute mental health symptoms; danger to self or others; recurring suicidal ideation; and/or not in treatment; and/or in denial
- 1. Recurrent mental health symptoms that affect behavior, but not a danger to self/others; persistent problems with functioning ; in or out of treatment
  1. Symptoms may be present but are managed by treatment; moderate difficulty functioning
  2. Minimal symptoms that are appropriate responses to life stressors; only slight or no impairment in functioning
  3. Symptoms are absent or rare; good or superior functioning in wide range of activities

### \*10. Substance Abuse

-2    -1    1    2    3

#### Substance Abuse Threshold

- 2. Meets criteria for severe abuse/dependence; resulting problems so severe that institutional living or hospitalization may be necessary
- 1. Meets criteria for dependence; preoccupation with use and/or obtaining drugs/alcohol; evidence of withdrawal or withdrawal-avoidance behaviors; and/or use results in avoidance or neglect of essential life activities
  1. Use within last 6 months; evidence of persistent or recurrent social, occupational, emotional or physical problems related to use (such as disruptive behavior or housing problems); problems that have persisted for at least one month
  2. Client has used during last 6 months but no evidence of persistent or recurrent social, occupational, emotional, or physical problems related to use; no evidence of recurrent, dangerous use
  3. Stable in recovery with no drug use/alcohol abuse

### \*11. Family Relations

1  2  3  4  5

### Family Relations Threshold

1. Lack of necessary support from family or friends; abuse (DV, child) or child neglect are present
2. Family/friends may be supportive but lack ability or resources to help; and/or family members do not relate well with one another; and/or potential for abuse or neglect
3. Some support from family/friends; family members acknowledge and seek to change negative behaviors; are learning to communicate and support
4. Reliable support from family or friends; household members support each other's efforts, including financially
5. Building healthy/expanding support network; household is stable, communication is active and consistent

### \*12. Transportation/Mobility

1  2  3  4  5

### Transportation/Mobility Threshold

1. Transportation is not accessible, and/or not affordable; mobility is by walking
2. Reliant on others for transportation; inconsistent availability; may have car but non-functioning, and/or no insurance, license, etc.
3. Reliant on Disability Transport and/or bus tickets from agencies
4. Usually has reduced-fare access to minimal public transport, to meet the most basic travel needs
5. Has sufficient income for needed transportation; and/or reliable, adequately insured vehicle

### \*13. Community Involvement

1  2  3  4  5

### Community Involvement Threshold

1. No community involvement; avoids people; in "survival" mode
2. Socially isolated and/or no social skills; and/or lacks motivation to become involved
3. Lacks knowledge of ways to become involved; and/or does not take advantage of opportunities for socialization
4. Some community involvement (advisory group, support group) but has barriers such as transportation, childcare or psych issues
5. Actively involved in community

### \*14. Safety

-2  -1  1  2  3

### Safety Threshold

-2. Home or residence unsafe; immediate danger likely; and/or staying on street or in abandoned building, level of lethality is high.

-1. Safety is threatened/temporary protection is available; may be staying in Emergency Shelter or temporarily with friends

1. Current level of safety is minimally adequate; ongoing safety planning is essential
2. Environment is safe, yet future of such is uncertain; safety planning is important
3. Environment appears safe and stable

### Sub-total Score

0

Update Hudson County Assessment Matrix Section

COMPLETE ONLY FOR FAMILIES WITH ONE OF MORE CHILDREN UNDER AGE 18:

**\*Are you currently accompanied by one or more children under the age of 18? If not, please skip the remaining questions.**

yes  no

### 15. Childcare

1  2  3  4  5

Childcare Threshold

1. Needs childcare, but none is available/accessible and/or child is not eligible
2. Childcare is unreliable or unaffordable/ inadequate supervision is a problem for childcare that is available
3. Affordable subsidized childcare is available but limited
4. Reliable, affordable childcare is available/ no need for subsidies
5. Able to select quality childcare of choice

### 16. Children's Education

1  2  3  4  5

Children's Education Threshold

1. N/A
2. One or more eligible children not enrolled in school
3. One or more eligible children enrolled in school but not attending classes
4. Enrolled in school, but one or more children only occasionally attending classes
5. Enrolled in school and attending classes most of the time
6. All eligible children enrolled and attending on a regular basis

### 17. Parenting Skills

1  2  3  4  5

Parenting Skills Threshold

1. There are safety concerns regarding parenting skills
2. Parenting skills are minimal
3. Parenting skills are apparent but not adequate
4. Parenting skills are adequate
5. Parenting skills are well developed

**Section Sub-total**

0

Update Hudson County Assessment Matrix Section

**Final Self-Sufficiency Score**

0

**Notes**

[Empty text box for notes]

Spell Check

Update Hudson County Assessment Matrix Section

**Additional Vulnerability Questions**

**\*Have you ever been incarcerated in Hudson County?**

yes  no

**Have you had ten (or more) jail visits in the last five years?**

yes  no

**Have you had ten (or more) hospital visits in six months?**

yes  no

Update Hudson County Assessment Matrix Section

**Hospitalization History**

**Dynamic section content**

Update Hospitalization History

**How many times have you experienced homelessness in the past three (3) years?**

**Chronically Homeless?**

**Special Needs?**

SAVE Jump Back New Messages Help Menu Log Out

## **APPENDIX B Homeless Prescreening Tool**

# GSECDC Hudson CASA Coordinated Entry Program

## Homeless Prescreening Tool

Program: ..... Call  Walk-In  Day/Date: ..... Time: .....

Name: ..... M  F  MtF TG  FtM TG

Phone #'s: .....

Where did you hear about us? .....

What do you Need?: .....

Situation: .....

Where did you stay last night? .....

How long have you stayed there? .....

How long can you stay there? .....

How many in Family? Single Adult  Couple  Children  Children's Ages: .....

**Are you currently homeless?** Y  N  (*"Homeless" is defined as staying in a place not fit for human habitation OR a shelter OR a hotel/motel paid by a third party.*)

Where will you stay tonight? ..... **Need Shelter** for Tonight? Y  N

*(Intake is Indicated if s/he is currently OR imminently [i.e. within 14 days] at risk of being Homeless)*

You're not homeless today, but are you at risk of becoming homeless? Y  N

Do you have any Income? Y  N  Amount: \$ ..... PER: .....

Schedule (for making an appointment): .....

Are you or your spouse a veteran? Y  N  Are you unsafe: Y  N  How?: .....

Had an **Intake** with us before? Y  N  Program: ..... When? .....

Received Security or Rental Assistance from this agency before? Y  N  When? .....

DISPOSITION:

Appointment for Intake: Staff Name: ..... Date/Time: .....

Information Given: .....

Referred to Another Program: .....

Shelter Arrangement: .....

Staff: ..... Notes: .....

.....

.....

## **APPENDIX C Homeless Resource Guide**

## Do you need LEGAL Services?

If so, call these agencies for help:

Community Health Law Project for low income individuals with disabilities (201) 963-6295

Legal Services of NJ 1-888-576-5529

Northeast NJ Legal Services (201) 792-6363

The Waterfront Project (201) 308-3986

**TENANT/LANDLORD AND/OR FORECLOSURE COUNSELING**

Hudson County Housing Resource Center (201) 795-5615

Jersey City Division of Tenant Landlord Relations (201) 547-5127

North Hudson Community Action Corp. (201) 866-3140 for tenant & advocacy counseling

## Do you need FOOD?

If so, call these agencies for help:

### **Soup Kitchens**

**Hoboken Shelter** serves breakfast at 9am & lunch at 1:30pm daily & dinner at 7pm every night. (201) 656-5069, 300 Bloomfield St., Hoboken

**Let's Celebrate** serves hot breakfast at 8am on weekdays and lunch 11:30am – 1:30pm on weekdays. (201) 433-5438, 46 Fairview Ave., Jersey City

**PERC Shelter** serves dinner at 6pm every night (201) 348-8150, 111 37th St., Union City

**Salvation Army** serves lunch Wednesdays, Thursdays and Fridays at 11:45am (201) 867-4093, 515 43rd St., Union City

**Call 2-1-1 or 1-800-435-7555 to find food pantries & other food resources in your community**

## Other Resources

### **For people living with HIV/AIDS**

Canaan House (201) 434-3939

Franciska Residence (201) 653-3366

Garden State Episcopal Comm Dev Corp. (201) 604-2600 x0

Hudson County Housing Resource Center (201) 795-5615

Let's Celebrate (201) 433-5438

### **Domestic Violence**

Women Rising Domestic Violence Hotline (201) 333-5700

NJ Domestic Violence Hotline 1-800-572-SAFE (7233)

### **LGBTQ**

**Hudson Pride Connections Center** for LGBTQ & HIV is open 11am-8pm Mondays-Fridays & 2nd & 4th Saturdays monthly 12pm-6pm; 32 Jones St., Jersey City, (201) 963-4779

### **Employment Training**

**Hudson County One-Stop Career Center** is open on weekdays 8:30am-4:30pm; 530 48th Street Union City, (201) 369-5205 ext. 3736

**Jersey City One Stop Center** is open on weekdays 8:30am-4:30pm; 438 Summit Avenue, 1st Floor, Jersey City, (201) 795-8800



To connect with a caring professional who knows community resources, dial: **2-1-1 or 1-800-435-7555.**



# Hudson County Resources to Prevent &

# End Homelessness 2016



THE HUDSON COUNTY ALLIANCE TO END HOMELESSNESS

<http://www.hudsoncountynj.org/hudson-county-alliance-to-end-homelessness-headers>

The **Hudson CASA Coordinated Entry** provides centralized, focused access to Homelessness Services for Homeless Individuals & Families throughout Hudson County.

Services include comprehensive intake & assessment, as well as linkages to Case Management, Housing & Supportive Services.

Please call or visit

**Hudson CASA Coordinated Entry**  
514 Newark Avenue, Jersey City

Weekdays: 9am—4pm  
**201-604-2600 x0**

Or

**PERC Coordinated Entry**  
111 37th St., Union City  
Weekdays: 7am—3pm

## Do you need HOUSING / UTILITY FINANCIAL ASSISTANCE?

If so, call these agencies for help:

### HOMELESS PREVENTION FUNDS

Bayonne Economic Opportunity Foundation (BEOF) (201) 437-7222 x17

Catholic Charities (201) 798-9960 (*Priority given to Bayonne & Jersey City — Families Only*)

North Hudson Community Action Corp. (201) 210-0333 x22105

Garden State Episcopal Community Development Corp. (201) 604-2600 x0 (for Jersey City Residents Only)

Hudson County Welfare (201) 420-3000 x2064

### UTILITY ASSISTANCE

Bayonne Economic Opportunity Foundation (BEOF) (201) 437-7222

Energy Assistance Hotline NJ Shares (866) 657-4273

PACO (201) 217-0583

## Do you need BENEFITS?

If so, call these agencies for help:

Hudson County Welfare & SNAP (Food Stamps) (201) 420-3000

[www.nj.gov/humanservices/dfd/programs/nisnap/apply/](http://www.nj.gov/humanservices/dfd/programs/nisnap/apply/)

Social Security 1-800-772-1213

[www.socialsecurity.gov](http://www.socialsecurity.gov)

Unemployment (201) 601-4100

<http://lwd.dol.state.nj.us/>

Jersey City Health & Human Services, WIC (201) 547-6842 199 Summit Ave, Suite A, Jersey City; weekdays 7am to 4pm & some Saturdays 7am to 12pm. *Serves all Hudson County residents.*

## Do you need EMERGENCY SHELTER / HOUSING?

If so, call these agencies for help:

### EMERGENCY SHELTERS

#### Single Adult Men & Women

Hoboken Shelter (201) 656-5069

PERC Shelter (201) 348-8150

St. Lucy's Shelter (201) 656-7201

#### Youth 18-21

Covenant House (973) 621-8705

#### Women with Children

Hope House (201) 420-1070

St. Joseph's Home (201) 413-9280

Hudson County Division of Welfare Homeless

Hotline for Families 1-800-624-0287

*Available after 5pm & only used for emergencies*

## Do you need MEDICAL / MENTAL HEALTH Services?

If so, call these agencies for help:

Bridgeway Crisis Intervention Services (201) 885-2539, 152 Central Avenue, Jersey City

Medical & Social Services for the Homeless (MASSH) (201) 204-0040  
1825 John F. Kennedy Blvd., Jersey City

Metropolitan Family Health Network (201) 478-5800, 857 Bergen Ave., Jersey City  
*\*Ask for healthcare for the homeless*

North Hudson Community Action Corp. (201) 210-0200 for a medical or dental appointment

Jersey City Health & Human Services Immunization Clinic (201) 547-4743 199 Summit Ave., Suite G, Jersey City

## Do you need DROP-IN Services?

If so, call these agencies for help:

Covenant House for homeless youth is open Weekdays, 10am-5pm  
(609) 513-7373, 797 West Side Ave., Jersey City

Garden State Episcopal Comm. Dev. Corp. Hudson CASA Coordinated Entry is open 9am-4pm weekdays (201) 604-2600 x0 514 Newark Ave., Jersey City

Hoboken Shelter is open daily 9am-11am & 12-7pm. SHOWERS: 12pm-2pm daily (201) 656 5069, 300 Bloomfield St., Hoboken

Hudson County Self Help Center Drop-in services are available 9am-8pm weekdays & until 9pm on Thursdays; & 12pm-7pm on Saturdays, (201) 420-8013, 124 Claremont Ave., Jersey City

PERC Shelter Drop-in services are available from 7am-3pm. SHOWERS: 3pm-5pm on weekdays. (201) 348-8150, 111 37th St., Union City

St. Lucy's Shelter SHOWERS: 9:30am-11am on Tuesdays & Fridays (201) 653-3366, 619 Grove St., Jersey City

## Are you a Veteran?

If so, call these agencies for help:

Catholic Charities SSVF 1-855-767-8387

Community Hope / Hope for Veterans 1-855-483-8466

North Hudson Community Action Corp. SSVF (201) 366-8443

Soldier On 1-866-406-8449

Veterans Affairs 1-877-424-3838

Veterans Affairs Health Care Benefits 1-877-222-VETS (8387)

Veterans Affairs Outpatient Clinic (201) 435-3055

## **APPENDIX D HCAEH Consent Form**



**HUDSON COUNTY ALLIANCE TO END HOMELESSNESS**  
**830 BERGEN AVE, SUITE 5B**  
**JERSEY CITY, NJ 07306**

**CONSENT for RELEASE or EXCHANGE of INFORMATION**

The HCAEH is a consortium of agencies that work together to coordinate services and housing for homeless individuals and families throughout Hudson County. From time to time, agencies must collaborate to provide the most effective services to an individual or family.

This document, as executed by the individual below, authorizes the following agencies (“Agencies”) to release, exchange and discuss medical, housing, social, psychological, employment, education, progress and other information among each other concerning the participant named below for the purpose of shelter, housing and making appropriate referrals for other services. The sharing of this information will enable the Agencies to effectively work together in order to better assist you. *Services provided by the Hudson County Alliance to End Homelessness are not conditioned on you signing this authorization.*

**Agencies involved in the Release or Exchange of Information:**

- |   |  |
|---|--|
| Care Point Hospitals                                    | Garden State Episcopal Community Development Corporation       |
| Catholic Charities Archdiocese of Newark                | Hudson County Division of Housing and Community Development    |
| Community Hope  | Hudson County Department of Health and Human Services          |
| Collaborative Support Programs of New Jersey            | Hudson County Department of Corrections                        |
| Department of Veteran Affairs                           | Hudson County Prisoner Reentry Program                         |
| Hoboken Shelter   | Superior Court of New Jersey Criminal Division Hudson Vicinage |
| Jersey City Medical Center, a Barnabas Health affiliate | North Hudson Community Action Corporation – SSVF Program       |
| Metropolitan Family Health Network                      | Soldier On   |
| PERC Shelter  |  |

**List other agencies individual is involved with:**

---

I understand that all the information will be handled confidentially in compliance with the Federal Privacy Act (PL 930575). I understand I may revoke this consent at any time, except to the extent action has been taken in reliance thereon. I also understand that the above consent may be revoked at any time with my written communication to any of the listed agencies. This consent will expire in two years from the date of my signature as dated below or on the date of \_\_\_\_\_ if sooner.

*I understand that this consent allows all the above-listed Agencies, their employees and agents, to release and exchange any and all of my health information contained in my medical records under their control and in their possession. If my medical record contains information relating to HIV infection, AIDS or AIDS-related conditions, this disclosure will permit that information to be included. I acknowledge and am aware that New Jersey has a statutory privilege accorded to confidential communication between a patient and a licensed physician and that my signing this form waives this privilege. I also acknowledge that any information used or disclosed under the authorization may also be redisclosed and no longer protected by the Final Rule.*

The above listed Agencies shall treat all information with the utmost confidentiality, as previously.

**Name (Print):** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**HMIS PIN #:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Witness (Print):** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Name of Agency:** \_\_\_\_\_

**Date:** \_\_\_\_\_

## **APPENDIX E Continuum of Care Funded Program Entry Requirements**

Program Type	Program Name	Eligibility Criteria
<b>Permanent Housing</b>	Catholic Charities- Canaan House	Homeless men, women or families with HIV/AIDS and either a substance abuse or psychiatric history.
	Catholic Charities- St. Jude's Oasis	Homeless families with children. Households of at least 4. One family member must present a disability.
	Hoboken Shelter PSH S+C/JCHA	Chronically Homeless Individual Adult with Disability of Mental Illness &/or Substance Abuse. Must be able to live independently in their own apartment with supportive services.
	GSECDC Corpus Christi Ministries	Permanent supportive housing for homeless individuals and families with at least one member of household HIV positive and disabled. Must be able to live independently with supportive services. One of the properties (8 units) is fully handicapped accessible, but others have stairs. Client pays 30% of income towards rent.
	GSECDC Home at Last	Chronically homeless individuals (8) and families (2). Must be able to live independently in their own apartment in the community with supportive services. Client pays 30% of income towards rent.
	PERC/GSECDC Shelter Plus Care	Chronically Homeless individuals (10) with mental health or substance use diagnosis/disability. Must be able to live independently in their own apartment with supportive services.
	GSECDC- RIST Program	Individuals with diagnosis of Severe Mental Illness who are homeless in the community (33 slots) or being discharged from Greystone Hospital on CEPP status (5 slots). Must be able to live independently in community apartment with intensive supportive services. Individual pays 40% of income towards rent.
	United Way- Collaborative Solutions PH	Chronic Homelessness with Disability. Individuals residing in shelters or living on the streets will receive priority for housing assistance. Potential applicants may only be referred by a shelter, non-profit or government agency. Applicants with substance abuse issues should be in recovery or in treatment programs
	United Way- Live United	Chronically homeless families with a disability.
	United Way- Life Starts	Chronically homeless individuals that have a disability. Works in partnership with CSP, MASSH, GSECDC and Covenant House.
	Youth Consultation Services- Shelter plus Care	Permanent supportive housing for homeless youth with a disability
	WomenRising	Permanent supportive housing for 20 chronically homeless families with a disability.

<b>Program Type</b>	<b>Program Name</b>	<b>Eligibility Criteria</b>
<b>Rapid Rehousing</b>	North Hudson Community Action Corporation	Literally homeless from street or shelter. 6 months- 1 year program
	Covenant House	Literally homeless from street or shelter. Youth age 18-14
	York Street Project	Literally homeless from street or shelter. Long-term RRH
	Garden State Episcopal CDC	Literally homeless from street or shelter- short term up to 4 units of assistance
<b>Program Type</b>	<b>Program Name</b>	<b>Eligibility Criteria</b>
<b>Transitional Housing</b>	Catholic Charities- Franciska Residence	Homeless single men with HIV/AIDS.
	Catholic Charities- Strong Futures	Youth aging out of foster care/ homeless youth
	EMET- Transitional Housing	Referrals are taken from welfare, parole, Garden State Episcopal and the Hudson County Community Re-integration Program.
	NHCAC Temporary Housing Program	Homeless single individuals and/or families. The income requirement for an applicant is 150% of the poverty guideline, and they cannot be receiving GA, TANF, or SSI.
	The House of Faith Inc.	Homeless adult, living conditions not mean for humans or ask to leave a shared residency, released from rehab, jail. Employed 35 to 40 hours. Need a referral from a shelter or other social agency (jail, rehab etc.) or a notarized letter stating what their circumstances are. Appointment is given to the consumer for the first interview. At the time of the interview, the consumer must have the following documentations: A letter from the shelter, with the date that you started staying there. A notarized letter if the referral was made by the consumer, and what their circumstances are. A picture ID, and Social Security Card. If the consumers are coming from a correctional facility their release papers and a referral from their case worker. Three most resent pay stubs. The consumers TB test results.

Program Type	Program Name	Eligibility Criteria
<b>Emergency Shelter</b>	Catholic Charities- Hope House	Homeless women with children. Women who are at least 7 months pregnant with no other children are also accepted. Now accepting families with boys up to 17 years old
	Catholic Charities- St. Lucy's Shelter	Homeless men and women 18 years of age and older who are capable of self-care meaning the person/s can eat, dress, toilet and perform personal hygiene activities without assistance. Women who are more than 6 months pregnant are not accepted.
	Hoboken Shelter	Homeless Individual Adults who are capable of self-care. Therefore, the person(s) must be able to eat, dress, toilet, shower, and perform personal hygiene activities without assistance. We prioritize Hoboken Residents 1st, Hudson County Residents 2nd, & New Jersey Residents 3rd, & all others 4th. We implement a Sobriety Rule & prohibit any Violent Behavior. We will not provide shelter to Sex Offenders.
	TANF / GA Assistance- Hudson County Department of Family Services	Must meet WFNJ TANF, General Assistance or SSI eligibility requirements.
	Motel Placements- NHCAC	SSH income guidelines apply. Clients must be homeless and do not have the resources to pay for shelter.
	PERC Overnight Drop In Center	Homeless men and women 18 years of age and older who are capable of self-care meaning the person/s can eat, dress, toilet and perform personal hygiene activities without assistance. No sobriety requirement. We provide shelter on day to day basis.
	PERC Shelter	Homeless men and women 18 years of age and older who are capable of self-care meaning the person/s can eat, dress, toilet and perform personal hygiene activities without assistance. We then prioritize Union City residents 1st, Hudson County residents 2nd, and New Jersey residents 3rd. We provide shelter only to those clean and sober. We do not provide shelter to those with history of sexual offense, pyromania, or arson.
	PERC Family Shelter	Homeless families with two or more children. Caregivers must be able to maintain independent living.
	WomenRising- Domestic Violence Shelter	Victims of Domestic Violence who are in <b>immediate danger</b> .
	St. Joseph's Home	Homeless women with children.