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**St. Louis County Coordinated Entry System**

**Policies and Procedures**

As of February 17, 2022

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**IMPLEMENTATION AND PLANNING**

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The St. Louis County Continuum of Care Advisory Committee is the management entity for the SLC CoC Coordinated Entry System (CES). The Advisory Committee has established a Housing Response Committee which supports CES planning for the St. Louis County Continuum of Care (CoC). This committee consists of a chair and fifteen voting members representing various sectors of the CoC. Meetings are held monthly.

St. Louis County CoC acknowledges the limited resources to manage a CES. The Advisory Committee is committed to identifying potential resources to support infrastructure for the CES. Resources will be sought on behalf of the CES, as a whole, to support a regional operation of the CES and targeted to households experiencing homelessness or at risk of becoming homeless.

Communication about CES policies, management decisions, and performance results will be communicated broadly through various forms to clients, stakeholders, broader community, and as needed.

All clients will have fair and equal access to the system. SLC CoC first adopted the state strategic vision, guiding principles, and values on October 16, 2015.

Policies and Procedures for the CES must be in alignment with Minnesota and HUD CES policies and procedures. These policies and procedures must be approved by the Advisory Committee.

SLC CoC will identify barriers to operating the CES as a region. Concerns and issues will be brought to the Coordinated Entry Priority List Manager(s) and/or the Housing Response Committee (HRC) and then addressed at the monthly HRC meeting. Barriers will be addressed either regionally or locally depending on best solution. The strategy used to address local barriers will be shared and documented through the HRC meeting minutes.

CES is the system to access housing for all households throughout St. Louis County experiencing homelessness or at risk of becoming homeless. Housing programs must comply with HUD, state and local priorities for filling of units. CES does not exclude any household from seeking assistance through the CES.

**MARKETING/ EDUCATION AND TRAINING**

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SLC CoC will market the CES. Strategies include aggressive repeated marketing and communication:

1. Ensuring CES contact numbers are updated in commonly used resource guides (i.e. 211 and Handbook of the Streets)
2. Targeting non-housing provider groups who may encounter households experiencing homelessness
	1. Hospitals/Clinics
	2. Law enforcement
	3. Faith communities
	4. Mental Health providers
	5. Schools
	6. Employment and training providers
	7. Treatment centers

CES will ensure and support ongoing trainings related to the CES. Trainings will be made available to the following groups:

1. Access Points and Assessors
	1. Training check list
	2. Job description
	3. Script for conducting VI SPDAT
	4. Policies and procedures
	5. Long term homelessness and chronic homelessness definitions
	6. Other trainings as deemed necessary / helpful; i.e. Trauma Informed Care
2. Housing Providers
3. Stakeholder groups (how to access the system)
	1. Law enforcement
	2. Health care providers
	3. Faith communities
	4. Local government entities

**SLC CES COORDINATED ENTRY STEPS**

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1. **Step 1: Housing Assistance Pre-Screening** -

**Attachment 1:** Job description and Script

* 1. Households experiencing homelessness or at risk of homelessness contact 2-1-1 for a pre-screen via:
		1. Calling 2-1-1 or **1-800-543-7709**
	2. Pre-screen assessors utilize the Pre-Screen tool to determine level of need and ensure household safety and security protections are addressed expeditiously.
		1. Victims of domestic violence are referred immediately to advocacy programs for victims of domestic violence.
	3. Determine if household is experiencing homelessness, in need of services to maintain housing (prevention), in need of emergency shelter or other resources.
	4. Determination is made that client can be diverted from homelessness through alternative methods – household diversion will be tracked and the process in the CES will end.
	5. Household is determined at risk of homelessness but able to maintain housing with some assistance, household will be connected to the prevention door.
	6. If household is determined homeless or not able to maintain housing even with assistance, pre-screen assessor will schedule an assessment appointment with an Assessor in the household’s local geographic region via Google calendar.
1. **Step 2: Assessment** - Assessor

**Attachment 2**: Job description and Script

* 1. The VI-SPDAT is the common assessment tool used throughout the SLC CoC. The common assessment further includes supplemental questions – all of which are in the St. Louis County CES in the Homeless Management Information System (HMIS). This assessment assists in determining housing needs.
		1. All assessors will use the protocol established by OrgCode to administer the VI-SPDAT.
		2. Standard script will be used prior to administration of the VI SPDAT by all Assessors
		3. All Assessors will enter each household into the SLC CE project in HMIS, so long as household provides consent.
		4. Assessors will provide a CES receipt to each household upon completion of the assessment. The receipt includes name and contact information of the assessor.
		5. Assessors will provide household with a list of documentation they may begin to gather to expedite housing.
		6. The assessor will make a warm referral to programs assisting with applying for disability benefits or to employment services as appropriate.
		7. If a household remains on the Prioritization List for 45 days and the Assessor attempts to contact them 3 times (at least one time around but after the first of the month), after that time the Assessor will exit the client from the Prioritization List and close them out in HMIS.
		8. When a household obtains housing, the Assessor will exit the household from the CES provider in HMIS.
	2. Household receives a numerical score that suggests the type of housing that will best fit the household’s needs.
		+ 1. If the assessment score is deemed to be not indicative of level of service needed, the assessor or case manager may advocate for a scoring adjustment with the placement team at the Tuesday morning meetings either in Duluth or on the Iron Range – dependent on household location.
	3. Documentation collected from the client at this stage in the CES process is:
		+ 1. The VI-SPDAT and additional questions and score
			2. HMIS data privacy release signed
			3. Community releases of Information
	4. Client receives the following:
		+ 1. Receipt
			2. Assessor contact information
			3. Information on how to submit a grievance
			4. Verification checklist
			5. Referral to agency to assist with applying for disability benefits and/or employment and training services resources.
1. **Step 3: Priority List management**

**Attachment 3:** Job description and Script

* 1. The priority lists will be located and maintained by the following:
		1. City of Duluth – HRA of Duluth
		2. Iron Range – Kanerva Consulting, LLC
	2. Housing priority list manager will:
		1. Pull prioritization list from HMIS.
		2. Track households outside of HMIS as appropriate. Some examples may include:
			1. Victims of Domestic Violence who chose not to share their information or if residing at a DV shelter
			2. Households who do not sign the HMIS consent or refuse to share their information in HMIS.
		3. Share relevant priority list information with meeting attendees for weekly provider meetings.
			1. Relevant priority list information includes:
				1. Client ID #
				2. Date of assessment
				3. Homeless status of the client (Chronic, LTH, HUD Homeless, MN Homeless)
				4. Relevant sub-population information to determine housing placement
				5. Assessment score
				6. Assessment score prioritization (RRH, TH, PSH, etc.)
		4. Provide referrals off the Prioritization Waitlist for housing openings as available.
		5. Communicate with other waitlist managers – both within and outside of the St. Louis County Continuum of Care - when clients are being referred.
	3. All households who complete a VI SPDAT will be placed on the Prioritization list.
		1. Each Assessor will be responsible for the household whom they assessed.
			1. If the Assessor is unable to contact the consumer with 3 attempts being made in 45 days, at least one of which was shortly following the first of the month, the consumer will be exited from the CEs wait list.
			2. The Assessor will be responsible for exiting households from the CES in HMIS when they have procured housing.
	4. Each region (Northern & Southern SLC) will utilize the same Prioritization List format that contains the following information:
		1. Client ID #
		2. Client age
		3. Agency name
		4. Interviewer name
		5. Date of assessment
		6. Homeless status of the client (Chronic, LTH, HUD Homeless, MN Homeless)
		7. Assessment score
		8. Assessment score determination (RRH, TH, PSH, etc.)
		9. Program specific criteria (Program specific criteria as need for placement)
			1. This list may be tailored for each region within St. Louis County CES
	5. All Clients will be placed on the priority list and will be ranked by their score and the assessment date. The highest scores will be highest on the list. If two people have the same score, they will be placed on the list in the order that they were assessed.
	6. Chronically homeless households with disabilities will be prioritized. This document prescribes the following order for PSH prioritization:
		1. Order of Priority in dedicated/prioritized PSH
		2. Order for non-dedicated/prioritized PSH
		3. If the household does not score for PSH the Case manager must explain to the placement committee why they feel the household needs PSH.
		4. TH program participants who are reassessed and score at a PSH level will be prioritized for PSH at the agency where they are currently being served. (this does not exclude participant from other PSH opportunities – client choice)
	7. Weekly case conferencing meetings:
		1. Prioritization list is reviewed by identifier update – if no update, follow up takes place
		2. If score adjustment needed, come to weekly meeting
		3. Fill vacancies
	8. Veterans will be prioritized as follows: If Coordinated Entry Scores two households identically in terms of acuity and one household is a Veteran household and the other is not, the Veteran household should be served first. A Veteran, for CES purposes, will be defined as qualifying after a single day of federal Active Duty service, including Active Duty for Training, regardless of type of discharge. Note that this definition includes many people who do not meet the federal definitions used for most Veteran benefit programs and is also much broader than the state definition of Veteran.
	9. If a client is on the priority list but has a significant life event the client should be reassessed at that time.
	10. If one household splits into multiple households, and separated members need to be assessed as individuals for the first time, the original prioritization date should be used for the new assessment.
	11. Residency – Households should be assessed in the area of residency or the area where they are homeless.
		1. Households should be placed on the priority list in the area where they are assessed unless they want to move to a different community and need to be on that priority list.
			1. The assessor completes the Assessment and enters information into HMIS choosing area household would like to reside. If outside of St. Louis County CoC, the priority list manager will make referral to the other priority list manager as appropriate. Based on differences in assessment tools, the consumer may need to go through the assessment process in the CoC where they wish to reside.
		2. Victims of Domestic Violence or Sexual Assault that choose to access the Coordinated Entry system may be placed on the priority lists of their choice where they believe they may be able to safely live.
			1. When a household who is on Duluth and Iron Range priority lists is accepted to a program, the other priority list holders will be notified if on list maintained outside of HMIS.
		3. If a household needs to be on a priority list in a non-SLC CoC region, the priority list manager should make every attempt to work with that region to ensure a successful referral to that region’s priority list.
	12. When an opening is made available, the housing program will be referred the top scoring households for the household type.
1. **Step 4: Referral to Housing Providers**
	1. Local Communities will participate in weekly meetings to review the priority list and seek openings for those seeking housing. Those present for these meetings will include:
		1. Local Coordinated Entry committee/Placement team (Access Point / Assessors)
		2. Providers
		3. Priority list manager
	2. During the meetings, providers will announce their housing openings and the group will seek clients from the priority list that fit those openings.
		1. Further discussions may include:
			1. Alternative housing options
			2. System issues
			3. Review complex client issues as needed.
			4. News/updates
	3. The referral will be made in HMIS. For consumers on the list maintained outside of HMIS, the Assessor will send the provider the following documents in order to facilitate the referral to a program:
		1. VI-SPDAT
		2. Any pertinent signed releases of information
		3. Signed HMIS Data privacy document
	4. If no potential clients exist on the priority list, and no potential clients can be found within 30 days of the opening being reported by the provider, the provider must seek clients in another region if the program is able to serve clients from outside of their county.
	5. Housing Provider will contact referred client for formal program intake process and collect necessary documentation to determine ultimate eligibility for their program.
		1. At times, the original assessor may need to assist the provider in communicating to the client that they are being referred to a housing program.
		2. *Client Choice and Assignment Refusal* – See below.
	6. The housing provider will make every attempt to contact the referred household. Provider will document all attempts including contacting emergency contacts.
		1. Client contact should be attempted at least 3 times over the course of 3 business days. Then attempts to communicate with secondary contacts may be used.
		2. Provider will collect all required documentation to ensure eligibility at the time of their intake.
		3. The goal is to meet with the client and enroll or deny them as quickly as possible and within an average of 15 days of initial client contact.
	7. Provider denial – It is understood that all client referrals will be accepted by the provider. If a provider wishes to deny a referral they may do so to the local placement team for consumers on the list maintained outside of HMIS or for referrals done in HMIS through the coordinated entry event), noting one of the following legitimate reasons:
		1. Client does not meet the program funder’s eligibility criteria.
		2. Client cannot be reached within 10 days of the referral being made to the program.
		3. Client is not following through with the referral process after initial contact.
		4. Client cannot locate Scattered Site housing within time frame required by the program.
		5. Agency does not have the capacity or expertise to meet a client’s disability needs and a service partnership is not currently available.
		6. Conflict of interest.
	8. Referred household will be accepted into the housing program if found appropriate and eligible for program.

**CLIENT CHOICE, ASSIGNMENT REFUSAL, PROGRAM CRITERION AND GRIEVANCE PROCESS**

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1. SLC CoC requires that LTH Housing Support programs fill vacancies through the Coordinated Entry System. As of March 1, 2022 for a one year pilot project, LTH Housing Support programs will be required to fill only 50% of their vacancies through the CES. When filling outside of the CE referral process, the LTH provider shall contact the priority list manager in their region with the name of the consumer moving into their program. If the household is on the priority list, the Priority List Manager will send a referral in HMIS. However, this counts as a household filled outside of the CES.
2. When the Priority List Manager matches an opening with the next household on the list, a referral will be made for that household through HMIS. (Refer to HMIS referral process). For consumers on a list maintained outside of HMIS, the Priority List Manager will request that the assessor forward the information to the agency with the opening. After the program has accepted the household, the assumption is that the household will accept the referral and move into that program.
3. If the client chooses not to accept the referral for good cause, they will be placed back on the priority list in the same position as they had been prior to referral. Good cause is individual and is to be discussed at the weekly meeting.
4. At assessment, the assessor does their best to determine if the household meets “chronic” or “long term homelessness”. When a referral is done to a program requiring the household meet the chronic definition of homelessness and is than determined to not meet the definition when a timeline is completed, the program will still be able to enter the household into their program.
5. If a client is referred to a program, is accepted to that program, but then cannot find an apartment that will accept them within the appropriate time frame allowed by the program’s requirements, they may be placed back on the priority list in the same position as they had been prior to referral – following the weekly meeting and review of the cause.
6. If the client is in shelter, they must always be informed that refusing a referral to a housing program could result in them being asked to leave shelter depending upon the shelter’s policies.
7. Clients in Transitional Housing who wish to transfer to PSH within the same agency may do so without another assessment or being placed on the waiting list. Case manager must provide documentation of increased need that makes them eligible for PSH.
8. Program criterion:
	* 1. HUD funded programs may establish requirements for programs and preferences for programs. If the program is not able to fill vacancies for their targeted requirements as outlined above, the program may reduce some requirements to stay within the framework of the targeted consumers. Some examples may include: housing programs that target age 55+ and chronic, programs for youth, etc. These programs may choose to accept households that stay within the targeted age group but do not meet chronic definition of homelessness. This criterion generally applies to those programs that are focused on a specific subpopulation. This need to be communicated to the SLC CoC Coordinator and HUD. This is ONLY done if there are not enough households seeking assistance to fill the units with the targeted criterion.
9. If a client has concerns with any part of the Coordinated Entry process they have the right to submit a grievance form. Instructions on how to start the grievance process are provided at initial assessment. The grievance process is as follows:
	* 1. Client requests a grievance form from the Assessor. If there are significant concerns with the Assessor, the client may request a form from any of the Access Points within the SLC CoC.
		2. Client completes grievance form and submits form to Access Point they received the form from.
		3. Access Point brings the grievance form to the weekly meeting
		4. Weekly team meeting attendees review the grievance within 10 business days of receipt and decide on any resulting action.
		5. Weekly team meeting chair informs the Access Point of their decision and action steps.
		6. Access Point communicates weekly team decision and action steps to the client.

**Weekly Team Meeting**

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* 1. Participate in weekly provider calls/meetings to ensure that policies and procedures are being followed while referrals are being made.
	2. Meet at least quarterly to discuss overall functions of Coordinated Entry and determine if changes need to be recommended to the St. Louis County Continuum of Care Advisory Committee.
	3. Be available to consult regarding difficult placement decisions, denied referrals, client refusals and other related issues.

**MEETINGS**

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1. Local Provider meetings/phone calls – Weekly
2. Local CE committee meetings – As needed
3. SLC CES meetings – monthly
4. Statewide Priority List Manager meeting - quarterly

\*SLC CES will work to have specialized populations part of meetings that will inform the planning and evaluation of the CES. If specialized populations are unable to participate in meetings SLC CoC will solicit input from these groups outside of the meeting forum for use in planning and evaluation.

* + Veterans
	+ Domestic Violence
	+ Youth

**HOUSING PROVIDER**

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1. Housing providers who are taking referrals exclusively from the CES will have a signed MOU on file with St. Louis County.
	* 1. Housing provider definition of housing program and eligibility will be attached to the MOU

ADDITIONAL ATTACHMENTS

1. **Attachment 4 -** HMIS Release of Information
2. **Attachment 5 –**

**Attachment 1 – Access Point Description and Script**

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| --- |
| **JOB SUMMARY – PRE SCREEN** |
| Coordinated Entry point for the St. Louis County CoC. This entry point will be marketed broadly and provided to HUD as 1st step in accessing housing throughout the St. Louis County region. Pre-screen provider will use Governing board approved Pre-screen tool and enter all data collected into a database. In addition to pre-screen data, Governing board approved phone call in data will be collected and entered into the database.Data base pre-screen and phone data will be sent on the 1st day of each month to City/County identified staff persons.Attend regularly scheduled meetings to discuss system process, review of what is going well and discussion on improvement to be made.  |

***ESSENTIAL FUNCTIONS***

1. Use standard script and questions provided by SLC CES committee to solicit “just enough” information from callers to determine if the housing crisis is Diversion, Prevention or Homeless.
2. Refer Prevention households to the Prevention door in their region.
3. Schedule the household experiencing homelessness for an Assessment at an Assessor Agency in their area via Google calendar.
4. Follow ALL CES policies/procedures posted.
5. Ensure data tracking requirements are met including Pre-screen data and homeless call data reporting. Provide reports on 10th of each month to City/County assigned staff persons. .
6. If issues arise, please e-mail all of the following (at minimum):
* *Priority List Managers (north and south)*
* *St. Louis County CoC Coordinator*
1. Assume other duties as assigned

**Attachment 2 – Assessor Description & Script**

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| --- |
| **JOB SUMMARY - ASSESSMENT**  |
| Provide weekly availability via Google calendar to conduct coordinated entry assessments for individuals/families experiencing homelessness to identify housing barriers and to determine the type and level of housing that would be the best fit. Implement case conferencing at weekly meetings when assignments are in question. Responsible for assisting with obtaining verifications that may be needed to meet provider eligibility criteria. Communicate frequently with providers ensuring eligibility criteria are accurate and assignments are effective. Work closely with the Duluth and Iron Range priority list managers. Be mobile working across a variety of sites. Responsible for client data tracking and entry into HMIS. Keep abreast of changes in the field and research new methods of service delivery. Attend weekly meetings in your geographic region to review households experiencing homelessness and address issues within the Coordinated Entry System. This position is an essential component of the St. Louis County Continuum of Care Coordinated Entry System (CES) and participates in regular CES communication processes and program evaluation. |

***ESSENTIAL FUNCTIONS***

1. Ensure the Assessor has completed the components of the training checklist.
2. Ensure the Assessor has a strong working knowledge of state and federal definitions of homelessness including chronic, long term etc..
3. Keep up to date agency availability weekly on google calendar to conduct VI SPDAT tool and CES provider HMIS universal elements.
4. Provide standardized assessments (VI SPDAT (singles), VI SPDAT (family), or VI SPDAT (youth).
5. Maintain productive relationships with all CES partners, housing providers and funders. .
6. Provide leadership in communication between the CES and providers to ensure program efficiency and effectiveness. Stay well informed around provider eligibility criteria and referral processes.
7. Ensure appropriate data is entered into HMIS or sent to the Prioritization waitlist holder if household will not be entered into the St. Louis County CES in HMIS.
8. Work with HMIS CES program to ensure accurate data entry.
9. Ensure the program significantly and consistently contributes to the positive community culture that promotes learning, diversity, problem solving, resourcefulness, accountability and excellence in serving homeless households.
10. Assume other duties as assigned.

**Assessor:**

**Phase 1: Introduction (agency and VI SPDAT)**

Hello, my name is [interviewer name] and I work for [organization name].

*To determine your eligibility for homeless services, I would like to assess your housing and service needs. If you give me permission, I will ask you questions about your health and housing. The assessment will take about 15 minutes. Some of the questions will ask personal questions, but only require yes or no answers. The questions are not intended to judge you, but to assess your current needs and eligibility for services. If you ask, I can clarify or you can decide not to answer a question. If you do not answer a question, no one will be upset with you. However, this information is important to help determine if you qualify for services. Skipped or inaccurate answers may affect your eligibility. It will benefit you to answer as honestly as possible, especially since we may need to verify some of your answers later.*

**Phase 2: HMIS Release of Information (ROI)**

Assessor will use the HMIS Release of Information script –

**Phase 3: HMIS – SLC CES**

Assessor will enter client in HMIS into the SLC CES

**Phase 4:** **VI SPDAT**

Administer tool based on household (VI SPDAT singles/VI SPDAT family/VI SPDAT youth) into HMIS.

**Phase 4: Thank you – Q/A**

Thank you for completing the Assessment with me today. Do you have any additional questions? It is important that you keep in contact with me. My information is on the bottom of the receipt.

 Additional:

 Provide verification checklist

 Provide housing applications for mainstream resources and mainstream housing as appropriate

**Attachment 3 - Prioritization List management description**

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| --- |
| **JOB SUMMARY** |
| Provide priority list information, on a weekly basis to the providers in order to fill vacancy and obtain updates on households experiencing homelessness. Communicate frequently with providers ensuring eligibility criteria are accurate and assignments are effective. Be mobile working across a variety of sites. Responsible for client data tracking. Keep abreast of changes in the field. This position is an essential component of the St. Louis County Continuum of Care Coordinated Entry System (CES) and participates in regular CES communication processes and program evaluation.Work closely with HMIS users and ICA. Submit appropriate referrals when a vacancy occurs. |

***ESSENTIAL FUNCTIONS***

1. Work closely and collaboratively with determined entry points Duluth and on the Iron Range to expeditiously fill program vacancies.
2. When notified of a vacancy, send appropriate referrals with highest acuity.
3. Work closely with the Heading Home St. Louis County Governance Board, Pre-Screen agency, Assessor agencies, housing providers and general community.
4. Develop and update the referral processes when recommendations are approved by the HHSLC Governance board.
5. Maintain productive relationships with all CES partners.
6. Maintain communication between the CES, housing providers, and City/County staff to ensure program efficiency and effectiveness. Ensure wait list data tracking requirements are met. Provide wait list reports as needed to City/County staff for review.
7. Work with CES committee for program evaluation, progress and goals
8. Ensure the program significantly and consistently contributes to the positive community culture that promotes learning, diversity, problem solving, resourcefulness, accountability and excellence in serving homeless families
9. Assume other duties as assigned