Tehama County Continuum of Care
Coordinated Entry Policies and Procedures

Version 2.0 | December 8, 2021

Version History

Version	Approval Date	Change Notes
1.0	October 28, 2015	N/A
1.1	September 9, 2016	• Included new HUD CE requirements • Added Prioritization guidance • Updated Assessment Access guidance
1.2	September 27, 2018	Updated Assessment Access guidance
1.3	September 25, 2019	No changes; updated as part of overall Policies and Procedures Manual
2.0	December 8, 2021	• Substantial updates per CES Workgroup recommendations • Substantial formatting changes • Included new HUD CE requirements • Added information relevant to the State of California's No Place Like Home Program • Updated Assessment Aging and Update procedures • Updated Access Points

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Introduction and Overview

1. Purpose of Coordinated Entry

Coordinated entry (CE) is a process developed to ensure that all people experiencing a housing crisis have fair and equal access and are quickly identified, assessed for, referred, and connected to housing and assistance based on their strengths and needs.

2. Guiding Principals

The Tehama County Continuum of Care (Tehama CoC) hereby establishes the following guiding principles for its CE:

a. The CE will operate with a person-centered approach, and with person-centered outcomes.

b. The CE will ensure that participants quickly receive access to the most appropriate services and housing resources available.

c. The CE will reduce the stress of the experience of being homeless by limiting assessments and interviews to only the most pertinent information necessary to resolve the participant's immediate housing crisis.

d. The CE will incorporate cultural and linguistic competencies in all engagement, assessment, and referral coordination activities.

e. The CE will implement standard assessment tools and practices and will capture only the limited information necessary to determine the severity of the participant's needs and the best referral strategy for him or her.

f. The CE will integrate mainstream and community-based service providers into the system wherever possible.

g. The CE will utilize HMIS for the purposes of managing participant information and facilitating quick access to available CoC resources.

h. The CE will strive to ensure that participant information stored in the CE is accurate and up-to-date to allow for appropriate prioritization and connection to resources.

3. CE Participation Expectations

All CoC Program- and ESG Program-funded projects are required to participate in the local CE. The CoC still aims to have all homeless assistance projects participating in its CE process and will work with all local projects and funders in its geographic area to facilitate their participation in the CE.

4. CoC and ESG Coordination

The CoC is committed to aligning and coordinating CE policies and procedures governing assessment, eligibility determinations, and prioritization with its written standards for administering CoC and ESG Programs funds.

5. Full Geographic Coverage

The CoC's CE process covers the CoC's entire geographic area.

6. Affirmative and Equitable Access

All persons participating in any aspect of CE such as access, assessment, prioritization, or referral shall be afforded equal access to CE services and resources without regard to a person's actual or perceived membership in a federally protected class such as race, color, national origin, religion, sex, age, familial status, or disability. Additionally, all people in different populations and subpopulations in the CoC's geographic area, including people experiencing chronic homelessness, veterans, families with children, youth, and survivors of domestic violence, shall have fair and equal access to the coordinated entry process.

7. Safety Planning and Risk Assessment

All persons who are fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking shall have immediate and confidential access to available crisis services within the defined CE geographic area.

8. Nondiscrimination

The CE system and its participating projects must adhere to all jurisdictionally relevant civil rights and fair housing laws and regulations. Failure to comply with these laws and regulations will result in a monitoring finding on the project, which may affect its position in the local CoC rating and ranking process and eligibility for funding administered by the CoC.

a. Fair Housing Act – prohibits discriminatory housing practices based on race, color, religion, sex, national origin, disability, familial status or age. This includes prohibiting housing providers from influencing, limiting, or steering participants to particular referral options based on perceived ability.

b. Section 504 of the Rehabilitation Act – prohibits discrimination on the basis of disability under any program or activity receiving federal financial assistance.

c. Title VI of the Civil Rights Act – prohibits discrimination on the basis of race, color, or national origin under any program or activity receiving federal financial assistance.

d. Title II of the Americans with Disabilities Act – prohibits public entities, which include state and local governments and special purpose districts, from discriminating against individuals with disabilities in all their services, programs, and activities, which include housing and housing-related services such as housing search and referral assistance.

9. Roles

Tehama CoC Executive Council	The governing body responsible for the general oversight of the CoC, including the CE system and approval of the CE Policies & Procedures document.

CE Coordinating Entity	Tehama CoC's CE Coordinating Entity is Empower Tehama. Empower Tehama's role in the CE system includes acting on behalf of the CoC in matters concerning the CE and overseeing the day-to-day operations of the CE system, including serving as the system administrator for the CE database, maintaining the Community Queue, monitoring CE activity, and preparing CE monitoring and evaluation reports.
Coordinated Entry System (CES) Workgroup	Coordinating body made up of representation from the CE Coordinating Entity, CE participating agencies, CE entry points, and other relevant stakeholders.
Participating Project	Agencies or organizations that operate one or more projects that have agreed to refer participants into the CE and/or receive referrals from the CE to fill vacancies within their projects. Participating projects may be homeless service providers, mainstream service providers and other community providers.

Access

1. Access Model

The CoC has adopted an enhanced "no wrong door" approach to CE. This approach ensures that persons experiencing homelessness can enter the CE system through participation in the same standard assessment whether they choose seek services from a participating homeless assistance provider or to enter the CE without accepting other services.

2. Access Coverage

The CoC's entire geographic area is accessible to CE processes either through location-specific access points or through the 211 Tehama community information and referral hotline. The 211 Tehama hotline provides access to basic CE intake services and referrals to other community resources 24 hours a day and can be contacted from any location within the CoC.

3. CE Entry Points

a. **211 Tehama serves as the CE's primary entry point.** Live assistance with identifying and accessing emergency services is available 24/7 through 211 Tehama. Telephone access to the CE assessment is available during most hours through 211 Tehama but is dependent on availability of Call Specialists trained to administer the assessment. When a trained call specialist is not available, 211 Tehama will coordinate with callers to facilitate access to the CE assessment within 24 hours or at the convenience of the caller.

b. **Providers of homeless assistance services, mainstream services or other community-based services** may offer CE assessments either as an "a la cart" service without requiring participants to enroll in any other service in order to access the CE assessment, as part of intake and/or participation in existing programs, or both.

c. Providers for whom conducting assessments on-site and entering data directly into the CE system is **prohibited by law or poses a safety or other risk** to program participants may opt to provide participants with information on accessing CE assessments through 211 Tehama and should, if needed, provide access to a telephone with which to contact 211 Tehama to undergo assessment.

4. Accessibility of Access Points

The CoC will ensure that CE services are physically accessible to persons with mobility barriers. All CE communications and documentation will be accessible to persons with limited ability to read and understand English.

Tehama CoC and CE participating projects will, to the greatest extent practicable, make CE materials available in English, and Spanish and provide communication accommodation through translation services to effectively and clearly communicate with persons who have disabilities, as well as with any person with limited English proficiency. Additionally, the CE coordinating entity will provide

visually and audibly accessible CE materials when requested by agencies or participants in CE.

5. Emergency Services

In-person CE screening and assessment services may only be available during a limited number of hours on-site at participating homeless assistance provider facilities based on staff availability. When prospective participants present for services outside the hours that CE screening and assessment services are available, participants will still be able to access emergency services, including emergency shelter, when those emergency services are available. CE screening and assessment should be completed with emergency services participants within 3 days after entry, either in-person or by connecting the participant with 211 Tehama. When connecting participants with 211 Tehama to be assessed, homeless assistance services providers will assess the participant's access to a telephone and adequate privacy for completing the assessment and, if needed, provide the participant with access to a telephone and space away from other participants and where needed, advocacy and assistance with completing the call to 211 Tehama.

6. Prevention Services

The CE system will ensure that all CE participants who are found not to qualify for homeless assistance service are screened for homelessness prevention (HP) assistance, regardless of the access point at which they initially seek assistance.

HP access points and general homeless assistance access points will coordinate information and referrals back and forth to ensure persons at imminent risk of literal homelessness are provided coordinated access to CoC homelessness prevention services regardless of where the participant first contacts the CoC.

7. Street Outreach

Street outreach teams will function as access points to the CE process and will seek to engage persons who may be served through CE but who are not seeking assistance or are unable to seek assistance via projects that offer crisis housing or emergency shelter.

Street outreach teams will be trained on CE and the assessment process and will have the ability to offer CE access and assessment services to participants they contact through their street outreach efforts. Street outreach teams will be considered an access point for CE.

Assessment

1. Standard Assessment Approach

The CoC's CE process utilizes a standardized assessment for all CE participants, ensuring uniform decision-making and coordination of care for persons experiencing a housing crisis.

All persons served by CE will be assessed using the ***Tehama Coordinated Entry Survey (TCES)***, access to which is made available to participating projects by the CE coordinating entity.

All access points must use this tool to ensure that all persons served are assessed in a consistent manner, using the same process. The TCES documents a set of participant conditions, attributes, need level, and vulnerability, allowing the access point and/or assessment staff to identify strategies for immediate assistance with crisis needs while at the same time collecting information needed to prioritize assessed individuals and households for available housing services.

The TCES consists of a series of digital forms in the Tehama HMIS database, including those that facilitate collection of the HMIS Data Elements required for producing the Coordinated Entry Annual Performance Report (CE APR) required by HUD as well as the full Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT), an evidence based tool designed to assess service needs for households experiencing literal homelessness, and an abbreviated assessment for households at risk of homelessness designed to expediate matching to appropriate services to ensure that housing that can be retained is retained.

Scoring and eligibility determinations are automatically calculated within the system based on responses entered by assessors to minimize inaccuracies and allow provider staff to focus on assisting CE participants in addressing their immediate housing crisis.

2. Phases of Assessment

All projects participating in CE will follow the assessment and triage protocols of the CE system. The assessment process will progressively collect only enough participant information to prioritize and refer participants to available CoC housing and support services.

The CoC has adopted the following phased approach to engage and appropriately serve persons seeking assistance through the CE system.

a. **Phase *1: Pre-Screen***
   The Pre-Screen phase is designed to identify and respond to participant's immediate crisis and determine whether a full CE assessment would be appropriate.

   1. Participants determined to be in immediate danger due to domestic violence will be immediately offered a referral to Empower Tehama's 24/7 DV Crisis Hotline at 530-528-0226. Participants who accept the immediate referral to Empower Tehama should be advised that they can call 211 Tehama to be assessed into CE once safe, if they still have unaddressed housing needs. If the participant declines immediate

referral to Empower Tehama or states that they are already working with Empower Tehama but wish to be assessed into the CE system, assessors should continue with the CE assessment phases. Participants who decline referrals to Empower Tehama should be advised that they may contact Empower Tehama's DV Crisis Hotline at any time, independent of the CE process.

2. If the participant expresses needs for non-housing services such as mainstream resources, medical services, behavioral health services, etc. at any point during the CE assessment process, assessors should provide them with referrals to the appropriate resources once completing the CE assessment phases.

b. ***Phase 2: Diversion/Emergency Services***
The second phase is designed to divert participants from entering the homeless assistance system when possible, through exploring resources and support systems that they may be able to utilize to resolve their immediate housing crisis. Participants for whom no support system or existing resource is identified should be referred to emergency shelter, if available.

c. ***Phase 3: CE Enrollment and Assessment***
Phase 3 includes collection of basic identifying and demographic information on the participant as well as that of any additional household members, information regarding the household's current and historical housing circumstances for purposes of determining potential eligibility for available housing services and evaluate the participant's service needs. This process includes assessing persons experiencing literal homelessness using the VI-SPDAT tool and assessing persons at risk of homelessness using a custom assessment designed to quickly match them with services that can prevent them from entering the homeless assistance system.

3. Access to Screening and Assessment tools

Detailed instructions for conducting each phase, as well as online response tools will be available in the Tehama HMIS. Providers conducting assessments under circumstances that warrant hard copy forms may request hard copy forms from the CE coordinator. Data from all screenings and assessments conducted using hard copy forms are to be entered into Tehama HMIS within 24-48 hours to ensure equitable access to housing resources.

4. Protected Classes

The CE process may collect and document participants' membership in Civil Rights protected classes but will not consider membership in a protected class as justification for restricting, limiting, or steering participants to particular referral options.

5. Assessor Training

The CoC is committed to ensuring that all staff who assist with CE operations receive sufficient training to implement the CE system in a manner consistent with the vision and framework of CE, as well as in accordance with the policies and procedures of its CE system.

The CoC will provide at least annual training for persons who will manage access point processes and conduct assessments for CE. Training will be offered at no cost to the agency or staff, and will be delivered by an experienced and professional trainer who is identified by the CoC. Topics for training will include the following:

a. Review of CoC's written CE policies and procedures, including variations adopted for specific subpopulations;

b. Requirements for use of assessment information to determine prioritization;

c. Intensive training on the use of the CE assessment tool; and

d. Criteria for uniform decision-making and referrals.

6. Participant Autonomy

It is crucial that persons served by the CoC's CE system have the autonomy to identify whether they are uncomfortable or unable to answer any questions during the assessment process, or to refuse a referral that has been made to them. In both instances, the refusal of the participant to respond to assessment questions or to accept a referral shall not adversely affect his or her position on the CE's Community Queue.

Note that some funders require collection and documentation of a participant's disability or other characteristics or attributes as a condition for determining eligibility. Participants who choose not to provide information in these instances could be limiting potential referral options.

7. Nondiscrimination Complaint and Appeal Process

The CoC is committed to ensuring that no information is used to discriminate or prioritize households for housing and services on a protected basis such as race, color, religion, national origin, sex, age, familial status, disability, actual or perceived sexual orientation, gender identity, or marital status.

The CE participant information packet must include a form that details who the point of contact is for filing and addressing any nondiscrimination complaints, which can be filed by participants if they believe the nondiscrimination policy has been violated in their case during the CE process.

Additionally, this form will describe and provide contact information on how to access the appeal process if they are not satisfied with or have any questions regarding how their complaints are handled. This form must be reviewed at the access point by CE staff and must be signed by each participant.

8. Privacy Protections

CE participating projects are required to notify and obtain participant consent for the collection, use, and disclosure of participants' personally identifiable information (PII).

a. A participant's request for housing crisis response assistance initiated through phone or email communication will be considered notification of intent and inferred to be client consent to collect, use, and disclose that PII collected via phone or email.

b. CE participating projects shall obtain written client consent using the Tehama CoC Standard CES Release of Information (ROI) when conducting a CE assessment in-person or when an update is conducted in-person for a participant initially assessed via telephone.

c. All participant information collected, stored, or shared in the operation of CE functions, regardless of whether that data is stored in HMIS, shall be considered personal and sensitive information worthy of the full force of protection and security associated with data collected, stored, or shared in HMIS.

d. The CoC must protect all participants' personally identifiable information (PII), as required by HUD's HMIS Data and Technical Standards, regardless of whether or not PII is stored in HMIS. All CE participating projects will ensure participants' PII will only be collected, managed, reported, and potentially shared if that data is able to be secured in compliance with the HUD-established HMIS privacy and security requirements.

e. Data entered into the CE must be shared between participating projects for the CE to function properly and ensure equable access to housing services for all participants. Agencies for whom entering data into the system conflicts with applicable laws or internal guidelines may choose to refer individuals in need of housing to 211 Tehama to be assessed

9. Disclosure of Disability or Diagnostic Information

Throughout the assessment process, participants must not be pressured or forced to provide CE staff with information that they do not wish to disclose, including specific disability or medical diagnosis information.

10. Assessment Updates

Participant assessment information should be updated at least once a year, if the participant is served by CE for more than 12 months. Additionally, staff may update participant records with new information as new or updated information becomes known by staff.

To minimize the need to provide personal information more than once, except for identification purposes, or repeatedly discuss potentially sensitive topics, assessments will remain available in the system and can be updated.

a. Participants may update the information in existing CE assessment to reflect changes in their circumstances via any designated access points, regardless of which access point conducted their initial assessment.

b. The HMIS Administrator will provide a tool through which CE Assessors can identify assessments that have aged four months or more without update.

c. CE Assessors are encouraged to contact CE participants whose assessments have aged six months or more to update existing assessments.

d. Contingent on staff capacity, the HMIS Administrator may conduct follow-up calls to participants with aging assessments.

e. Attempts to contact participants to conduct assessment updates will be documented in participant records.

f. Provider staff collecting project entry or exit HMIS data for enrollments in services other than CE will ask participants with existing CE assessments if they wish to update their existing assessments, however, CE Assessments are not to be updated using subsequent HMIS data without the consent of the CE participant.

g. Assessments that have aged nine months or more without update and for which at least 3 unsuccessful attempts to contact the participant to conduct an update since the most recent prior update have been documented will be suspended from the Community Queue and all Project Queues until such time as they have been updated, with the exception of CE assessments for persons who presumptively meet, through self-reported information, the definition of Chronically Homeless per 24 CFR 578.3 or eligibility requirements described in the No Place Like Home Program Guidelines. (See also, Appendix A).

h. Assessments for persons who presumptively meet, through self-reported information, the definition of Chronically Homeless per 24 CFR 578.3 or eligibility requirements described in the No Place Like Home Program Guidelines will remain active on Community Queue and all applicable Project Queues unless or until marked inactive due to no longer needing housing.

i. CE Enrollments will be exited if or when a participant is determined to no longer need housing assistance. If a participant returns to homelessness, they must be re-assessed, however, all efforts will be made to pre-populate data points based on the participant's most recent previous assessment to prevent repeated requests for the same information.

Prioritization

1. The Community Queue System

The ***Community Queue System*** provides an effective way to manage an accountable and transparent process for prioritizing CE participants according to need, vulnerability, and risk.

To minimize inappropriate referrals and ensure that CE participants are prioritized equitably, the Community Queue process is made up of two sections:

a. The ***Community Queue*** is a master list of all known persons experiencing homelessness who are seeking or may need CoC housing and services to resolve their housing crisis.

b. Every participant in the Community Queue is also included in one or more ***Project Queue*** - sub-lists filtered based on eligibility factors associated with project types or individual projects.

The CoC's Community Queue and Project Queues are dynamic lists that update without manual intervention as new CE assessments are added to the database and removed from the databased when a participant is successfully housed.

2. Project Recommendation Ranges

VI-SPDAT scoring ranges for rating the severity of service needs recommended by the OrgCode Consutling, Inc., developer of the VI-SPDAT, and recognized by the CoC are as follows:

Assessment Type:	**Score**	**Recommended Project Type Referral**
Single Adults	0-3	Diversion/Prevention Services
	4-7	Assess for Rapid Rehousing
	8+	Assess for Permanent Supportive Housing
Family	0-3	Diversion/Prevention Services
	4-8	Assess for Rapid Rehousing
	9+	Assess for Permanent Supportive Housing
Unaccompanied Youth	-	All unaccompanied youth are to be referred to the designated community provider for more detailed assessment.

3. Standardized Prioritization

CoC will use data collected through the CE process to prioritize participants for available services and to match participants with the services most likely to meet their needs. All CE assessments active in the system at a given time will appear in the ***Community Queue*** in descending order beginning with those assessed as having the highest service needs within the overall system.

Project Queues will be filtered based on eligibility criteria and prioritization configurations applicable to standard HUD CoC/ESG project types or, where an individual project is subject to narrower or different eligibility and/or prioritization matrix, based on a custom configuration. Custom Project Queue configurations may be requested by individual projects and must be accompanied with documentation of funder-approved eligibility and/or prioritization guidelines. Projects requesting custom project queue configurations will be expected to participate in the process of testing the requested customization configuration to ensure that it meets funder requirements.

4. CoC and ESG Program Standard Prioritization

The prioritization standards described below are consistent with current HUD guidance and will be applied to Project Queues for the listed project type unless otherwise required by project funders. Projects supported by federal CoC Program and ESG Program funding are not permitted to deviate from these standard requirements.

Permanent Supportive Housing (PSH)

The prioritization for PSH is consistent with HUD's Prioritization/PSH Notice. Persons eligible for PSH will be prioritized for available units based on the following criteria (applying the definition of chronically homeless set by HUD in 24 CFR 578.3; see also Appendix A):

1. Chronically homeless individuals and families with the longest history of homelessness and with the most severe service needs.
2. Chronically homeless individuals and families with the longest history of homelessness but without severe service needs.
3. Chronically homeless individuals and families with the most severe service needs.
4. All other chronically homeless individuals and families not already included in priorities 1 through 3.
5. Homeless individuals and families who are not chronically homeless but do have a disability and severe service needs.
6. Homeless individuals and families who are not chronically homeless but do have a disability and a long period of continuous or episodic homelessness.
7. Homeless individuals and families who are not chronically homeless but do have a disability and are coming from places not meant for human habitation, Safe Havens, or emergency shelters.
8. Homeless individuals and families who are not chronically homeless but have a disability and are coming from transitional housing.

Tie Breaker—When two households in the same priority are scored equally on the Prioritized List, the following tiebreakers will be used in this order:

1. a Veteran household
2. longest length of homelessness
3. lowest household income.

Rapid Re-Housing (RRH):

Each RRH Project Queue will include two sub-Queues:

1. The **Primary RRH Queue** will include individuals and families whose VI-SPDAT scores fall within the *Project Recommendation Range* associated with recommendation to RRH. When using the Primary RRH Queue, individuals and families should be selected from the top of the queue to ensure that in-range participants are served in order of prioritization.
2. The **Bonus RRH Queue** includes only individuals and families whose VI-SPDAT scores are *higher* than the *Project Recommendation Range* associated with recommendation to RRH. RRH Providers are encouraged to serve individuals and families with significant service needs when it is assessed that the services offered by the project are likely to meet the needs of the individual or family and the individual or family wishes to be housed through RRH. Any individual or family listed on the Bonus Queue is considered prioritized due to significant service needs, regardless of the order in which they are served.

Primary RRH Queue Prioritization: Homeless individuals and families with the most significant service needs are prioritized among individuals and families whose VI-SPDAT scores fall within the *Project Recommendation Range* associated with recommendation to RRH. Providers using this list should select participants from the top of this list and must formally decline a participant to move to the next assessment on this list.

When two or more assessments are scored equally by level of service needs, those assessments will be further prioritized according to current living situation in this order:

a. Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)
b. Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or RHY-funded Host Home shelter

When two or more assessments are scored equally by level of service needs and current living situation, those assessments will be further prioritized by number of days since approximate date homelessness started, listed in descending order from highest to lowest.

Bonus RRH Queue Prioritization: Homeless individuals and families whose VI-SPDAT scores are higher than the *Project Recommendation Range* associated with recommendation to RRH will appear on the Bonus RRH Queue in the order described above, however, providers are not obligated to serve them in order and are not required to formally decline individuals and families not selected from the Bonus RRH Queue prior to selecting another assessment from the Bonus RRH Queue.

Transitional Housing (TH):

Because the VI-SPAT does not account for TH in its scoring rubric, TH providers will have the flexibility to set the VI-SPDAT scoring range on their Project Queue as appropriate to the level of support available at the project. In all other aspects, TH Project Queues will be configured in the same way as RRH Project Queues as described above.

Emergency Services

Emergency services are a critical crisis response resource, and access to such services will not be prioritized.

5. Project Queues - Custom Prioritization

Custom Project Queues will be created for any project required to follow program-specific eligibility and/or prioritization guidelines. Requests should be submitted in writing to the CE coordinating Entity along with a copy of the program guidelines and/or authorizing legislation. Projects requesting custom Project Queues are responsible for notifying the CE coordinator of any errors identified in the functionality of the custom Project Queue.

6. Pre-Approved Custom Project Queues

The following Custom Project Queues have been pre-approved for inclusion in the CE:

No Place Like Home

Eligibility: Adults, 18 years or older, with serious mental health disabilities who are either homeless, chronically homeless, or at-risk of chronic homelessness.

Prioritization: The prioritization matrix for NPLH units will follow the standard prioritization configuration for Permanent Supportive Housing with the exception that Individuals and families determined to presumptively meet the definition of "At-Risk of Chronic Homelessness" will be prioritized at the same level as persons and/or households determined to presumptively meet the definition of "Chronically Homeless".

Custom Project Queue for NPLH projects will be configured to display assessments active in the Community Queue for adults or older adults presumptively determined to have a Serious Mental Disorder and families that include one or more adults or older adults presumptively determined to have a Serious Mental Disorder who have been presumptively determined to be Chronically Homeless, At-Risk of Chronic Homelessness or homeless, who will appear in the list in descending order according to the following priority configuration:

1. Chronically homeless individuals and families and individuals and families At-Risk of Chronic Homelessness with the longest history of homelessness and with the most severe service needs.
2. Chronically homeless individuals and families and individuals and families At-Risk of Chronic Homelessness with the longest history of homelessness but without severe service needs.
3. Chronically homeless individuals and families and individuals and families At-Risk of Chronic Homelessness with the most severe service needs.
4. All other Chronically homeless individuals and families and individuals and families At-Risk of Chronic Homelessness not already included in priorities 1 through 3.
5. Homeless individuals and families who are not chronically homeless but do have a disability and severe service needs.

6. Homeless individuals and families who are not chronically homeless but do have a disability and a long period of continuous or episodic homelessness.
7. Homeless individuals and families who are not chronically homeless but do have a disability and are coming from places not meant for human habitation, Safe Havens, or emergency shelters.
8. Homeless individuals and families who are not chronically homeless but have a disability and are coming from transitional housing.

Referral

1. Referrals

All CE participating projects will fill vacancies or openings in caseloads using one of the approved processes below unless otherwise required by funding program guidelines:

Option 1: The Next-in-Queue Process

This option is recommended for RRH projects with few eligibility restrictions and flexible caseload limits and TH projects with few eligibility restrictions and frequent vacancies.

1. When vacancies occur or room is available in the project's caseload, consult the appropriate CE Project Queue.
2. Contact the participant at the top of the list to confirm the participants' eligibility and confirm that the participant wishes to be considered for placement in the project.
3. If the participant is determined eligible for the project and accepts the referral, enroll them in the project and begin providing services. If the participant is determined to be ineligible or declines referral to the project, update the participant's assessment to include the date the participant declined the referral or to accurately reflect the participant's assessment information, move on to the next name on the Project Queue list and repeat steps 1-3.

Option 2: The Eligibility Pool Process

This option is recommended for PSH project and TH, RRH and TH/RRH projects with dedicated units, infrequent caseload openings and/or rigid eligibility guidelines.

1. When a unit vacancy or caseload opening occurs or is expected to occur in the immediate future, access the appropriate CE Project Queue.
2. Identify the top 3-5 households represented on the Queue. These 3-5 households are considered the Prioritization Pool for the current vacancy/opening.
3. Contact the participant to coordinate any verification necessary to determine the participants' eligibility and confirm that the participants wish to be considered for placement in the project. Any participants in the Prioritization Pool who declines referral to the project who is determined to be ineligible for the project should be replaced in the Prioritization Pool with the next participant on the list. The replaced participant's assessment should be updated to include the date the participant declined the referral or to accurately reflect the participant's assessment information.
4. Utilize a Housing First, low barrier process for selecting participants to fill the caseload vacancy from the pool of prioritized households. (NOTE: If a participant not selected to fill the vacancy/opening appears in a subsequent Prioritization Pool or another opening in the same project, that participant

should be prioritized for the subsequent opening unless formally declined by the provider.)

No Place Like Home Process

NPLH projects will utilize a Prioritization Pool process modified to include the required partnership between Tehama County Health Services Agency – Behavioral Health (TCHSA-BH) and property management at projects that include NPLH units.

1. The property management will notify TCHSA-BH when NPLH units become available.
2. TCHSA-BH case managers will access the appropriate Project Queue and identify the 3 highest ranked eligible participants and verify their homeless status and serious mental illness disability and refer them to property management.
3. Property management will utilize a Housing First, low barrier process for selecting participants to fill the caseload vacancy from the pool of prioritized households.

2. Additional Considerations

a. Each project is responsible for verifying and documenting any eligibility and/or prioritization criteria associated with the project.

b. If, during the further assessment and verification process, a participant indicated as meeting the project's eligibility criteria is found not to meet one or more of those criteria, project staff must update the participant's CE assessment to accurately reflect the participant's circumstances. This will remove the participant from the project's Project Queue and prevent repeated attempts to qualify an ineligible participant.

3. Participant-Declined Referrals

a. Participants may decline referrals to any project without impacting their eligibility or prioritization on the Community Queue or on other Project Queues.

b. If a participant declines an opportunity to be further assessed or declines an offer of enrollment into a project, project staff must indicate the date the participant declined the referral in a project-specific field in the participant's assessment.

c. Participants who decline a referral to a project will remain on the Community Queue and any other Project Queues for which they meet eligibility but will not appear in that project's Project Queue for the 180 days following the declined referral.

d. If, on the 181st day following the declined referral, the participant's assessment is still open on the Community Queue, the assessment will again appear in the Project Queue for the project whose previous referral they declined. Projects must not consider previous declinations as a factor on which to screen the participant out of future opportunities to receive assistance through the project unless formally declined by the project. One

or more participant-declinations cannot be cited as the reason on the provider's request to formally decline the participant.

4. Provider-Declined Referrals

Providers are afforded the discretion to decline to accept a participant that appears on their Project Queue for one of the following reasons:

a. The participant would be a danger to self or others if allowed to stay at this particular project.

b. The services available through the project are not sufficient to address the intensity and scope of participant need.

c. Other justifications as specified by the "referred to" project.

To formally decline a referral and have the participant's current assessment removed from their Project Queue, the provider must submit a request through the CE system. The CE Coordinating Entity will remove the declined assessment from the Project Queue permanently. The provider may reverse their decision at any time if the circumstances that prompted them to decline the referral change by submitting a request to the CE Coordinating Entity.

The CE Coordinating Entity will track provider-declined referrals through an automated tool within the CE system. If a participant's assessment is declined by all of the projects for which they meet eligibility, the CE Coordinating Entity will request that the declining projects and any relevant providers conduct case conferencing regarding the participant to problem solve.

Data System

1. Data System

CE process partners and all participating projects contributing data to CE must ensure participants' data is secure regardless of the systems or locations where participant data is collected, stored, or shared, whether on paper or electronically. Additionally, participants must be informed of how their data is being collected, stored, managed, and potentially shared, with whom, and for what purpose.

2. Data Collection Stages and Standards

Participants must receive and acknowledge a Tehama CES Standard Release of Information (CES-ROI) prior to the collection of data for CE. The form identifies what data will be collected, where the data will be stored/managed, how the data will be used for the purposes of helping the participant obtain housing and assistance and for other administrative purposes, and what data will be shared with others (if the participant consents to such data sharing).

3. Participant Consent Process

Data must not be collected without the consent of participants, according to the defined privacy policies adopted by the CoC.

As part of the assessment process, participants will be provided with a written copy of the CoC's Tehama CES Standard Release of Information (CES-ROI), which identifies what data will be collected, what data will be shared, which agencies data will be shared with, and what the purpose of the data sharing is. Participants will have the option to decline sharing data; doing so does not make them ineligible for CE.

Tehama CoC's CES-ROI is available at www.tehamacoc.org/providerresources.

Evaluation

1. Evaluation of CE System

Regular and ongoing evaluation of the CE system will be conducted to ensure that improvement opportunities are identified, that results are shared and understood, and that the CE system is held accountable.

The CES Workgroup has selected the following as key outcomes for CE:

1. Reduction in the length of time homeless (system and project level).
2. Reduction in the number of persons experiencing first-time homelessness (system and project level).
3. Increase in the number of placements into permanent housing (system and project level).

2. The Evaluation Process

Regular and ongoing evaluation of the CE system will be conducted to ensure that improvement. The CE will be evaluated using HMIS data and feedback from participating projects and CE entry points on a quarterly basis. Participating projects, CE entry points, and the CE Coordinating Entity and the CES Workgroup will play crucial roles in the evaluation process.

1. The CE Coordinator will pull aggregate reports the data system that reflect movement towards goals as well as routine data points.
2. At least one representative from each participating project will be sent the aggregate reports of the CE System evaluation and invited to participate in a CES Workgroup meeting to provide feedback on the system's effectiveness and usability.
3. A quarterly report, including aggregate report data and feedback from the CES Workgroup will be developed by the CE Coordinating Entity for presentation to the Tehama CoC Executive Council
4. The Tehama CoC Executive Council will review the quarterly report and authorize implementation of recommendations.

Feedback from individuals and families experiencing homelessness or recently connected to housing through the Coordinated Entry process will be gathered at least annually and used to improve the process. Feedback methodologies may include:

5. Surveys designed to reach either the entire population or a representative sample of participating households;
6. Focus groups of five or more participants that approximate the diversity of the participating providers and households;
7. Individual interviews with enough participants to approximate the diversity of participating households; or
8. Any combination of these methods.

APPENDIX A: GLOSSARY

DEFINITIONS OF KEY TERMS

At-Risk of Homelessness (ARH)

HUD definitions at 24 CFR 91.5:

Category 1: Individuals and families

An individual or family who:

i. Has an annual income below 30% of median family income for the area; AND

ii. Does not have sufficient resources or support networks immediately available to prevent them from moving to an emergency shelter or another place defined in Category 1 of the "homeless" definition; AND

iii. Meets one of the following conditions:

a. Has moved because of economic reasons 2 or more times during the 60 days immediately preceding the application for assistance; OR

b. Is living in the home of another because of economic hardship; OR

c. Has been notified that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance; OR

d. Lives in a hotel or motel and the cost is not paid for by charitable organizations or by Federal, State, or local government programs for low-income individuals; OR

e. Lives in a Single Room Occupancy or efficiency apartment unit in which there reside more than 2 persons or lives in a larger housing unit in which there reside more than one and a half persons per room; OR

f. Is exiting a publicly funded institution or system of care; OR

g. Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

Category 2: Unaccompanied Children and Youth

A child or youth who does not qualify as homeless under the homeless definition, but qualifies as homeless under another Federal statute.

Category 3: Families with Children and Youth

An unaccompanied youth who does not qualify as homeless under the homeless definition, but qualifies as homeless under section 725(2) of the McKinney-Vento Homeless Assistance Act, and the parent(s) or guardian(s) or that child or youth if living with him or her.

At-Risk of Chronic Homelessness (ARCH)

No Place Like Home (NPLH) Program Guidelines definition:

All persons qualifying under this definition must be prioritized for available housing by using a standardized assessment tool that ensures that those with the greatest need for Permanent Supportive Housing and the most barriers to housing retention are prioritized for the Assisted Units available to persons At-Risk of Chronic Homelessness pursuant to the terms of the Project regulatory agreement.

Qualification under this definition can be done in accordance with established protocols of the Coordinated Entry System, or other alternate system used to prioritize those with the greatest needs among those At-Risk of Chronic Homelessness for referral to available Assisted Units, that meet the requirements of these Guidelines, including but not limited CA Department of Housing and Community Development NPLH October 2020 Program Guidelines Page 2 to, Section 206 (Occupancy and Income Requirements), and Section 211 (Tenant Selection).

Persons qualifying under this definition are persons who are at high-risk of long-term or intermittent homelessness, including:

(1) Pursuant to Welfare and Institutions Code Section 5849.2, persons exiting institutionalized settings, such as jail or prison, hospitals, institutes of mental disease, nursing facilities, or long-term residential substance use disorder treatment, who were Homeless prior to admission to the institutional setting;

(2) Transition-Age Youth experiencing homelessness or with significant barriers to housing stability, including, but not limited to, one or more evictions or episodes of homelessness, and a history of foster care or involvement with the juvenile justice system; and others as set forth below;

(3) Persons, including Transition-Age Youth, who, prior to entering into one of the facilities or types of institutional care listed herein, had a **history of being Homeless** as defined under this subsection (f)(3): a state hospital, hospital behavioral health unit, hospital emergency room, institute for mental disease, psychiatric health facility, mental health rehabilitation center, skilled nursing facility, developmental center, residential treatment program, residential care facility, community crisis center, board and care facility, prison, parole, jail or juvenile detention facility, or foster care.

Having a history of being Homeless means, at a minimum, one or more episodes of homelessness in the 12 months prior to entering one of the facilities or types of institutional care listed herein. The CES (as defined in Section 101(n)), or other local system used to prioritize persons At-Risk of Chronic Homelessness for available Assisted Units may impose longer time periods to satisfy the requirement that persons under this paragraph must have a history of being Homeless.

(4) The limitations in subsection (w)(a)(iii) pertaining to the definition of "Homeless" shall not apply to persons At-Risk of Chronic Homelessness, meaning that as long as the requirements in subsections (f)(1) - (3) above are met:

i. Persons who have resided in one or more of the settings described above in subsection (f)(1) or (f)(3) for any length of time may qualify as Homeless upon exit from the facility, regardless of the amount of time spent in such facility; and

ii. Homeless Persons who, in the 12 months prior to entry into any of the facilities or types of institutional care listed above, have resided at least once in any kind of publicly or privately operated temporary housing, including congregate shelters, transitional, interim, or bridge housing, or hotels or motels, may qualify as At-Risk of Chronic Homelessness.

Case Conferencing

Local process for CE staff to coordinate and discuss ongoing work with persons experiencing homelessness in the community, including the prioritization or active list. The goal of case conferencing is to provide holistic, coordinated, and integrated services across providers, and to reduce duplication.

Chronically Homeless (CH)

HUD definition at 24 CFR 578.3:

(1) An individual who:

i. Is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

ii. Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions in the last 3 years; and

iii. Can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000 (42 U.S.C. 15002)), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability;

(2) An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or

(3) A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Continuum of Care (CoC)

Group responsible for the implementation of the requirements of HUD's CoC Program interim rule. The CoC is composed of representatives of organizations, including nonprofit homeless providers, victim service providers, faith-based organizations, governments, businesses, advocates, public housing agencies, school districts, social service providers, mental health agencies, hospitals, universities, affordable housing developers, law enforcement, organizations that serve homeless and formerly homeless veterans, and homeless and formerly homeless persons.

Continuum of Care (CoC) Program

HUD funding source to (1) promote communitywide commitment to the goal of ending homelessness; (2) provide funding for efforts by nonprofit providers, and state and local governments to quickly rehouse homeless individuals and families while minimizing the trauma and dislocation caused to homeless individuals, families, and communities by homelessness; (3) promote access to and effect utilization of mainstream programs by homeless individuals and families; and (4) optimize self-sufficiency among individuals and families experiencing homelessness.

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Emergency Shelter (ES)

Emergency Solutions Grant (ESG) definition at 24 CFR 576.2:

Any facility, the primary purpose of which is to provide a temporary shelter for the homeless in general or for specific populations of the homeless and which does not require occupants to sign leases or occupancy agreements.

Emergency Solutions Grant (ESG) Program

HUD funding source to (1) engage homeless individuals and families living on the street; (2) improve the quantity and quality of emergency shelters for homeless individuals and families; (3) help operate these shelters; (4) provide essential services to shelter residents; (5) rapidly rehouse homeless individuals and families; and (6) prevent families and individuals from becoming homeless.

Homelessness Categories

HUD definitions at 24 CFR 91.5:

Category 1: Literally Homeless

An individual or family who lacks 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.

Category 2: At 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.

Category 3.: Homeless under other Federal Statutes

Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who:

i. Are defined as homeless under section 387 of the Runaway and Homeless Youth Act (42 U.S.C. 5732a), section 637 of the Head Start Act (42 U.S.C. 9832), section 41403 of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2), section 330(h) of the Public Health Service Act (42 U.S.C. 254b(h)), section 3 of the Food and Nutrition Act of 2008 (7 U.S.C. 2012), section 17(b) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)), or section 725 of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a);

ii. Have not had a lease, ownership interest, or occupancy agreement in permanent housing at any time during the 60 days immediately preceding the date of application for homeless assistance;

iii. Have experienced persistent instability as measured by two moves or more during the 60-day period immediately preceding the date of applying for homeless assistance; and *(iv)* can be expected to continue in such status for an extended period of time because of chronic disabilities; chronic physical health or mental health conditions; substance addiction; histories of domestic violence or childhood abuse (including neglect); the presence of a child or youth with a disability; or two or more barriers to employment, which include the lack of a high school degree or General Education Development (GED), illiteracy, low English proficiency, a history of incarceration or detention for criminal activity, and a history of unstable employment.

Category 4: Fleeing domestic abuse or violence

Any 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, faith-based or other social networks, to obtain other permanent housing.

Homeless Management Information System (HMIS)

Local information technology system used by a CoC to collect participant-level data and data on the provision of housing and services to homeless individuals and families and to persons at risk of homelessness. Each CoC is responsible for selecting an HMIS software solution that complies with HUD's data collection, management, and reporting standards.

Homelessness Prevention (HP)

From *ESG Requirements* on the HUD Exchange website:

Housing relocation and stabilization services and short-and/or medium-term rental assistance as necessary to prevent the individual or family from moving to an emergency shelter, a place not meant for human habitation, or another place described in paragraph (1) of the [ESG] homeless definition.

The costs of homelessness prevention are only eligible to the extent that the assistance is necessary to help the program participant regain stability in their current housing or move into other permanent housing and achieve stability in that housing.

Eligible costs include:

- Rental Assistance: rental assistance and rental arrears
- Financial assistance: rental application fees, security and utility deposits, utility payments, last month's rent, moving costs
- Services: housing search and placement, housing stability case management, landlord-tenant mediation, tenant legal services, credit repair

See 24 CFR 576.103.

Public Housing Authority (PHA)

Local entity that administers public housing and Housing Choice Vouchers (HCV) (aka Section 8 vouchers) and may administer additional housing programs. The PHA that administers HCVs in Tehama County is the Plumas County Community Development Corporation (PCCDC). PCCDC is based in Plumas County but serves Plumas, Lassen, Trinity and Tehama County.

Permanent Supportive Housing (PSH)

HUD definition at 24 CFR 578.3:

> Permanent housing means community-based housing without a designated length of stay, and includes both permanent supportive housing and rapid rehousing. To be permanent housing, the program participant must be the tenant on a lease for a term of at least one year, which is renewable for terms that are a minimum of one month long, and is terminable only for cause.
>
> Permanent supportive housing means permanent housing in which supportive services are provided to assist homeless persons with a disability to live independently.
>
> **NOTE:** As used by the No Place Like Home (NPLH) Program, "permanent supportive housing" has "Permanent Supportive Housing" has the same meaning as "supportive housing," as defined in Section 50675.14 of the Health and Safety Code, except that "Permanent Supportive Housing" shall include associated facilities if used to provide services to housing residents. Section 50675.14 of the Health and Safety Code reads:
>
> "Supportive housing" means housing with no limit on length of stay, that is occupied by the target population, and that is linked to onsite or offsite services that assist the supportive housing resident in retaining the housing, improving their health status, and maximizing their ability to live and, when possible, work in the community.

Rapid Rehousing (RRH)

From *ESG Requirements* on the HUD Exchange website:

> Housing relocation and stabilization services and/or short-and/or medium-term rental assistance as necessary to help individuals or families living in shelters or in places not meant for human habitation move as quickly as possible into permanent housing and achieve stability in that housing.
>
> Eligible costs include:
>
> - Rental Assistance: rental assistance and rental arrears
> - Financial Assistance: rental application fees, security and utility deposits, utility payments, last month's rent, moving costs
> - Services: housing search and placement, housing stability case management, landlord-tenant mediation, tenant legal services, credit repair
>
> See 24 CFR 576.104

Release of Information (ROI)

> Written documentation signed by a participant to release his/her personal information to authorized partners.

Serious Mental Disorder (SMD)

As used in this document and the No Place Like Home (NPLH) Program, "Serious Mental Disorder" has the same definition as California Welfare and Institutions Code Section 5600.3(b), which reads:

(b)(1) Adults and older adults who have a serious mental disorder.

(2) For the purposes of this part, "serious mental disorder" means a mental disorder that is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time. Serious mental disorders include, but are not limited to, schizophrenia, bipolar disorder, post-traumatic stress disorder, as well as major affective disorders or other severely disabling mental disorders. This section shall not be construed to exclude persons with a serious mental disorder and a diagnosis of substance abuse, developmental disability, or other physical or mental disorder.

(3) Members of this target population shall meet all of the following criteria:

(A) The person has a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a substance use disorder or developmental disorder or acquired traumatic brain injury pursuant to subdivision (a) of Section 4354 unless that person also has a serious mental disorder as defined in paragraph (2).

(B)(i) As a result of the mental disorder, the person has substantial functional impairments or symptoms, or a psychiatric history demonstrating that without treatment there is an imminent risk of decompensation to having substantial impairments or symptoms.

(ii) For the purposes of this part, "functional impairment" means being substantially impaired as the result of a mental disorder in independent living, social relationships, vocational skills, or physical condition.

(C) As a result of a mental functional impairment and circumstances, the person is likely to become so disabled as to require public assistance, services, or entitlements.

(4) For the purpose of organizing outreach and treatment options, to the extent resources are available, this target population includes, but is not limited to, persons who are any ofthe following:

(A) Homeless persons who are mentally ill.

(B) Persons evaluated by appropriately licensed persons as requiring care in acute treatment facilities including state hospitals, acute inpatient facilities, institutes for mentaldisease, and crisis residential programs.

(C) Persons arrested or convicted of crimes.

(D) Persons who require acute treatment as a result of a first episode of mental illness with psychotic features.

(5) California veterans in need of mental health services and who meet the existing eligibility requirements of this section, shall be provided services to the extent services are available to other adults pursuant to this section. Veterans who may be eligible for

mental health services through the United States Department of Veterans Affairs should be advised of these services by the county and assisted in linking to those services but the eligible veteran shall not be denied county mental or behavioral health services while waiting for a determination of eligibility for, and availability of, mental or behavioral health services provided by the United States Department of Veterans Affairs.

(A) An eligible veteran shall not be denied county mental health services based solely on his or her status as a veteran, including whether or not the person is eligible for services provided by the United States Department of Veterans Affairs.

(B) Counties shall refer a veteran to the county veterans service officer, if any, to determine the veteran's eligibility for, and the availability of, mental health services provided by the United States Department of Veterans Affairs or other federal health care provider.

(C) Counties should consider contracting with community-based veterans' services agencies, where possible, to provide high-quality, veteran specific mental health services.

(c) Adults or older adults who require or are at risk of requiring acute psychiatric inpatient care, residential treatment, or outpatient crisis intervention because of a mental disorder with symptoms of psychosis, suicidality, or violence.

(d) Persons who need brief treatment as a result of a natural disaster or severe local emergency.

Seriously Emotionally Disturbed Children or Adolescents

As used in this document and the No Place Like Home (NPLH) Program, "Serious Mental Disorder" has the same definition as California Welfare and Institutions Code Section 5600.3(a), which reads:

(a) (1) Seriously emotionally disturbed children or adolescents.

(2) For the purposes of this part, "seriously emotionally disturbed children or adolescents" means minors under the age of 18 years who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:

(A) As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:

(i) The child is at risk of removal from home or has already been removed from the home.

(ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

(B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

(C) The child has been assessed pursuant to Article 2 (commencing with Section 56320) of Chapter 4 of Part 30 of Division 4 of Title 2 of the Education Code and determined to have an emotional disturbance, as defined in paragraph (4) of subdivision (c) of Section 300.8 of Title 34 of the Code of Federal Regulations.

Street Outreach (SO)

From *ESG Requirements* on the HUD Exchange website:

> Essential Services related to reaching out to unsheltered homeless individuals and families, connecting them with emergency shelter, housing, or critical services, and providing them with urgent, non-facility-based care. Eligible costs include engagement, case management, emergency health and mental health services, transportation, and services for special populations.
>
> See 24 CFR 576.101.

Transition Age Youth (TAY)

Unaccompanied youth under age 25, including youth with children.