Palm Beach County Continuum of Care
Written Standards of Operating Policies & Procedures
For
Coordinated Intake & Assessment

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INTRODUCTION

National research has highlighted Coordinated Intake & Assessment as a key factor in the success of ending homelessness. Coordinated Intake & Assessment can enhance the quality of client screening and assessment and better target program assistance where it can be most effective. As a result, the system for preventing and ending homelessness is less fragmented and scarce resources are used more efficiently.

What is Coordinated Intake & Assessment?

Coordinated Intake & Assessment for Palm Beach County CoC is a centralized access point through the Homeless Resource Center (HRC), outreach, and telephone based centralized intake model. Initial screening can be conducted for all populations at one of the outreach locations or through a Navigator over the phone. Coordinated Intake & Assessment includes the following core components:

- Information so that people will know where or how to access intake for homeless prevention or housing services;
- A screening and assessment process and tools to gather and verify information about the person and his/her housing and service needs and program eligibility and priority;
- Information about programs and agencies that can provide needed housing or services;
- A process and tools for referral of the person to an appropriate program(s) or agencies; and assistance in making program admissions decisions

While most housing and services are made available through other agencies, a variety of services may be provided on site at the “HRC” or by a “Navigator”. These services typically meet basic client needs and may include diversion services, showers, laundry, assessment, referral, shelter, bus pass and/or access to mainstream resources.

KEY TERMS

A number of key terms are subject to varying interpretations and thus should be defined for purposes of this document. They are as follows:

- **Central Point of Access –** For the purpose of this document, Central Point of Access is the Homeless Resource Center where individuals or families can go to for intake and assessment of homeless and housing services for which they may qualify.
- **Admission –**authority to admit a client into a program
- **Assessment –** A process that reveals the past and current details of a individual's/household's strength, and needs, in order to match the client to appropriate services and housing. For the purpose of this document, assessment will refer to a process (whether at primary screening and intake or at entry to a housing program) that reveals a client's eligibility, needs, barriers and strengths.
- **Chronic Homelessness- A chronically homeless individual is someone who has** experienced homelessness for a year or longer, or who has experienced at least four episodes of homelessness in the last three years and has a disability. A family with an adult member who meets this description would also be considered chronically homeless.
- **Coordinated Assessment –**relates to the utilization of the same assessment tool to connect clients to services as a means for a coordinated entry system. For the purpose of this document, that tool is the SPDAT (The Service Prioritization Decision Assistance Tool)
- **Coordinated Systems –** Within our community, coordinated systems is defined as interconnected network of systems that services homeless and at risk households, and consists of coordinated intake and assessment, diversion, prevention, rapid re-housing, transitional housing, permanent supportive housing and other tailored programs and services, and linkages to mainstream resources.
- **Diversion**- is a strategy that prevents homelessness for people seeking shelter by helping them identify immediate alternate housing arrangements and, if necessary, connecting them with services and financial assistance to help them return to permanent housing. The main difference between diversion and other permanent housing-focused interventions centers on the point at which intervention occurs. Prevention targets people at imminent risk of homelessness, diversion targets people as they are applying for entry into shelter, and rapid re-housing targets people who are already homeless.

- **Fiscal Agent –** For the purpose of this document, the entity that coordinates funding and provides oversight to the coordinated intake and assessment system.
- **HEARTH ACT –** The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) act of 2009 that includes Emergency Solutions Grant (ESG) and Continuum of Care (CoC) grants.
- **HMIS –** Homeless Management Information System; a centralized data base designated to create an unduplicated accounting of homelessness that includes housing and services.
- **Homeless –** HUD definition as of January 2012; an individual or family who lacks a fixed regular, and adequate nighttime residence, which includes a primary nighttime residence of: a place not designed for or ordinarily used as a regular sleeping accommodation (including car, park, abandoned building, bus/train station, airport or camping grounds); a publicly or privately operated shelter or transitional housing, including a hotel or motel paid for by government or charitable organizations. In addition a person is considered homeless if he or she is being discharged from an institution where he or she has been a resident for 90 days or less and the person resided in shelter (but not transitional housing) or place not meant for human habitation immediately prior to entering the institution.
- **Housing First –**Evidence-Based programming for housing homeless individuals and families according to the provisions of a standard lease without requiring services other than case management in order to attain and retain housing.
- **Housing Ready –** A case management/housing approach that placed homeless households into permanent housing only when determined the household was ready. Until that time, households were placed into long-term shelter or transitional housing programs. The approach is being replaced by the Evidence Based Practice of Housing First and "rapid re-housing."
- **HUD –** The Department of Housing and Urban Development; the United States federal department that administers federal program dealing with homelessness. HUD oversees HEARTH-funded programs.
- **Information –** Specific facts about a program, such as its location, services provided, eligibility requirements, hours of operation, and contact information
- **Intake** – the general process between the client's initial point of contact and screening for eligibility. This step involves primary assessment of needs, strengths and resources to refer households into appropriate services
- **Homeless Resource Center –** The agency identified as the primary administrator of coordinated intake and assessment. For the purpose of this document, that is the Philip D. Lewis Center and the partners administering the coordinated assessment process; Gulfstream Goodwill Industries, Adopt-A-Family and the Homeless Outreach Teams.

- **Linkage or Access to Mainstream Resources –** An approach to help people stabilize their housing for the long term by linking them to resources for which they are eligible within their community.
- **Navigator –** An intake worker whose responsibility is to provide coordinated intake and assessment for individuals or families seeking housing services.
- **Outcome –** The specific result of what was provided from a specific activity or service; in relation to HUD/HEARTH, a specific result as detailed by HUD/HEARTH funding requirements.
- **Prevention –** An approach that focuses on preventing homelessness by providing assistance to households that otherwise would become homeless and end up in a shelter or on the streets.
- **Progressive Engagement**- refers to a strategy of providing a small amount of assistance to everybody who enters your homelessness system, then waiting to see if that works. If it doesn't, you provide more assistance and wait to see if that works. If not, you apply even more, until eventually you provide your most intensive interventions to the few people who are left.
- **Rapid Re-housing –** An approach that focuses on moving homeless individuals and families into appropriate housing as quickly as possible by providing the type, amount and duration of housing assistance needed to stabilize the household. Clients do not need to be considered "Housing Ready".
- **Referral –** Referring a client to a particular program for possible help
- **Screening –** For the purpose of this document, the process by which eligibility for housing and services is determined at the initial point of contact through coordinated entry. Once screening determines eligibility, the intake and referral process follows.
- **Systems Change –** For the purpose of this document, the process by which our CoC has altered the way homeless and at-risk households engage with the homeless and housing providers within our communities. The purpose of system change is to implement practices that have shown to decrease the incidence and length of time in homelessness, with a long term goal of reducing and ending homelessness.
- **Tailored Programs and Services –** An approach to case management services that matches the services to the particular individual's or family's needs rather than using a one-size-fits-all approach.
- **Targeting –** Process of determining the population to whom assistance will be directed. That is, the target population. The targeting process can occur at both the system and the program levels.
- **Coordinated Intake Provider Network –** is a consortium of partners that includes homeless service providers, advocacy groups, government agencies, and homeless

individuals who are working together to address the housing and support needs of the homeless in Palm Beach Count.

- **Verification –** The gathering and review of information to substantiate the applicant's/client's situation and support program eligibility and priority determination.

ENTRY SYSTEM

Applicants and Clients :

- Clients who are in need of homeless prevention or housing services can access information and eligibility criteria through the HRC which serves as the Central Point of Access. Participants seeking assistance must be screened at the HRC by a Navigator or by the Homeless Outreach Teams during off-site outreach. Participants not eligible for services will be referred to other appropriate community resources.
- Eligibility. Individuals and families that are **"Literally Homeless"** (meeting HUD's Category 1 definition of homelessness).
- Participation Requirement. All households (with the exception of households in domestic violence situations) must be screened prior to program entry.

- Clients can expect :
    - To be treated with respect and dignity
    - Their initial phone call for assistance to be answered live or returned within one business day
    - To be scheduled for an in-person, intake and assessment within two to seven business days as capacity allows
    - To be matched to an appropriate program based upon their unique needs, and referred based on their priority status to opening in a program
    - To wait until the system has the capacity to assist them, and to get help through diversion or other resource available to them.
- Responsibilities. Client must:
    - Answer all questions truthfully and to the best of their ability
    - Bring all required documentation
    - Keep their contact information current in order to be notified of available opening, and referred in a timely manner.

Providers :

- Participation Requirement.
  - All providers receiving funding through HEARTH or a HUD funded program are required to participate in the coordinated intake and assessment process.
  - Providers must be live on the HMIS system and must maintain data which is inputted no later than within 24 hours of a service or outcome being achieved or rendered.
  - Providers must have an appeal process for those applicants who have been denied service or entry into a program.

HRC Partners :

- It is the HRC Partners responsibilities to:
  - Regularly update and make current all program eligibility guidelines and program contact information so that Navigators can make the best referrals possible.
  - Ensure that when a placement referral is made, to confirm within two business days whether the referral is accepted, declined by provider, declined by client, or pending, or the provider is unable to contact the client.
  - Bring problems and suggestions to the monthly Standard Policies & Procedures Committee meeting.
  - Oversee provision of homeless diversion and housing services for eligible clients.
  - Ensure utilization of the same screening and assessment tool, data collection forms, policies on eligibility verification and referral/information-sharing systems.

NOTE : *This system acknowledges that the needs of a household fleeing or attempting to flee, domestic violence , dating violence, sexual assault or stalking, may be different than the needs of non-victims. Navigators will be trained on sensitivity in regards to victim's assistance, and referrals will only be made to domestic violence providers.*

ASSESSMENT TOOLS & PROTOCOLS

This system is focused on providing a continuum of care including prevention, diversion, rapid re-housing and permanent supportive housing approaches. The plan requires each Navigator to assess household's eligibility for services. Prevention services target people at imminent risk of homelessness and will be referred to available homeless prevention programs. Diversion services will target participants as they are applying for entry into shelter. For housing programs, rapid re-housing services will target participants who are already homeless and the SPDAT score warrants the most appropriate housing. Housing first and permanent supportive housing will target participants that are chronically homeless and the SPDAT score identifies this housing type.

Applicants and Clients :

- Each applicant is evaluated on a variety of criterion, including rental history, criminal history, domestic violence, mental health challenges, disabling conditions, language barriers, educational attainment, employment status, and length of homelessness. Services are then assigned based on the SDPAT score.
- The Assessment tool provides a procedure for determining which applicants are eligible and appropriate for the variety of housing and support services available in the community as well as other eligibility factors such as for permanent supportive housing must have a disabling condition and lack the resources to obtain housing.

Providers :

- Each participant who is referred for housing or services will have been evaluated through an assessment based on their current barriers to obtaining and successfully maintain permanent housing.
- The Assessment will be used as a guide, with the understanding that each applicant has a unique set of circumstances.

HRC Partners and CoC Partners:

- The Service Prioritization Decision Assistance Tool (SPDAT) is the assessment tool utilized for this system.
- The SPDAT will utilize 15 domains for individuals and 20 for families to determine an acuity score that will help inform Navigators and Providers about the following :
  - ✓ People who will benefit most from Permanent Supportive Housing
  - ✓ People who will benefit most from Rapid Re-Housing
  - ✓ People who are most likely to end their own homelessness with little to no intervention on your part

- ✓ Which areas of the person's life that can be the initial focus of attention in the case management relationship to improve housing stability.
- ✓ How individuals and families are changing over time as result of case management process.

- The SPDAT will be integrated into the HMIS System and each agency will ensure data is being maintained and monitored.
- The HRC Partners will provide a system of care that allows clients to give feedback on suggestions and improvements of the Intake and Assessment Process.
- The HRC Partners will ensure that the SPDAT is not used to :
    - Provide a diagnosis
    - Assess current risk or be a predictive index for future risk
    - Take the place of other valid and reliable instruments used in clinical research and care

CoC Partners that receive federal CoC and ESG funds and any local funds required by the funder must participate in the Coordinated Assessment process and track data in the Client Management Information System (CMIS). Only Domestic Violence providers are exempt from the CMIS required as per Florida Statute and Federal regulations. CoC partners receiving federal CoC and ESG funds or any other local funds dedicated to homeless services must fill vacant beds based on acuity from highest to lowest as per CPD-14-012.

PREVENTION / DIVERSION (Category 2 Homeless Definition)

According to the National Alliance to End Homelessness many people seeking homeless assistance still have an opportunity to remain in their current housing situation, whether it's their own housing or the housing of a friend, relative, acquaintance or coworker. In light of this prevention and shelter diversion are key interventions in the fight to end homelessness. Immediate screening for these possibilities at entry is an important tactic, and can preserve emergency beds for individuals/households that truly have nowhere else to go. Access to rental subsidies and case management at entry is often enough to ensure the household successfully remains housed.

While prevention and diversion are two separate concepts, they are utilized almost interchangeably in this strategy, as they both focus on preventing homelessness. Prevention targets people at imminent risk of homelessness, diversion targets people as they are applying for entry into shelter, and rapid re-housing targets people who are already homeless.

Once an individual/household enters into the system, they should be assessed to determine what housing needs they have. To determine which individuals/households are appropriate for

prevention/diversion, Navigators can ask applicants a series of questions during the assessment, such as those delineated below.

Client :

Clients who are being referred for prevention/diversion will be asked:

- Where did you sleep last night? *If they slept somewhere safe where they could potentially stay again, this might mean they are good candidates for diversion*
- What other options do you have for the next few days or week? *Even if there is an option outside of shelter that is only available for a very short time, it worth exploring if this housing resource can be used.*
- (If staying in someone else's housing) What issues exist with you remaining in your current housing situation? Can those issues be resolved with financial assistance, case management, etc? *If the issues can be solved with case management, mediation, or financial assistance (or all of the above), diversion is a good option.*
- (If coming from their own unit) Is it possible/safe to stay in your current housing unit? What resources would you need to do that (financial assistance, case management, mediation, transportation, etc.)? *If the individual or family could stay in their current housing with some assistance, systems should focus on a quick prevention-oriented solution that will keep the individual or family in their unit.*

Providers :

Referrals to prevention/diversion providers must be at imminent risk of homelessness AND meet the following threshold.

- No appropriate subsequent housing options have been identified;
- The household lacks the financial resources to obtain immediate housing or remain in its existing housing; and
- The household lacks support networks needed to obtain immediate housing or remain in its existing housing

HRC Partner Agency :

The following list includes some, but not all risk factors that may be considered when determining imminent risk of homelessness. SPDAT will be utilized to determine acuity of the risk factors (scores 0-5 for families and 0-4 for individuals):

- Eviction within two weeks from a private dwelling (including housing provided by family or friends)
- Residency in housing that has been condemned by housing officials and is no longer meant for human habitation
- Sudden and significant loss of income

- Sudden and significant increase in utility cost
- Mental health and/or substance abuse issues
- Physical disabilities and other chronic health issues including HIV/AIDS
- Severe housing cost burden (greater than 50% of income for housing costs);
- Homeless in last 12 months
- Young head of household (under 25 with children or pregnant)
- Current or past involvement with child welfare, including foster care
- Pending foreclosure of rental housing
- Extremely low income (less than 30% of AMI);
- High overcrowding (the number of person exceeds health and/or safety standards for housing unit size)
- Past institutional care (prison, treatment facility, hospital)
- Recent traumatic life event, such as death of a spouse or primary care provider, or recent health crisis that prevented the household from meeting its financial responsibilities.
- Credit problems that preclude obtaining of housing or
- Significant amount of medical debt.

Some participants may not be good candidates for diversion programs due to a lack of safe and appropriate housing alternative and require immediate admittance to shelter, e.g. client fleeing domestic violence. A client's safety should always be the top consideration when developing an individual /household referral to a program.

RAPID REHOUSING

Generally, rapid re-housing is intended to assist eligible participants to quickly obtain and sustain stable, permanent housing. Effective rapid re-housing requires case management and financial assistance, as well as housing search and locations services. Support and duration of service are tailored to meet the needs of each household and each household has a lease in their name and is connected to mainstream resources in the community in which they reside.

Clients :

Eligible households must:

- Be literally homeless as defined by HUD
- Be prepared to put together a reasonable plan that shows how they are going to maintain housing once housing assistance has ended, a budget, a financial worksheet and or a narrative description of changes in household circumstances that made them homeless.

- Entry is based on SPDAT Acuity score (highest to lowest)

Providers :

Providers who are funded for rapid re-housing:

- Will utilize the **"Progressive Engagement"** methodology; that is, providers will determine the amount of rent and utility assistance and/or supportive services that a household will receive using the progressive engagement approach. Household will be asked to identify the minimum amount and duration of assistance needed to achieve housing stability. If it becomes clear that a rapid re-housing intervention is insufficient and or inappropriate for a particular household, the provider will work with the Navigator and/or other housing provider to find a more suitable program.
- Households should be housed within 30 days of acceptance into the program.
- Providers are expected to remain engaged with the household from first contact to program exit as per the CoC approved Rapid Re-Housing Standards.

CoC Partners:

The following process will be used to refer clients to any Rapid Re-Housing program. Providers will receive referrals from any of the following sources, provided they have been assessed by the Navigator and all eligibility and vacancy information is up to date in HMIS.

- Coordinated Access Point and/or Outreach Workers
- Shelters
- Transitional Housing Programs

All households being referred for Rapid Re-Housing must be assessed by a Navigator. While they may be identified through other resources, e,g., shelter or transitional housing provides, McKinney-Vento Liaisons in school districts, or other service providers, they will require screening and assessment through the HRC Coordinated Intake and Assessment System. School Liaisons can conduct the SPDAT and provide this information to the Navigator to be included on Rapid Re-Housing Placement Priority List.

- Navigators are responsible for gathering documentation for verification of homeless status.
- All Rapid Re-Housing clients must be entered into HMIS by the Navigator once the provider has confirmed entry into the program. Information should all include all HUD required data elements.

HOUSING AND/OR MORE INTENTSIVE PROGRAM REFERRAL

Participants unable to be served by prevention, diversion or rapid re-housing programs will most likely need more intensive housing and service interventions, such as transitional housing or permanent supportive housing. Those fleeing domestic violence that are not eligible or appropriate for prevention and rapid re-housing services may fall into this category of needing more intensive service intervention, and should be referred to a domestic violence provider prior to intake and/or HMIS data entry.

Table 1 below delineates the characteristics of Permanent Support Housing and Transitional Housing Programs.

Characteristics of Transitional Housing & Permanent Supportive Housing Programs

Programs & Characteristics	Transitional Housing	Permanent Supportive Housing
Length of Stay	Maximum stay 24 month	No time limit
Occupancy Agreement	Participant are clients , not tenants and sign an occupancy or program agreement instead of a lease	Participant have a lease
Service Requirements	Services are required	Services are optional
Eligibility	Applicant must meet HUD's definition of homeless	Applicant must meet HUD's definition of homeless and member of the household must have a disabling condition

Provider:

Transitional Housing: programs that provide transitional housing to individuals and/or families, usually for a period of four to twenty-four months along with supportive services to help them become self-sufficient. In addition to providing a place to live, transitional housing providers should help participant to increase their life management skills and resolve the problems that have contributed to their homelessness. Individuals/Households who are homeless and have two or more of the following barriers are appropriate for referral to Transitional Housing:

- Domestic Violence victims fleeing a domestic violent situation
- youth (18-24)
- No income
- Poor rental history
- Sporadic employment history
- No high school diploma or GED
- History of homelessness
- Poor rental history (i.e current eviction, rent/utility arrears)

Permanent Supportive Housing: As a minimum, candidates for Permanent Supportive Housing must meet the following basic requirements:

- Literally homeless
- Lacks the resources to obtain housing
- Has a member of the household with a severe or significant disabling condition
- Qualifies as a high need based on the SPDAT
- Priority is given to those meeting the definition of homelessness

Permanent Supportive Housing is targeted to individuals/households who need services in order to maintain housing and there is prioritization for those who have been homeless for long periods of time or have experienced repeat episodes of homelessness as defined as chronic homeless per HUD.

CoC Partner Agencies :

The navigator provides: needed housing navigation services, frequent communication with the client and serves as the primary liaison between the client and the housing provider. The CoC Partner Agency is responsible for overseeing and ensuring that:

- Advocacy and services to collect required housing documentation are provided
- A climate of trust is created and maintained between clients and navigators.
- A current housing inventory is maintained within HMIS
- Clients are housed based upon a prioritization determination; that is, those who score on the SPADAT as the most vulnerable will be prioritized for housing depending on the availability of housing and services. Legacy programs with beds not dedicated to CH must prioritize the beds for CH individuals and Families as bed become available.

If the Partner Agency is denying the placement, the Agency must submit in writing the reasons for denial to the HRC Partners.

UNACCOMPANIED YOUTH AND YOUNG ADULTS

Unaccompanied youths is a fast growing and underserved sub- populations, in our community.

Clients:

Unaccompanied Youth and Young Adults are defined as youth (ages 13-17) and young adults (ages 18-24) who are unaccompanied by a parent or guardian and are without shelter where appropriate care and supervision are available, whose parent or guardian is unable or unwilling to provide shelter and care, or who lack a fixed, regular and adequate nighttime residence. Undocumented unaccompanied youth and young adults may also be served under these provisions except where exclusions are noted. Unaccompanied youth may be encountered

during outreach but would not enter the Homeless Resource Center due to their age. (City provisions prevent anyone under 18 from entering the program unless they had legally been as an emancipated as an adult. Those under 18 would be connected to the appropriate program based on their age and circumstances.

Providers:

Providers of services for unaccompanied youth and young adults should be able to provide safe and high quality housing and supportive services (scattered-site independent apartments, host homes, and shared housing) to youth and young adults experiencing homelessness that involve integrated affordable housing, intensive strength-based case management, self-sufficiency services, trauma informed care, and positive youth development approaches.

HRC Agency:

All housing service referrals for unaccompanied youth and young adults must be screened and assessed. The HRC Agency is responsible for overseeing and ensuring that:

- Young adults willingly engage with coordinated intake for a screening and when appropriate, a full SPDAT.
- Low barriers of entry for this highly vulnerable population are necessary.
- Navigators consult with expert providers of this population when conducting intake to properly match clients and providers, and reduce the risk of flight for this highly vulnerable population.

PROGRAM EVALUATION

Coordinated Intake and Assessment is one of many projects within our community that addresses the needs of individuals and families that are at risk or experiencing homelessness within our communities. The HRC Partner Agencies will evaluate the effectiveness as well as required HEARTH Act outcomes by utilizing data from HMIS. As recommended by the National Alliance to End Homelessness, the HRC Partner Agencies will track progress in the following areas to evaluate the Coordinated Intake and Assessment process:

- Length of stay, particularly in shelter: If participants are referred to the right interventions and those interventions have the necessary capacity, fewer individuals and families should be staying in shelter waiting to be moved elsewhere. Also if clients are referred immediately to the right provider, over time, clients will likely spend less time jumping from program to program looking for help, which could reduce their overall length and/or repeated episodes of homelessness.
- New entries into homelessness: if every individual and family seeking assistance coming through the front door and the front door has prevention and diversion resources

available, more people should be able to access these resources and avoid entering a program unnecessarily.

- Repeat episodes of homelessness: If clients are sent to the intervention that is the best suited to meet their needs on the first time, families are more likely to remain stably housed.

To track the outcomes summarized above, the CoC Lead Agency will analyze the following Performance Measures annually.

1) PBC CoC will reduce the number of person experiencing homelessness.
    a. Reduction in the total number of person experiencing homelessness
    b. Reduction in the total number of persons experiencing first time homelessness.
2) PBC CoC will reduce the length of homelessness episodes
    a. Reduction in the mean length of homelessness episode for individuals
    b. Reduction in the mean length of homelessness episode for families with children
    c. Reduction in the mean length of homelessness episode for youth

3) PBC CoC will reduce the number of persons returning to homelessness.
    a. Reduction in return to homelessness within one year following exit
    b. Increase in exits to permanent housing
    c. Increase in income at exit

Measuring the success of this system and transparency with the community and providers will be a key to the success of coordinated assessment process. The CoC Lead Agency will summarize the data annually. The performance measures are utilized for all CoC programs regardless of funding source. For CoC funded and ESG funded programs, these criteria will be utilized for consideration for renewal or new projects based on the program type.

Moving forward, the CoC Lead Agency will expand the evaluation of outcomes by establishing mechanisms to monitor the quality of service through system-wide monitoring. For example, once a client enters shelter an assessment is to be completed within 72 hours. Procedures will be built into the monitoring system to determine how often this goal is met. This will allow for ongoing monitoring of the quality of services and how the program and Providers are able to follow through with this goal.

As part of the evaluation process, as recommended by the National Alliance to End Homelessness, the CoC Lead Agency will set a goal to establish an integrated feedback loop

that involves using information gained from these assessments to make any necessary program/process adjustments to the system. Additionally, the CoC Lead Agency will continue working to develop data tools to ensure overall system efficiency and effectiveness.

Ratified by Homeless & Housing Alliance Executive Committee -February 23, 2015
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