

Centralized Intake for Helping People Experiencing Homelessness: Overview, Community Profiles, and Resources

About this Tool

This document provides an overview of centralized client intake for prevention and rapid re-housing programs. It includes community profiles as well as a resource list on centralized client intake. This document is intended for use by governmental and community-based planning groups interested in centralized intake as a strategy for improving the effectiveness of homelessness prevention and rapid re-housing programs. The overview and best practice profiles are to help planners better understand centralized intake, its variations, and its potential benefits, while the list of resources will be of use to anyone who wants to conduct further research in support of his/her centralized intake planning goals.

BACKGROUND/OVERVIEW

Recent national research (Burt) has highlighted centralized intake as a key factor in the success of homelessness prevention and rapid re-housing programs (and many other kinds of homeless programs). Centralized intake can enhance the quality of client screening and assessment, and better target program assistance to 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. Because of these and other benefits (described below), centralized intake was a key program requirement under the U.S. Department of Housing and Urban Development's (HUD) 2008 Rapid Re-Housing for Families Demonstration Project. While centralized intake was not a requirement for programs funded by HUD's 2009 Homelessness Prevention and Rapid Re-Housing Program (HPRP), some of its functions were allowable under eligible HPRP activities, such as outreach, engagement, and service coordination. Thus, many communities have included some form of centralized intake as a part of their strategies for implementing HPRP programs. Other communities use centralized intake primarily for prevention clients because rapid re-housing clients are more likely referred to HPRP programs directly from their shelters.

DEFINING "CENTRALIZED INTAKE" AND OTHER IMPORTANT TERMS

What is Centralized Intake?

Centralized intake, in this context, refers to a single place or process for people to access the prevention, housing, and/or other services they need. It may be the only "door" for particular kinds of assistance, or there may be other ways to access assistance. It includes the following core components:

- Information so that people will know where or how to access centralized intake;
- A place or means to request assistance, such as a walk-in center or a 211 call center;
- 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 appropriate programs or agencies; and
- In some cases, a process and tools for 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 centralized intake location. These services typically meet basic client needs and may include crisis counseling, emergency funds, shelter or motel vouchers, bus tokens, information, phone, food, and clothing. However, some programs have evolved to provide more comprehensive on-site services, such as therapy, family counseling, parenting programs, legal assistance, childcare, healthcare, and other more intensive services.

Centralized intake can serve as a point of referral or admissions for a broad variety of service and housing programs that operate in a community. In practice, however, existing centralized intake programs often serve a limited part of the system, such as State-funded prevention programs or city-funded family emergency shelters, or serves different programs or populations in different ways.

Other Important 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:

- **Intake** – the general process between the client’s first point of contact and the decision whether or not to admit the client to a program. The intake process can include screening, assessment, referral, and verification. Intake may or may not result in program admission;
- **Information** – specific facts about a program, such as its location, services provided, eligibility requirements, hours of operation, and contact information;
- **Referral** – referring a client to a particular program for possible help, without any obligation on the part of the receiving program to actually offer or provide the help;
- **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.
- **Screening** – a first-level decision about whether the client is eligible for a program and/or would have a priority for those services. Screening determines who receives assistance;
- **Assessment** – a deeper level of inquiry into the actual problem and the client’s strengths and needs related to solving the problem. Assessment helps with service-matching and provides the information needed to determine the expected type, intensity, and duration of assistance a client or household might receive;
- **Verification** – the gathering and review of information to substantiate the crisis situation and support program eligibility and priority determinations; and
- **Admission** – using authority to admit the client into the program.

LEVEL OF AUTHORITY

The term “centralized intake” is used here to broadly cover different kinds of programs with varying roles and level of authority. Some programs provide only centralized information and referral, while others have full authority to admit clients to receiving programs, while still others combine roles in different ways. The following provides a continuum of different kinds of centralized intake programs based upon level of authority:

- **Centralized Information and Referral Only** - the centralized intake program provides a central point for information and referral, but has no authority to commit services;
- **First-Level Screening** – the centralized intake program conducts initial screening and service matching, while the receiving program conducts further screening, assessment, verification, and makes final admissions decisions;
- **Admissions Authority** – the centralized intake program conducts full screening, assessment, verification, and makes admissions decisions that are binding on the receiving program; and
- **Mixed Authority** - the centralized intake program provides centralized information and referral, and has admissions authority over some housing/service types (e.g., shelter beds), but not others (e.g., rental assistance).

Any community developing centralized intake should plan very carefully around the question of authority. The approach taken should depend on the particular needs and circumstances of the community, and may evolve with time. In some cases, the community will decide that the benefits of a centralized admissions approach outweigh any countervailing concerns, while in others the community will decide that admissions authority should remain with the receiving program. One example would be where the receiving program has unique skills in intake and expertise with the target client population.

In cases where centralized admissions is being considered to replace a diffused admissions approach, the receiving programs (and other community members) will have questions and concerns about control of the centralized intake program that must be adequately addressed. For example, the receiving programs may be concerned that the centralized intake program will not properly screen and verify clients for their unique program and thus will send them too many ineligible or inappropriate clients. A process for regular communication and collaboration between the centralized intake and receiving programs will help prevent such problems.

It is critical to be very clear, including in written program information, about what the centralized intake program can actually deliver in terms of information and referral or admissions. Being clear will help avoid confusion, frustration, and even chaos among potential clients seeking something that is not actually being offered.

WHAT ARE BENEFITS OF CENTRALIZED INTAKE?

Following are some of the benefits of centralized intake:

For service seekers, it can:

- Simplify and speed the process for people to locate and access needed services;
- Help to ensure that people get the right services;
- Save people precious time in looking for and traveling to service sites;
- Provide access to multiple service programs through one process, saving further time;
- Be available on weekends and after hours.

For prevention and homeless service agencies, it can:

- Provide a ready and certain source of appropriate client referrals;
- Furnish immediate written information about the client's needs and requests;
- Allow staff to focus more on serving clients and less on gathering information and filling out forms;
- Support interagency collaboration and coordination around a single intake process;
- Improve cost efficiency by replacing duplicative intake functions with a single approach;
- Reduce the effort needed and cost for agencies to publicize their services.

For policy planners, decision-makers, and funders, it can:

- Improve the speed, accuracy, and consistency of the screening, assessment, and referral process; these are the primary functions of the intake workers, who are trained for the job;
- Make it possible to target resources more efficiently and accurately in order to be most effective (e.g., allow triaging to the most vulnerable people and/or urgent situations);
- Enhance the overall coordination of prevention and homeless services and reduce system-wide fragmentation;
- Improve the system's ability to deliver accessible, culturally competent services, for example by providing information in multiple languages; and
- Create a pool of data about people seeking help and their housing and service needs, and about unmet needs and gaps in the service system.

CENTRALIZED INTAKE MODELS AND FACTORS TO CONSIDER

Different Models

As stressed earlier, centralized intake is not a single programmatic approach. As homeless prevention and service systems have developed around the country, the following three centralized intake examples have evolved as common approaches (although variations and combinations also exist). In selecting or designing a program model, planners should consider not only the desired benefits and the question of authority (above), but also a variety of additional factors such as service area geography, service philosophy, collaborative styles, and available technology:

1. Single Location Central Intake

The term “central intake” is typically and most often applied single location models, which are the most likely to conduct extensive screening, assessment, verification, and to control client admission to receiving programs. In this model, clients call or go to a central intake site at a specific geographic location, where they typically meet with an intake worker and sometimes receive basic services on site. The site can be a dedicated central intake site or it can be an office within a broader prevention or homeless program, such as a shelter, day center, or food program.

2. Multiple Location Uniform Intake

In support of an “any door” services strategy, clients may call or go to any one of multiple participating prevention and homeless programs at different geographic locations. Intake workers at each location use standardized intake, assessment, and referral procedures and tools, often in the context of shared HMIS data collection and reporting.

3. 211 Phone Centralized Intake

In an “anywhere” services contact strategy, clients call 211 or another hotline number to request assistance. Phone intake workers use standardized procedures and tools to conduct first level screening and/or referral, often in the context of shared HMIS data collection and reporting. Typically, the receiving program conducts additional assessment and verification and makes final admissions decisions.

Choice Factors

The particular model chosen by a community will depend on many different factors, which could include the geography of the service area, the desired system role and authority for the centralized intake provider, the existing level of service integration and collaborative relationships, and resources available for centralized intake. For example, a Single Location Central Intake approach might make more sense in a smaller geographic area, such as a city, where it is relatively easy for the client to travel to the intake site, and where there is sufficient provider interest and buy-in to centralized admissions for at least in one part of the service system.

On the other hand, a Multiple Location Uniform Intake approach might be the preferred approach in a spread out geographic area, such as a county, region, or even state, where it would be difficult or impossible for the client to travel to a single central location, and where providers are willing to adopt uniform intake procedures and tools.

A 211 Phone Central Intake approach may make sense when the community already has a 211 or other hotline infrastructure, which it would like to leverage in order improve the delivery of prevention and homeless services.

The chart below compares key program choice factors of the three centralized intake models above.

Comparison of Centralized Intake Models and Community/Program Choice Factors			
Community or Program Choice Factor	Centralized Intake Model		
	Single Location	Multiple Location	211 Phone
Service approach	Single point of service access, single process	“Any door” service access, single process	“Anywhere” service access, single process
Authority/role	Good for centralizing all aspects of intake and referral, including program admissions	Intake and admissions usually remain with the receiving programs, which use a standardized process and tools	Typically conducts first level screening, while further assessment and admissions remain with the receiving programs
Geography	Good for urban areas with reliable transportation where the service system is well integrated	Facilitates client contact in a larger geographic area, or where transportation is poor	Makes client contact possible irrespective of geography and the level of service coordination
Program collaboration	Need willingness to share authority and good communication between participating programs	Need provider willingness to change intake process and adopt uniform procedures and tools	Need provider support for integrating client intake procedures with 211 or other hotline provider
Method of client contact	Initial contact can be by phone or walk-in; some programs begin with phone contact followed by in-person appointment		Contact by phone followed by referral to an in-person meeting or appointment with the receiving program
Depth of client contact	Face to-face meeting allows for more in-depth client contact/assessment		Phone meeting is usually brief, with more in-depth client contact/assessment by the receiving program
On-site services	On-site services (vouchers, food, etc.) are possible	On-site services (vouchers, food, etc.) are possible, and often co-located with other service programs	On-site services are typically not possible

Facilities	Need a single office, disability accessible, close to public transportation, with space for confidential meetings	Intake is integrated into existing programs, should be disability accessible, close to public transportation, with space for confidential meetings	Need a call center with space for one or more phone workers; should have interpretation for language accessibility
Hours of operation	Depends upon resources for staffing; evening and weekend hours improve client access		
Staffing/caseload	May need to hire and train new intake staff with housing assessment skills	Likely can implement with existing program staff who may need training on uniform procedures	May be implemented with existing 211 or other hotline staff, but need to train for or hire a housing specialist
Cost	Staff, facility, and other costs may be offset by efficiencies at receiving programs	Staff, facility, and other costs may be absorbed in existing programs, some efficiencies may be lost	May need to pay a share of existing 211 or pay additional costs for a housing specialist

PLANNING CONSIDERATIONS AND DESIGN FACTORS

Planning Considerations

Since centralized intake can be a major systems change within a Continuum of Care (CoC), it is best planned through an inclusive community process that includes representatives from all key stakeholder groups, such as housing and service providers, information and referral agencies, local government departments, funders, coalitions, and homeless or formerly homeless people. It is especially important to find a way to include those who have something valuable to bring to the project, whether it is control over needed funds, program expertise, and/or skills in forging agreement and support for the program.

A centralized intake planning group could be a stand-alone body, a committee of the CoC Board, or even a sub-committee of the CoC Homelessness Management Information System (HMIS) committee. Where the planning group best fits into the overall system is a decision that should be based upon local preferences and needs. The important thing is to execute a consistent process and include key stakeholder groups.

Once the planning group has been established, it will be very important to develop a framework or work plan for identifying and making decisions on programmatic and operational issues. The decision process will work better if broader programmatic issues are addressed prior to more detailed operational questions. For example, first decide which populations or system sectors will be served by centralized intake before choosing the location of the centralized intake facility. Also, while it is a good idea to develop and follow a planning timeline, planners should be prepared to be flexible and take as much time as is actually needed to generate consensus and buy-in for the overall project vision and each key decision.

Finally, it will be critical to have an effective process to address the concerns and build the trust among participants, particularly among agencies that may be asked to grant a share of program admissions control to the centralized intake program. It is important to be realistic in planning. Consider starting with a relatively narrow, similar group of programs, such as County-funded prevention or shelter programs, rather than seeking to establish centralized admissions for all program types.

Design Factors

Some of the important design issues and decisions will include, but not be limited to:

1. What are the specific project goals or objectives?

Begin the planning process by thoroughly discussing and reaching consensus on the project goals and objectives. Take as much time as needed to reach consensus on what the project will accomplish. A goal is a broad statement of what the program or program component hopes to accomplish. Potential goals could be fairly general, such as: (1) improving accessibility to prevention and rapid re-housing assistance and services; (2) better coordinating emergency shelter referral and placement; and/or, (3) enhancing system capacity to intervene timely and effectively in housing and personal crises.

Objectives, on the other hand, are typically more specific. An objective is often expressed as a specific, measurable component that relates to the program goals, such as: (1) provide a central intake placement process for all adult emergency shelter beds, and (2) make information and crisis intervention and planning easily accessible 24 hours-per-day, seven days-per-week.

2. Which populations will be targeted?

It is very important to define which populations will be assisted and prioritized through centralized intake. Effective targeting requires assessment of the community's population characteristics and needs. A population may be targeted for assistance based upon any number of factors, including identified gaps in services for certain populations or in certain communities, the subpopulation expertise (e.g., persons with behavioral health disabilities) of the agency that will provide assistance or its geographic catchment area. For example, a program might consider targeting all people experiencing homelessness or a specific subpopulation, such as families, adults, or unaccompanied youth. A program may provide centralized intake for both homeless people and those at risk of homelessness or it may be designed to assist specific, such as domestic violence victims or people with mental illness.

3. What level of authority will be exercised?

Again, the level of authority to be granted is a core issue. Once it is clear which population and programs sectors will participate, consider and decide how much authority over program admissions will be exercised by the centralized intake entity. This need not be an all-or-nothing decision; it may make sense to take a mixed approach, whereby the centralized intake program controls admission to some programs or sectors, while it conducts initial screening and/or referrals for others. This is a decision that must be made in light of the desires, needs, and concerns of the community. Because centralized intake planning hinges largely on this issue, all of the following design factors will be significantly influenced by decisions relating to the granting of program admissions control.

4. Which program model or approach will be chosen?

Early on, identify the program model best suited to meet the project's goals and objectives. Will it be a Single Location, Multiple Location, 211 Phone, or combination approach? Again, the choice may depend largely on admissions control decisions (e.g., Single Location may be better for admission control, while 211 Phone may be better for first level screening). Geographic considerations will also be important. Please see the table above for a more complete discussion of choice factors.

5. Who will be the lead agency?

It is important to select a lead agency with the capacity and legal authority to manage the project as envisioned, as well as the ability to gain the trust of and collaborate with other agencies. In selecting a lead agency, consider:

- Prior experience in relevant hotline, intake, and eligibility screening processes;
- Background in crisis intervention;
- Previous experience working with the target client population, e.g., homeless youth;
- Proven ability to use and maintain data systems for managing client data, program information (e.g., shelter bed openings), and client referrals;
- Strong management and fiscal capacity.

6. What specific services will be offered/provided on-site?

The specific services to be offered or provided on-site should be determined largely by the goals or objectives of the project. Most centralized intake projects will provide some combination of client information and referral, program screening and assessment, and crisis intervention and de-escalation. These may be delivered through phone consultation and/or in-person meetings. Data collection and processing, both for client and program information, are often core activity for many centralized intake projects. If the project provides prevention programs, rental assistance and housing-related case management could actually be delivered on-site. Family-focused programs may want to provide additional family services, such as childcare and parenting programs. Some centralized intake programs also furnish basic or emergency services, such as bus tokens or toiletries.

7. What specific services will be offered/provided off-site?

The specific services to be offered or provided off-site, either through program admissions or non-binding referral, will also be determined largely by the goals and objectives of the project. Key off-site services, such as shelter beds or rental assistance, could be clearly defined and set aside through a Memorandum of Understanding (MOU) or other formal interagency relationship. Many other services can be made available through referral. Real-time information regarding programs, eligibility requirements, hours of operation, location, and public transit links is critical to the effectiveness of both the programs admissions and program referral processes. A regularly updated information and referral database, preferably linked to HMIS, is a good idea. Specific procedures should govern how staff make, follow-up, and document program admissions and referrals.

8. How will clients know about centralized intake?

Centralized intake cannot work unless clients are aware of where to go, when to go, and what services may be available. Therefore, centralized intake planners should think carefully about how to inform potential clients. Marketing strategies that may work include direct outreach to the street and other service sites, informational flyers left at services sites and public locations, wall postings, radio and television public service announcements, announcements during CoC or other coalition meetings, and website postings. To avoid attracting ineligible clients, marketing information should be very clear about what can be delivered in terms of admissions or referrals, to what programs, and for whom.

The marketing strategies utilized will depend on a variety of circumstances such as the anticipated clientele, how that clientele typically accesses information, and resources available to support marketing efforts. Programs should also consider other agencies that will likely refer clients, encourage them to do so, and make sure they have up-to-date information about centralized intake's hours of operation, location, and services. This may require revising information about former intake processes. Marketing should be directed toward agencies that already serve clients with housing crises; these clients will be somewhat pre-screened for prevention and rapid re-housing assistance.

9. How will screening, assessment, and verification be conducted?

While screening and assessment are functions of all centralized intake programs, the level and mix of information needed will vary depending upon such factors as whether program admissions decisions are being made or not, types of programs and services offered, priority and eligibility criteria, whether client contact is face-to-face or by phone, HMIS requirements, and other legal or funder requirements. In designing not only the data collection tools, but also the process for interacting with clients, consider:

- Immediate risks/crisis—quick steps may be needed to avert physical or psychological danger, the threat of immediate housing loss, etc.;
- Basic demographic and contact information—name, age, dependents, other family, current location, contact phone number, address, etc.;
- Problem definition—client-identified problems affecting housing such as late rent, landlord problems, credit history, and/or job and income issues;
- Solution definition—what the client wants or requests from among what is offered;
- Eligibility information – homeless or at risk of homelessness, household income level;
- Additional risk and vulnerabilities for prioritizing purposes – severe rent burden, domestic violence, prior incarceration or institutionalization, mental health issues, substance abuse, and other specific housing retention barriers, etc.;
- Verification – documentation of income source(s) and amount, and phone contact to substantiate rent arrears, notice of eviction, etc.;
- Additional data required for HMIS and reporting (including consent process); and
- Additional data required by law or other funders.

Avoid the temptation to assess too deeply on issues that do not directly affect housing status. Prevention and rapid re-housing programs work best when they focus primarily on housing problems.

10. How will data be effectively managed?

The effective management of information—about both clients and programs—is critical to the smooth functioning of centralized intake. HMIS participation is required for HPRP-funded programs and regularly updated information and a referral database will go a long way toward enhancing a centralized intake system. An electronic application process can facilitate screening, assessment, referral, and admissions, but may be too costly or complex for some.

11. What policies and procedures will help operate the program?

A benefit of centralized intake is that it standardizes and enhances screening, assessment, referral, and admissions. Written policies and procedures that spell out programmatic roles, responsibilities, and expectations of all staff, will make the program even more effective and efficient. Topic examples:

- Handling and documenting phone inquiries and intake;
- Handling and documenting in-person meetings, screening, and assessment;
- Hours of operation;
- Timeliness responses to requests for assistance;
- Gathering and verifying information for adult and children;
- Handling of crises and emergencies;
- Confidentiality of client information;
- Evaluating information and making eligibility determinations;
- Procedures for program placements or referrals; and
- Handling special situations, such as suspected child abuse or dangerous situations.

12. What resources are needed to implement the program?

Consider the resources needed to achieve the project's goals and objectives. The program may need only basic operational resources or may have unique features that require more support. Some resources that may be needed—and will require funding—include:

- An office or offices that meet the program's space and facility requirements;
- A data system, preferably linked to HMIS, for managing both client and program information;
- Access to an information and referral database;
- A phone system capable of handling hotline functions; and
- Staff trained in intake, assessment, verification, referral, and crisis response/de-escalation.

13. How will ongoing collaboration with stakeholders be supported?

Centralized intake projects work better when there is a regular process for communication with and input from key stakeholders, especially the program receiving admitted or referred clients. One format is to include these stakeholders

Resources for accessibility are critical for centralized intake programs and support the goal of improving clients' access to the assistance offered. Consider accessibility not only for people with physical and mental disabilities, but also for people with different language and cultures. Determine if interpreters for common languages be on-site or will a commercial language line be used as well as if information and forms be translated into all languages commonly used by members of the target clientele.

in an advisory committee, where they take part in regular conversations with centralized intake management and staff. Potential areas for advisory committee collaboration and input include:

- Policies and procedures development;
- Partner agency roles and responsibilities;
- Knowledge sharing and cross-training;
- Program and service development;
- Information updates on admissions procedures, eligibility, and priority;
- Handling of complex client cases; and
- Program evaluation.

Problems and confusion will be avoided if there is a process to regularly inform centralized intake staff about receiving program changes and details that can directly affect admissions or referrals, such as changes in admitting hours or to the allowable family composition (e.g., whether older teen boys are allowed in a family shelter).

Community Example: Connecting Point, San Francisco

PROJECT OVERVIEW

Founded in 1995 by the San Francisco community of family providers, Connecting Point provides a single point of service access for families who are homeless or facing a housing crisis. Replacing a previously fragmented, difficult-to-navigate system, the project provides a single location and process for families to obtain the specific types of housing they need, as well as a variety of supportive services.

Key to the success of the program is a screening and assessment process (described below), which thoroughly explores the family's situation and pinpoints their unique housing and service needs. Based upon the assessment, families are referred to the kinds of housing and services most appropriate to their situations. This can include placement in a family emergency shelter (all family shelter placements in San Francisco are made through Connecting Point), referrals to transitional housing or subsidized permanent housing (through a Housing Authority preference), or housing-related financial assistance through the agency's Rental Assistance Program (RAP). A range of drop-in services is available on-site. RAP financial assistance includes three tracks:

- One-time, no-interest loan for move-in costs with one-year of after care and follow-up;
- Short-term (3-6 months) rental subsidies; and
- Long-term (up to 24 months) shallow rental subsidies.

Connecting Point was developed through a collaborative community process. The Shelter Consortium currently advises Connecting Point and includes city staff, the representatives from all family shelters, and all Connecting Point staff. The Shelter Consortium meets weekly to develop program policies and procedures as well as to review and make decisions around priority family cases.

PROJECT OBJECTIVES

- Furnish the means for families to easily and efficiently access housing and services;
- Ensure that each family receives a thorough intake and assessment that uncovers the strengths and needs of the whole family; and
- Track each family to a housing and services package in which it will succeed.

Community Setting: San Francisco CA

Connecting Point, a program of Compass Community Services, is located in San Francisco, a compact, dense city with excellent public transportation.

Population: 808,976 people (2008 U.S. Census)

Homelessness: 6,514 homeless people point-in-time (2009 Homeless Census)

STAFFING AND SKILLS

Connecting Point has ten employees, including the Program Director, an Assistant Program Director, crisis case managers, a Drop-in Coordinator, as well as support for the Director of the agency's mental health services. All staff receive training in crisis intervention and hotline operations. Agency staff also speak a variety of languages including Spanish, Mandarin, and Cantonese. Prior experience in homeless programs and/or crisis intervention and relevant educational background are required for employees.

TARGET POPULATION

Families who are homeless and those facing a housing crisis. Families must have at least one child under 18 or a pregnant woman in the 3rd trimester. An average of 120 families are assisted on-site per week.

MARKETING AND INFORMATION

- Brochures regarding family shelter access and rental assistance program widely distributed;
- Direct contact with families at Project Homeless Connect and service sites;
- Information regarding Connecting Point services provided at coalitions, local government bodies, and CoC planning groups meetings;
- Every hotline in the city knows of Connecting Point and refers families; and
- MOUs call for partner agencies to refer families to Connecting Point.

SUMMARY OF AUTHORITY/RESPONSIBILITY

Connecting Point has complete authority to admit families to San Francisco family emergency shelters and provide families with financial assistance through the RAP, and conducts first level screening and referrals for transitional housing and subsidized housing.

ELIGIBILITY AND SCREENING PROCESS

As mentioned above, thorough intake and assessment is a key to ensuring families are properly helped in way that they can actually be successful. Intake and assessment has two steps:

1. Call Crisis Hotline

Families call the Connecting Point crisis hotline for a brief (15 - 20 minute) phone intake. The counselor gathers information, establishes eligibility for services, and schedules an in-person appointment.

2. Attend In-Person Appointment

Based upon the initial call, families receive an appointment for a complete family assessment covering all adults and children. Where there is an emergency, the appointment is set for the same day as the phone intake or the following day. Otherwise, all appointments take place within two weeks of the initial call. Topics explored with adults during the assessment include income, housing situation, mainstream benefits, safety and violence, health and mental health, and family finances and budgeting. Information from each child such as school, childcare, educational support needs is also gathered.

SERVICES PROVIDED ON-SITE

Core Services	On-Site Drop-In Services (3 days a week)
<ul style="list-style-type: none"> • Hotline and crisis intervention • Intake, assessment, counseling, follow-up • Shelter placements • Information and referral to housing and services • Housing-related financial assistance (see above) 	<ul style="list-style-type: none"> • Food, toiletries, baby supplies, clothing • Bus tokens (for adults) and Fast Passes (for kids) • Computer lab and phones • Therapist and medical care providers • Job specialist and financial counseling • Children's counselors, parenting services, childcare • Eviction defense (though co-located Eviction Defense Collaborative)

SOURCES OF FUNDING

Connecting Point has various funding sources and means of support including federal grants, city contracts, foundations grants (especially for rental assistance program), corporate and individual gifts, and proceeds from fundraising events.

POSITIVE IMPACT AND OUTCOMES

- A single place has been provided to assist more families to overcome homelessness or a housing crisis;
- Rapid, efficient intake and assessment has helped families get assistance faster;
- Comprehensive assessments and different services tracks have improved the targeting of assistance to families; and
- A fragmented family service system has been replaced by a coordinated, more efficient approach.

KEY LESSONS LEARNED

- An inclusive community process is critical to the successful planning of centralized intake. Having community expertise at the table helps ensure that all needs are addressed and all required program capabilities considered. For Connecting Point, it was very important to use the community process to gain the trust of participating family shelters.

- Centralized intake operates better if project partners are convened regularly in an advisory or steering committee format to share information and resolve problems and issues. As mentioned above, Connecting Point's Shelter Consortium meets weekly and brings to together city staff, Connecting Point staff, and family shelter representatives to resolve policy and procedural questions and provide input into complex client cases. These meetings allow all participants to learn from each other, which strengthens the program.
- The importance of a good data system cannot be underestimated. Without a data system, the efficient management of client intake, screening, assessments, referrals, follow-up, and program reporting would be exceedingly time-consuming and difficult.
- Put the family first! Do not let financial or political reasons divide participating agencies. Partners must work together for the benefit of each client.

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Community Example: Central Access Point, Cincinnati, OH

PROJECT OVERVIEW

Founded in March of 2008 to provide centralized intake for family shelters in the Cincinnati/Hamilton County Continuum of Care (CoC) area, the Central Access Point (CAP) project has quickly expanded to include intake for homelessness prevention and rapid re-housing programs for families and individuals, (and soon a men's shelter). Headquartered at the offices of the Cincinnati Continuum of Care CoC, the CAP project replaces the previously fragmented system for accessing shelter and financial assistance with a single hotline number—381-SAFE. Before the CAP project, persons and families needing shelter or assistance were forced through an obstacle course of different phone numbers, staffing patterns, intake criteria, and access systems just to get basic shelter. Now they can access what they need by simply calling one, well-publicized number.

Community Setting: Cincinnati/Hamilton County, OH

The CAP is located in Cincinnati, the seat of Hamilton County, on the banks of the Ohio River

Population: Cincinnati, 332,252 people (2006 U.S. Census), Hamilton County, 851,494 people (2008 U.S. Census)

Homelessness: 7,221 homeless people point-in-time Hamilton County (2008 Homeless Census)

A key to the success of the program is its extensive use of the Homeless Management Information System (HMIS). CAP intake workers use the HMIS not only to collect and enter basic client demographic data, but also for eligibility and risk assessment screening for shelter and prevention and rapid re-housing programs, and for tracking and documenting all phone calls. In addition, the HMIS includes a shelter "bed finder," which staff use to reserve beds in participating shelters. Referrals for check-in to shelters are submitted electronically through the HMIS call log page and are followed with an instant message to the shelter; this allows real-time information exchange without tying phone lines, and maintains a log of the information.

The CAP project is available seven days a week (10 a.m.-8 p.m. Monday through Friday and 10 a.m.-2 p.m. Saturday and Sunday). It receives an average of 30 calls per day, including an average of 18 from families needing shelter.

PROJECT OBJECTIVES

- Provide easier access to family shelters, prevention programs, and rapid re-housing programs;
- Better coordinate the shelter, prevention, and rapid re-housing system;
- Furnish improved information about clients served, their needs, and program outcomes.

STAFFING AND SKILLS

CAP has one full-time and two part-time Intake Workers. The program is planning to expand its staffing to help handle the increased caseload resulting from the program's growth. CAP requires a college degree for its employees and prefers prior experience or licensing in the field of homelessness.

TARGET POPULATION

The initial target populations were families experiencing homelessness (for shelter) and families at risk of homelessness (for the Ohio Family Homelessness Prevention Pilot Program). Homeless individuals are now being included for Homelessness Prevention and Rapid Re-Housing Programs and a men's shelter.

MARKETING AND INFORMATION

- A press release helped launch the program and informed potential clients;
- Informational posters and flyers were distributed at all emergency service agencies in Hamilton County;
- Print media are used to publicize the 381-SAFE number; and
- Area 2-1-1 and service providers regularly refer appropriate clients to the CAP program.

SUMMARY OF AUTHORITY/RESPONSIBILITY

CAP conducts in-depth screening for family shelters and prevention and rapid re-housing programs, while the receiving programs conduct further verification and retain final admissions authority.

ELIGIBILITY AND SCREENING PROCESS

Families and individuals in need call 381-SAFE to request help. CAP Intake Workers then assess the caller's situation, gather basic demographic information for every family member, ask program eligibility screening questions, and make placements (including appointments) and referrals to appropriate programs. As mentioned above, Intake Workers use HMIS to track all calls, enter client demographic and program screening information, reserve shelter beds, and electronically refer clients.

Screening for prevention rapid re-housing programs includes a needs-based scale that ranks clients from mild, to moderate, to severe difficulties; households with moderate to severe difficulties receive assistance.

Shelters and agencies receiving a client referred by CAP typically conduct a face-to-face interview with the client, review eligibility-related documentation, and make a final program admissions decision. Occasionally, a client will be sent back to the CAP for a more appropriate referral.

SERVICES PROVIDED ON-SITE

Core Services	Additional Services
<ul style="list-style-type: none"> • Phone Intake and eligibility screening • Shelter bed reservations • Facilitation of prevention and rapid re-housing program placements • Referrals to other needed services 	<ul style="list-style-type: none"> • Some crisis intervention • Data collection, management, and reporting • Supporting case management and services and collaboration among family service providers • Coordinating with mainstream children's services and income maintenance programs

SOURCES OF FUNDING

Foundations, federal HPRP funds, State of Ohio Family Homelessness Prevention Pilot funds, Hamilton County Department of Jobs and Family Services, and financial support from participating shelters (who save money by not having to employ intake workers).

POSITIVE IMPACT AND OUTCOMES

- Standard screening tools and program eligibility criteria have improved the targeting of programs and helped to prevent those who are ineligible from getting through the screening process;
- Shelter access for families has become dramatically easier because they no longer have to locate and call five different programs to request shelter;
- Shelters are operating closer to capacity than before because the CAP program is able to fill more beds; and
- The family service system has become better integrated and streamlined.

KEY LESSONS LEARNED

- A good data system is critical to the success of phone-based centralized intake; it can be used to streamline many program functions, including data collection, bed reservations, referrals, and it helps to bind together the family services system.
- Collaboration among participating programs is a key to the success of centralized intake. The CAP program grew out of Family Shelter Partnership Program (FSPP), collaboration among family shelter providers, the City of Cincinnati, and the Hamilton County Department of Jobs and Family Services to improve case planning and services for homeless families. HMIS data gathered by CAP Intake Workers is used in weekly staff case reviews and monthly planning and coordination meetings.

- It is critical to work closely with shelters to gather detailed information about programs admission criteria, rules, hours, curfews, etc. Each family shelter had different admissions criteria (e.g., relating to admission of families with teen-aged boys of families with a both parents). Some shelters had very specific written admissions criteria, while others did not. The CAP requested that each shelter put their criteria into writing so that Intake Workers could make appropriate placements.

CONTACT INFORMATION

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Community Example: United Way 2-1-1 Housing Plus, CT

PROJECT OVERVIEW

The United Way of Connecticut 2-1-1 is currently in the process of developing a new program called “2-1-1 Housing Plus.” Once operational, 2-1-1 Housing Plus will serve as a statewide “universal front door” for families and individuals who are in need of homelessness prevention and rapid re-housing services.

The United Way 2-1-1 has long been a critical resource for Connecticut residents in need of many kinds of help, including housing assistance or homeless shelter. In fact, an estimated 35,000 to 40,000 homelessness or housing-related calls are received per year (among many other calls for service assistance).

Community Setting: State of Connecticut

The United Way 2-1-1 serves all of Connecticut, a small state in New England with many cities, towns, and rural areas.

Population: 3,501,251 people (2008 U.S. Census)

Homelessness: 4,366 homeless people point-in-time (2008 Statewide Homeless Census)

Given this demonstrated need in the housing area, 2-1-1 Housing Plus will expand 2-1-1’s capacity to screen callers for eligibility for homelessness prevention or rapid re-housing assistance and to effectively refer callers to any HPRP-funded program in their own communities or areas of the state. All State and municipal HPRP subgrantees—an estimated 40 to 50 agencies—will participate in the program and receive referrals. 2-1-1 Housing Plus will not only screen and refer clients, but also will actively work to make sure people actually connect to HPRP programs, and will follow up with the client if necessary.

An expected key to success of the program will be its use of the Connecticut Statewide HMIS (administered by the Connecticut Coalition to End Homelessness) for collecting and storing HPRP client contact, demographic, and eligibility screening information. Participating HPRP-funded agencies will benefit because when they receive a referral from 2-1-1 Housing Plus, they will also receive access to the client’s HMIS record. The State and policymakers will benefit from a statewide pool of HMIS data on HPRP clients.

2-1-1 Housing Plus will be fully operational (taking calls) by October 1, 2009. It will be available from Monday – Friday, 8.a.m-6 p.m. Weekend hours might be added if needed. A call volume of 8,000 per year is anticipated.

PROJECT OBJECTIVES

- Streamline the process for referring clients to HPRP-funded programs throughout the state;
- Build the capacity of the United Way 2-1-1 to actively assist clients immediately and not just rely on the provider referral; and
- Better coordinate the statewide system for serving homeless and at-risk families and individuals.

STAFFING AND SKILLS

2-1-1 Housing Plus expects to employ two full-time Housing Plus Call Specialists. A Bachelor's or Associate's degree in a related field plus relevant work experience will likely be key requirements for the positions. The ability to handle a high call caseload, to use computers and HMIS, and to relate effectively with people from diverse backgrounds will also be important.

TARGET POPULATION

2-1-1 Housing Plus targets families and individuals who are eligible for HPRP prevention and rapid re-housing assistance because they are either homeless or at risk of homelessness.

MARKETING AND INFORMATION

United Way 2-1-1 will (dependant upon funding) seek to develop marketing materials for and publicize the 2-1-1 Housing Plus program.

SUMMARY OF AUTHORITY/RESPONSIBILITY

United Way 211 will conduct first level screening for all 40 to 50 State or municipal HPRP subgrantees, while the receiving subgrantees will conduct more detailed assessment and verification, and make final admissions decisions.

ELIGIBILITY AND SCREENING PROCESS

Families and individuals in need call 2-1-1 to request help. If the caller indicates the need for prevention or rapid re-housing assistance, he or she will be transferred to a Housing Plus Call Specialist. The Housing Plus Call Specialist will gather contact and demographic information about the caller and any family members, and conduct an HPRP eligibility screening using the HPRP "eligibility screen" in the Statewide HMIS.

If the caller is eligible for either the prevention or rapid re-housing program, he or she will be referred to an appropriate HPRP service provider. When appropriate, the Call Specialist will establish a three-way call with the agency receiving the referral in order to make sure contact is actually made. Factors considered include not only eligibility, but also whether the caller is ready to make contact and whether or not he/she would prefer to call independently. As mentioned above, the Call Specialist will enter all information collected into the Statewide HMIS.

Callers who are not eligible for HPRP services will be connected back to a regular 2-1-1 Call Specialist for assistance with non-HPRP program referrals.

Programs receiving a client referred by 2-1-1 Housing Plus will have immediate access to the client's HMIS record and assessment screen. The program will then conduct a face-to-face interview with the client, fill out a more detailed standard HPRP application, and review eligibility-related documentation. The final eligibility determination is made by the HPRP-funded program, not 2-1-1 Housing Plus.

2-1-1 Housing Plus will not be the exclusive door into HPRP programs. People in need may also choose to seek help from their local social service agencies or apply directly to an HPRP-funded program. Also, 2-1-1 Housing Plus will mostly serve prevention clients because rapid re-housing clients will likely be referred directly from their shelters to HPRP-funded programs.

SERVICES PROVIDED ON-SITE

2-1-1 Housing Plus Services	Other 2-1-1 Services
<ul style="list-style-type: none"> • HPRP phone intake and eligibility screening • Referrals to HPRP programs • Follow-up and advocacy if needed • HMIS data entry • Referrals to other needed services 	<ul style="list-style-type: none"> • Information and referral for a broad variety of human services • Crisis intervention • Searchable state database of human services • Statistics and publications on calls and service requests

SOURCES OF FUNDING

2-1-1 Housing Plus receives administrative funds from the State Program HPRP grant. The United Way 2-1-1 is also providing in-kind support in the form of office space and phones.

POSITIVE IMPACT AND OUTCOMES

Although the program has not yet started, key outcome and impact goals are as follows:

- A universal statewide “front door” for HPRP programs will be established;
- A centralized place and method to access needed assistance for people who are homeless or at risk;
- Better connections and improved operating procedures will be forged between 2-1-1 and service providers; and
- Better connections and operating procedures will go beyond HPRP to other systems of care.

KEY LESSONS LEARNED

- It was important in the planning process that United Way 2-1-1 agreed to enter data into HMIS. This helped gain the buy-in of HPRP-funded providers because they would receive a benefit—access to an already started HMIS record and completed eligibility screen.
- The process has led to renewed interest in data integration from the one CoC that does not use the Statewide HMIS—the Hartford CoC.

CONTACT INFORMATION

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LIST OF ADDITIONAL RESOURCES

For those wanting to conduct further research, the following includes web references for additional program examples, model tools and materials.

SUMMARY OF ADDITIONAL PROGRAM EXAMPLES

The Salvation Army Booth Family Services, Grand Rapids, MI

The Salvation Army's Booth Family Services is the community's entry point for persons needing immediate shelter placement or assistance to maintain housing. For further information, please visit: <http://www.boothfamilyservices.org/>

For further information about the program's involvement as the intake center in the HPRP-funded Prevention and Rapid Re-Housing coordinated community response model, please visit: http://www.grand-rapids.mi.us/index.pl?page_id=9763

YWCA Family Center, Columbus, OH

The YWCA Family Center is the community's "front door" central access point for a broad range of family prevention, emergency, diversion, and rapid re-housing services for families. For further information, please visit: http://www.ywcacolumbus.org/site/PageServer?pagename=services_familycenter

For further information about the program's involvement in the Stable Families Pilot Program to prevent homelessness and reduce school mobility among homeless children, please visit: <http://www.csb.org/?id=how.plan.access>

Michigan Coalition Against Homelessness Statewide HMIS, MI

The Michigan Coalition Against Homelessness operates the Michigan Statewide Homeless Management Information System (MSHMIS) for nearly 60 participating CoCs. MSHMIS has developed HMIS processes and tools to support local centralized intake and centralized housing plans required of HPRP subgrantees funded by the State of Michigan HPRP program. For further information, please visit: http://www.mihomeless.org/MCAH/Welcome_to_our_Web_Site.html

For further information about the State of Michigan HPRP program operated by the Michigan State Housing Development Authority, including the centralized intake and centralized housing plan provisions, please visit: http://www.michigan.gov/mshda/0,1607,7-141-5515_7534-213474--,00.html

MODEL TOOLS AND MATERIALS

Connecting Point, San Francisco

<http://www.compass-sf.org/>

Rental Assistance Program intake form, completion of intake form, project policy, referral form/application, client contract, and client satisfaction survey are all available in the on-line the HPRP Library at: <http://www.hudhre.info/index.cfm?do=findAResource>.

Central Access Point, Cincinnati

CAP Intake Worker job description: <http://www.cincinnatioc.org/docs/CAP%20Job%20Description%2008052009.pdf>

PowerPoint presentation about creating the CAP: <http://www.partnershipcenter.net/docs/ta/Creating%20a%20Central%20Access%20Point.pdf>

The Salvation Army Booth Family Services, Grand Rapids, MI

Coordinated Community Response Model (Attachment A to Substantial Amendment to the Consolidated Plan):

www.grand-rapids.mi.us/index.pl?binobjid=10292

YWCA Family Center, Columbus, OH

Evaluation of Central Ohio's Stable Families Program (including the Family Center's "front door" central access role: <http://www.csb.org/files/docs/Publications/2009/YWCA%20Diversion%20Study%20Report.pdf>

Michigan Coalition Against Homelessness Statewide HMIS, MI

Standardized HPRP HMIS workflow, release of information, MOU, screening tool, assessment tool, sharing agreement, and HMIS

HPRP overview all to support local centralized intake and centralized housing plan: http://www.mihomeless.org/MCAH/Welcome_to_our_Web_Site.html

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