

# North Carolina Balance of State Continuum of Care

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### **Regional Committee Veteran Plan**

In *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness*, the US Interagency Council on Homelessness (USICH) outlines goals for Continuums of Care that include ending Veteran homelessness by 2015.<sup>1</sup> To assist communities in reaching this objective, the USICH also published *Achieving the Goal of Ending Veteran Homelessness: Criteria and Benchmarks*, which outlines how systems can achieve an effective end to Veteran homelessness. Effectively ending homelessness for Veterans means that communities have designed systems to quickly identify and house homeless Veterans.<sup>2</sup> The North Carolina Balance of State Continuum of Care (BoS CoC) has set a goal to meet the USICH criteria and benchmarks by December 2017.

### Goal

The goal of the regional Veteran system is to meet the federal benchmarks and criteria in each of the 13 Regional Committees by establishing and continuing to maintain an optimized homeless assistance system that effectively and continually prevents and ends Veteran homelessness across the BoS CoC. To accomplish this goal, the BoS CoC and State and VA partners will create a regional Veteran system to quickly identify and house Veterans in all 13 Regional Committees.

### **Vision**

The BoS CoC Plan to End Veteran Homeless identifies a primary SSVF grantee for each of the 13 regions who will provide outreach to homeless Veteran households, assess them for eligibility, and oversee their connection to housing. These SSVF grantees will act as system navigators for each identified Veteran, no matter the Veteran's VA eligibility status, to ensure data collection and connection to permanent housing as quickly as possible. The permanent housing placement may be provided by SSVF, HUD-VASH, CoC or ESG programs, or other community housing programs. If a Veteran is ineligible for SSVF assistance, the SSVF provider, as navigator, will connect the Veteran to the Regional Committee's coordinated assessment system to access community housing programs.

### **Contact Information**

**Regional Committee:** 

Counties Served:

For the following questions please provide individual name, agency name and contact information.

Primary SSVF Provider:

Primary Authors of the Plan:

<sup>&</sup>lt;sup>1</sup> https://www.usich.gov/opening-doors

<sup>2</sup>https://www.usich.gov/resources/uploads/asset\_library/Achieving\_the\_Goal\_Ending\_Veteran\_Homelessness\_v3\_10\_01\_15.pdf

Regional Committee Lead:

Regional Committee Point of Contact for the Veteran System:

Other Key Partners in Veteran System:

### Criterion #1: The community has identified all Veterans experiencing homelessness.

#### Outreach

The goal of outreach is to immediately identify and engage unsheltered homeless Veterans and offer low-barrier shelter and permanent housing assistance to any homeless Veteran within the CoC. Outreach within Regional Committees will take two forms: passive and assertive.

### Passive Outreach

With passive outreach, SSVF providers, with the help of regional leadership, will identify key community partners to aid in identifying homeless Veterans. SSVF providers will train these community partners on how to identify Veterans experiencing homelessness and how to make a referral to the primary SSVF agency in the region. Referrals will be made on an ongoing basis. In addition, each region will also be responsible for contacting the identified community partners a minimum of 2 times per month, whether in-person or by phone, to ask for potential referrals. Examples of agencies that should be considered for passive outreach include local service agencies (libraries, clothing closets, feeding programs), Veteran services (National Guards, Veteran Service Officers, VFWs), jails, etc.

Use the Appendix A tab to identify key partners who will be contacted for passive outreach efforts.

Describe how key community partners will be trained to identify Veterans, including who will provide training, how the trainings will be conducted (in-person, community meetings, etc.), the target dates for initial trainings, and the plan for future trainings to refresh current staff and initiate onboarding staff.

Once communities identify Veterans through passive outreach, describe the process for engaging the Veteran, including: who will engage the Veteran, timeframe for first point of contact, how an offer of shelter will be made, housing plan development, and how the Veteran's information will be added to the regional by-name list.

### Assertive Outreach

Assertive outreach will be the primary responsibility of the SSVF providers in each Regional Committee. Assertive outreach involves visiting and surveying sites where unsheltered homeless people sleep or frequent to identify homeless Veterans and to offer them shelter and housing. Through this approach, providers can continue to engage known Veterans and identify new Veterans who need assistance. SSVF providers will also work with community partners who already conduct outreach to train them in how to identify and refer Veterans.

Use the following chart to list all agencies (SSVF providers, faith-based organizations, shelters, etc.) completing assertive outreach in the region:

Agency	Counties Served	How Often Outreach is Done
		Per Month

If community agencies are doing assertive outreach, describe how they will be trained to identify Veterans, including who will be providing training, how the trainings will be done (in-person, community meetings, etc.) the target dates for these trainings, and how staff turnover will be taken into account for future training.

How will the region obtain information about potential unsheltered sites (law enforcement, librarians, etc.)?

Once an unsheltered location is identified, how will the location be tracked by the region and how often will the locations be visited for ongoing engagement?

Once a Veteran is identified through assertive outreach, describe the process for engaging the Veteran, including: who will engage the Veteran, timeframe for first point of contact, how an offer of shelter will be made, housing plan development, and how the Veteran's information will be added to the regional by-name list.

How will transportation be provided for unsheltered Veterans once identified?

### **In-Reach**

The primary SSVF provider will coordinate in-reach efforts to identify homeless Veterans in shelter and transitional housing programs that do not participate in coordinated assessment or the HMIS system. SSVF providers will train agency staff at non-participating agencies on how to identify Veterans and how to make a referral to the primary SSVF agency in the region.

Use the Appendix B tab to identify key agencies that provide shelter, transitional housing, or other services that do not currently participate in HMIS or coordinated assessment and will be contacted for in-reach efforts.

Describe how agencies that provide shelter and transitional housing and do not participate in HMIS or coordinated assessment will be engaged in the Veteran system, including: who will engage the agencies and a projected timeline.

Describe how engaged community agencies will be trained to identify Veterans, including: who will be providing training, how the trainings will be done (in-person, community meetings, etc.), the target dates for these trainings, and how staff turnover will be taken into account for future training.

Once the community has identified Veterans through in-reach efforts, describe the process for engaging the Veteran, including: who will engage the Veteran, timeframe for first point of contact, how an offer of shelter will be made, housing plan development, and how the Veteran's information will be added to the regional by-name list.

## Criterion #2: The community provides shelter immediately to any Veteran experiencing unsheltered homelessness who wants it.

#### Offer of Shelter

When an unsheltered Veteran is identified during outreach, SSVF providers will make an immediate referral to the coordinated assessment system. If the region's coordinated assessment system identifies an unknown Veteran, the provider completing the screen will make an offer of shelter and refer the Veteran to the primary SSVF provider in the region. For Veterans ineligible for VA programs, the SSVF provider will work with providers in the region's coordinated assessment system to ensure that shelter placement has been offered and the Veteran's information has been entered into HMIS.

### Use Appendix C tab to identify shelter in the region that will be utilized to serve unsheltered Veterans.

For Veterans who decline an offer of shelter, the SSVF provider, acting as navigator, will routinely offer shelter in conjunction with the regional coordinated assessment system while also working to secure a permanent housing placement.

For regions that do not have shelter, an offer of emergency housing in a hotel or motel will be made.

Describe how unsheltered Veterans will be offered and connected to shelter once identified in outreach, including: how shelter bed(s) will be secured, how Veterans will be transported to shelter, etc.

If an unsheltered Veteran is identified in the region's coordinated assessment process through the Prevention and Diversion screen or the VI-SPDAT, describe how CoC agencies will make an offer of shelter and how Veterans will be connected to the primary SSVF provider to be added to the region's byname list.

Describe how Veterans who decline an offer of shelter will be routinely offered shelter and how these offers will be tracked for the region.
Does your region utilize emergency housing, such as hotel/motel vouchers, if no shelter beds are available? Yes No
If so, please describe the process for accessing this emergency housing:
Please describe any known barriers for accessing emergency housing:
Does your region need assistance with emergency housing and shelter?  Yes No If yes, please provide the name, email and phone number of the person to contact:
Criterion #3: The community only provides service-intensive transitional housing in limited instances.
nousing in minteu instances.
Transitional Housing
Though the BoS CoC does not have Grant Per Diem programs, service-intensive transitional housing programs funded through private sources are available to Veterans. Both the primary SSVF provider and the local agencies that serve as access points for the Regional Committee's coordinated assessment system will ensure Veterans are offered a choice of permanent housing assistance (e.g., SSVF) either prior to entering the transitional housing program or once identified in the transitional housing program.
Literally homeless Veterans referred to Grant Per Diem programs outside of the BoS CoC who originated from the BoS CoC will be welcomed back to their home counties, if they choose to return. SSVF providers are responsible for following up with Veterans while in Grant Per Diem programs and to develop housing plans for their return. For Veterans that entered Grant Per Diem programs without literal homeless status, SSVF providers will not accept referrals from Grant Per Diem programs until the program attempts a discharge into housing using the Veteran's support resources.
For each system, please describe how Veterans will be offered permanent housing and how that offer will be tracked prior to transitional housing referral.
Regional Coordinated Assessment System:
Veteran Service System (SSVF Providers and VA Medical Centers):
If a Veteran is referred to a Grant Per Diem program outside of the BoS CoC and wishes to return to the BoS CoC for housing, please describe how SSVF providers will follow-up with the Veteran to create housing plans for their return to the region.

## Criterion #4: The community has capacity to assist Veterans to swiftly move into permanent housing.

### **System Navigation**

As communities identify homeless Veterans through outreach or in-reach activities, the primary SSVF provider will be notified. The primary SSVF provider will either meet with the Veteran or identify another SSVF provider who covers the region to contact the Veteran. Upon contact, the assigned SSVF provider will connect the Veteran to the local VAMC to determine Veteran eligibility for SSVF and HUD-VASH and add them to the Regional Committee's by-name list.

If the VAMC identifies the Veteran as eligible for VA-funded services, the primary SSVF provider will ensure a connection to either an SSVF or HUD-VASH program in the region to assist with permanent housing placement. If the Veteran is ineligible for VA benefits or does not want to participate in a VA program, the SSVF provider will connect the Veteran to the Regional Committee's coordinated assessment system for assessment and prioritization for CoC and other community housing programs.

Please use the following chart to list the staff from the VA Medical Centers (VAMC) who serve the region:

VAMC	Counties Served	Contact Name	Contact Information	Primary or
			(email and phone)	Secondary staff
				Primary
				Secondary
				Primary
				Secondary
				Primary
				Secondary
				Primary
				Secondary

Please use the following chart to list the SSVF providers in the region:

Agency	<b>Counties Served</b>	Point of Contact	Contact Information (email and phone)	Primary SSVF Provider
				Yes No
				☐Yes ☐No
				Yes No
				☐Yes ☐No

Describe how the primary SSVF provider will follow up with referrals as Veterans are identified in the region, including: the timeframe for follow-up and how Veterans will be added to the regional by-name list.

If other SSVF provider(s) cover the region, describe how the primary SSVF provider will coordinate referrals and ensure that programs contact Veterans.

Describe how SSVF providers will coordinate with VA Medical Centers to assess Veterans for VA eligibility, including: transportation, timeframe, and determination of eligibility.

Describe how SSVF providers will assess eligibility for SSVF services, including: timeframe and how eligibility will be tracked.

If eligible for SSVF and/or other VA housing programs, describe the process that will be used to connect Veterans to permanent housing within 90 days.

If ineligible for SSVF and/or other VA housing programs or the Veteran refuses VA-funded programs, describe how the SSVF provider will connect Veterans to the region's coordinated assessment process.

Once a Veteran enters the region's coordinated assessment system, describe how the Veteran will be tracked by regional leadership and SSVF providers to ensure housing placement.

Describe the process by which the region will track housing plans on regional by-name lists.

Please use the following chart to list the region's coordinated assessment access points:

Agency	Counties Served	Role in the Coordinated Assessment Process
		Prevention and Diversion VI-SPDAT
		Prevention and Diversion

		VI-SPDAT
Does the region currently have ho for Veterans? Yes No	ousing programs, including public	housing authorities, with preferences
If so, please describe the each pro	ogram and preferences.	
	egional Veteran systems. Each reg	ran homelessness, key data will need gion should maintain a by-name list. will be updated at least monthly
CoC staff will pull regular reports	from agencies that use HMIS to ic SSVF provider for the region make	rrent by-name list for each region. BoS dentify Veterans, place them on the es contact. SSVF providers will make if any Veteran currently accesses
Who will oversee the by-name list	t for the region?	
What is the process the region wi	ill use to get consent from Vetera	ns to be added to the by-name list?
Please list all agencies that will ha describe how MOUs will be estab		ans and/or update information and
Please describe the process for re often, who will review, and in what		ation remains current, including: how one call, etc.)
Describe how the by-name list will Committees and other partners w		ng technology used and how Regional
Is region currently being served by If so, how will NC Serves informat	. — —	ame list?

Criterion #5: The community has resources, plans, and system capacity in place should any Veteran become homeless or be at risk of homelessness in the future.

<sup>&</sup>lt;sup>3</sup> https://www.hudexchange.info/resources/documents/HEARTH HomelessDefinition FinalRule.pdf

### **Advertisement**

Please explain the strategies that will be used to educate agencies and other community systems about the regional Veteran process. (Please attach any materials the Regional Committee uses in these efforts, like flyers, slides, posters, handouts, etc.)

Please explain the strategies the Regional Committee uses to educate Veteran households who are risk of homelessness or experiencing homelessness about the regional Veteran process. (Please attach any materials the Regional Committee uses in these efforts, like flyers, slides, posters, handouts, etc.)

### **Local Oversight**

The regional Veteran process provides community-wide accountability for housing Veterans experiencing homelessness as quickly as possible. It is recommended that each Regional Committee have a Veteran subcommittee to oversee the system, report out to the Regional Committee, address system grievances, educate and provide outreach to non-participating agencies, and assist in maintaining the by-name list.

Please describe how the Regional Committee will be updated about progress towards ending Veteran homelessness, including: who will provide the update, how often, and in what venue(s) (Regional Committee meetings, email, etc.).

Will the Regional Committee have a Veterans subcommittee to oversee the region's plan? Yes No
How will system gaps be identified and addressed?
How will system issues be identified and addressed?

#### **Grievances**

### Agency Grievance Policy

Please complete the following policy with details from your Regional Committee:

If a provider declines a client referral, that provider should work with the community to refer the client to the next appropriate housing provider and/or emergency shelter to ensure that the household has a safe place to sleep that night.

Providers are expected to submit a written reason for the denial to . Providers may decline out of referrals in a without a meeting. However, if a program declines more referrals than this, they will need to meet with to discuss the issue(s) that result in referrals being declined.

For all other grievances, providers must email a detailed grievance to within days of the adverse action/decision. The will schedule a hearing within days of receiving the grievance

and render a decision within days following the hearing. If grievances cannot be resolved at the local level, an appeal will be submitted to the BoS CoC Veteran Subcommittee.

### **Individual Grievance Policy**

Please complete the following policy with details from your Regional Committee:

If a household does not agree with a referral or the assessment process, the coordinated assessment site will attempt to make another appropriate referral based on the household's needs and the housing resources available.

If the household remains unsatisfied, they may file a grievance with , , or , either verbally or in writing, within days of the attempted referral. will respond within days. If the household does not agree with this local decision, an appeal will be submitted to the BoS CoC Veteran Subcommittee.