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.[1] 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.[2] 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: Region 1. Southwest

Counties Served: Cherokee, Clay, Graham, Haywood, Jackson, Macon, Madison, Swain

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

Primary SSVF Provider: ABCCM. Jill Carter. Jill.Carter@abccm.org 828-398-6785

Primary Authors of the Plan: Jill Carter

[1] https://www.usich.gov/opening-doors
[2]https://www.usich.gov/resources/uploads/asset_library/Achieving_the_Goal_Ending_Veteran_Homelessness_v3_10_01_15.pdf

Regional Committee Lead: Marilyn Chamberlin,chamberlin.marilyn@swcdcinc.org, 828-354-0999

Regional Committee Point of Contact for the Veteran System: Jill Carter, jill.carter@abccm.org, 828-398-6785

Other Key Partners in Veteran System: Charles George, VA, Asheville, (828) 298-7911

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. ABCCM will train key community partners on how to identify veterans in all our counties served.. Trainings may occur on-site with an individual community partner or at county level or regional level community meetings. Online trainings may also be conducted. The target date to train each community is within the next three months.

During the training process, each community partner will be encouraged to implement and adopt permanent processes that ensure veterans are being identified and referred to the primary SSVF provider. The Regional Contact for Veteran System will assist with developing these permanent processes for consistency in the Region. These permanent processes will help minimize gaps in service which might stem from staff turnover or oversight. Refresher trainings will occur at minimum annually.

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.

Veterans who have been identified within region 1 will be directed to the veterans lead. Veterans lead will contact the veteran within 24 hours. If the veteran needs any services, then services will be coordinated through Veterans Services of the Carolinas and all coordinating partners to ensure the veteran is provided all necessary services. The initial process will be the veterans lead followed up with a phone screening with the intake coordinator at VSC. The Intake Coordinator shall keep a by-name list of all Veterans referred to SSVF. If the veteran is unsheltered, then SSVF will offer to connect the veteran to emergency shelter during the phone screening and or a GPD program like the veterans quarters. Every effort will be made to ensure the veteran is housed. Once into a shelter or GPD program the veteran will work with their assigned case manager toward their housing goals. These goals will be set by the veteran themselves and reviewed monthly for any necessary updates.

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**
Veteran Services of the Carolinas	Cherokee, Clay, Graham, Haywood, Jackson, Macon, Madison, Swain	4 times monthly
Haywood Pathways Center	Haywood	Bi-Weekly
Reach of Haywood County	Haywood	Bi-Weekly
Reach of Macon	Macon	Bi-Weekly
Open Door	Haywood	Weekly

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.
Community partners in region 1 are already using the VI-SPDAT in which if a veteran is identified then a referral will be placed with the veteran's lead. ABCCM will contact each veteran within 24 hours of the referral's receipt and will conduct an intial SSVF assessment via phone screening. Training will be conducted in person, online and through monthly meetings. The veteran's lead will be available to follow up with any person in question to verify veteran's status. Target training will be within the next three months. Future training will occur as needed with any community partners.

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

Unsheltered sites can reach the veterans lead, regional lead or phone Veterans Services of the Carolinas directly. The region will obtain information on unshletered sites utilizing contact with law enforcement, soup kitchens, crisis centers, and other community partners. Unsheltered sites will be visited monthly for outreach.

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 identified, unsheltered locations will be tracked at community meetings at both the county and regional level. These locations will also be offered to join the monthly homeless coalition meetings. In order to accomplish this, each community meeting should introduce a segment of the meeting agenda to discuss movements and developments among known unsheltered sites. Unsheltered sites will be visited monthly for outreach.

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.
The identified veteran will be contacted by the veteran's lead withing 24 hours of receiving a referral. The SSVF provider will also begin screening the veteran for SSVF and other services and obtain the necessary consent to add the veteran's name to the by-name list.

How will transportation be provided for unsheltered Veterans once identified?

The veteran's lead is available for transportation assistance when necessary. In some instances the SSVF provider may utilize other community partners like Haywood Pathway or Reach to arrange transportation for the veteran. The provider might also direct the veteran to community resources that could facilitate transportation to shelter.

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.
ABCCM will train "in-reach" shelters and transitional housing providers on how to identify veterans in the counties served within region 1. Trainings may occur on-site with an individual community partner or at county level or regional level community meetings. Online trainings may also be conducted. The target date to train each community partner will be within three months once this plan is approved by the committee. During the training process, each community partner will be encouraged to implement

and adopt permanent processes that ensure veterans are being identified and referred to the veteran's lead.

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.
Trainings may occur on-site with an individual community partner or at county level or regional level community meetings. Online trainings may also be conducted. The target date to train each community partner will be within three months once this plan is approved by the committee. During the training process, each community partner will be encouraged to implement and adopt permanent processes that ensure veterans are being identified and referred to the veteran's lead.

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.
The identified veteran will be contacted by the veteran's lead withing 24 hours of receiving a referral. The SSVF provider will also begin screening the veteran for SSVF and other services and obtain the necessary consent to add the veteran's name to the 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.
Unsheltered veterans identified in outreach will be connected to shelter by the veterans lead and by community partners. The veterans lead may find it necessarry to transport the veteran to shelter. In some instances the veterans lead may utilize other community partners to arrange transportation for the veteran, or the provider might direct the veteran to resources that could facilitate transportation to shelter. If shelter is not readily available in the veteran's location, the veterans lead will work to locate

additional resources for shelter across the region which may include the GPD program at the veterans quarters.

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 by-name list.
Veterans will be identified through the VI-SPDAT and will be referred to ABCCM. ABCCM will then conact the veteran within 24 hours of the referral and begin assessment for SSVF. Upon completion of the VI-SPDAT unsheltered veterans will be directed to available shelter or placed on correspndonig shelter waiting lists if shelter is unavailable.

Describe how Veterans who decline an offer of shelter will be routinely offered shelter and how these offers will be tracked for the region.
SSVF staff members will periodically offer shelter to unsheltered SSVF participants who initially declined shelter. Offers of shelter will be documented through the internal records of individual SSVF providers at each contact with the veteran. The intake coordinator and/or veteran's lead will document each occoriance with the results on an internal database.

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:
Macon, Cherokee, Haywood and Jackson counties both have emrgency housing assistance. Veterans will be screened for eligibility within each county and services provided if the veteran is eligible. If the veteran resides in a county without emergeny shelter then the veteran will be screened for eligibility and transported to the nearest shelter based on availability.
Please describe any known barriers for accessing emergency housing:
Funding availability is limited and continued grant applications for additional funding is being pursued. ABCCM also can transport veterans to the main facility in Asheville at the Veterans Restoration Quarters.

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.

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:
The Coordinated Assessment System will identify veterans during the completion of the VI-SPDAT and refer those veterans to the primary SSVF provider ABCCM. The primary SSVF provider will offer to connect the veteran to permanent housing either through SSVF or other available housing resources. If the veteran declines the offer of permanent housing and requests a referral for transitional housing, the declination will be acknowledged and documented on a Declaration of Housing Preference form. The database will be maintained at ABCCM which will track how often the veteran is contacted along with results. This offer will be made at each contact with the veteran at least once a month. Veteran will be tracked once they have entered housing.

Veteran Service System (SSVF Providers and VA Medical Centers):
The primary SSVF provider will offer to connect the veteran to permanent housing either through SSVF or other available housing resources. If the veteran declines the offer of permanent housing and requests a referral for transitional housing, the declination will be acknowledged and documented on a Declaration of Housing Preference form.

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.
Veterans will reach out to their casemanger who will make a referral to the appropriate SSVF agency. The SSVF agency will follow up with a phone screening for eligibility and assign the veteran to an SSVF case manger based on where the veteran wants to reside. This SSVF case manager will make contact within 24 hours of being assigned the case. The process will begin with the veteran making contact with their main case manager to intiate the process. The housing plan for permanent housing will be addressed at each contact which will be once a week until housing is secured. Once housing is secured, veteran will be contacted every quarter for follow up on current housing status.

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 (email and phone)**	**Primary or Secondary staff**
Asheville VAMC	Cherokee, Clay, Graham, Haywood, Jackson, Macon, Madison, Swain	Whitney Lott	828.298.7911	☒ Primary ☐ Secondary
				☐ Primary ☐ Secondary
				☐ Primary ☐ Secondary
				☐ Primary ☐ Secondary

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

Agency	**Counties Served**	**Point of Contact**	**Contact Information (email and phone)**	**Primary SSVF Provider**
Veteran Services of the Carolinas	Cherokee, Clay, Graham, Haywood, Jackson, Macon, Madison, Swain	Jill Carter	Jill.Carter@abccm.org 828-398-6785	☒ 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.
SSVF provider will follow up with the veteran through the central office in which the intake coordinator will complete a phone screening. Once the screening is completed the case will be presented to the assistant director for eligibility. If the veteran is eligible for services then a case manger will be assigned to the case. The case manager has 48 hours to make an initial contact to establish an in person meeting.

If other SSVF provider(s) cover the region, describe how the primary SSVF provider will coordinate referrals and ensure that programs contact Veterans.
No other SSVF providers cover the region.

Describe how SSVF providers will coordinate with VA Medical Centers to assess Veterans for VA eligibility, including: transportation, timeframe, and determination of eligibility.
SSVF providers coordinates with the VA Medical Center by way of weekly coordinated meetings. These meeting are held every Thursday. Providers may also refer participants to local VSO's to address more formidable barriers restricting access to VA Health Care. In cases where the veteran participant is not eligible for VA Health Care, providers will make efforts to connect the veteran to other health care resources in their community. .

Describe how SSVF providers will assess eligibility for SSVF services, including: timeframe and how eligibility will be tracked.
ABCCM will assess initial eligibility for SSVF by conducting a phone screening within 24 hours of receipt of the veteran referral. If phone screening determines the veteran is initially eligible for SSVF, ABCCM will staff the veteran's case within 48 hours of that determination.

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.
Once a veteran is eligible for SSVF program. The veteran and case manager will work together to address housing stability. The time frame to locate and secure permanent housing is within 90 days. In many cases, the average time to house a veteran is 45 days. SSVF can accomplish this independently or in concert with other VA housing programs such as HUD-VASH.

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.
If found ineligible during the initial eligibility phone screening assessment, the veteran will be provided information on where to connect to a coordinated assessment access point. The Coordinated Assessment Lead is Monica Frizzell
828-586-5501 ext. 1225. The veteran lead will provided community resources to the veteran which will include local shelters. The veteran will work with local community agencies to address housing needs.

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.
The regional providers will utilize the region's by-name list to track each veteran's progress towards housing placement during their weely list update meetings. Regional leadership may participate in these list update meetings to participate in veteran tracking.

Describe the process by which the region will track housing plans on regional by-name lists.
The region will track housing plans on the regional by-name list through the weekly list update meetings.

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

Agency	**Counties Served**	**Role in the Coordinated Assessment Process**
Monica Frizzell smokymountaincenter	Region 1, Cherokee, Clay, Graham, Haywood, Jackson, Macon, Madison, Swain	☐ Prevention and Diversion ☒ VI-SPDAT
		☐ Prevention and Diversion ☐ VI-SPDAT
		☐ Prevention and Diversion

		☐ VI-SPDAT
		☐ Prevention and Diversion ☐ VI-SPDAT
		☐ Prevention and Diversion ☐ VI-SPDAT
		☐ Prevention and Diversion ☐ VI-SPDAT
		☐ Prevention and Diversion ☐ VI-SPDAT
		☐ Prevention and Diversion ☐ VI-SPDAT
		☐ Prevention and Diversion ☐ VI-SPDAT

Does the region currently have housing programs, including public housing authorities, with preferences for Veterans? ☐Yes ☒No

If so, please describe the each program and preferences.

Regional By-Name List

To track the BoS CoC's progress in meeting the goal of ending Veteran homelessness, key data will need to be tracked for each of the 13 regional Veteran systems. Each region should maintain a by-name list. This list will identify all homeless[3] Veterans within each region and will be updated at least monthly using the USICH template.

BoS CoC staff and SSVF providers will work jointly to maintain a current by-name list for each region. BoS CoC staff will pull regular reports from agencies that use HMIS to identify Veterans, place them on the list, and ensure that the primary SSVF provider for the region makes contact. SSVF providers will make bi-weekly contact with agencies not currently using HMIS to check if any Veteran currently accesses services in their programs.

Who will oversee the by-name list for the region?
Marilyn Chamberlin, Regional Lead and Jill Carter, Veteran's Lead

What is the process the region will use to get consent from Veterans to be added to the by-name list?
Consent to release form and VI-SPDAT

Please list all agencies that will have access to the list to add Veterans and/or update information and describe how MOUs will be established with these agencies.
All community partners

Please describe the process for reviewing the list to ensure information remains current, including: how often, who will review, and in what format (in-person meeting, phone call, etc.)

[3] https://www.hudexchange.info/resources/documents/HEARTH_HomelessDefinition_FinalRule.pdf

The region's SSVF providers will routinely review the region's by-name list through biweekly list update meetings. These meetings will take place in person or remotely utilizing encrypted email. These meetings ensure that all by-name list information remains current.

Describe how the by-name list will be stored for the region, including technology used and how Regional Committees and other partners will be updated.
The Regional Committee and other partners will be updated through remote meetings utilizing encrypted email or during in-person regional meetings.

Is region currently being served by NC Serves? ☐Yes ☒No
If so, how will NC Serves information be incorporated into the by-name 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.

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.)

Veteran Services of the Carolinas will distribute information to all the agencies during the monthly meetings. This will include our brochure, business cards and website information. During our outreach ministy we will also come provide this same information to the general public which can include libraries, post offices, department of social services and law enforcement agencies.

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.)

Comminty partners will provide and share veteran resources and contact information to the veteran.

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.).

ABCCM will update community partners on updates and progress towards ending Veteran homelessness. The veteran lead will provide monthly updates at at community meetings.

Will the Regional Committee have a Veterans subcommittee to oversee the region's plan? ☐Yes ☒No

How will system gaps be identified and addressed?

The system gaps will identified and addressed at the monthly agency meetings.

How will system issues be identified and addressed?

The system issues will be identified and addressed at the monthly community meetings.

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 ABCCM. Providers may decline 0 out of 0 referrals in a 0 without a meeting. However, if a program declines more referrals than this, they will need to meet with veteran lead to discuss the issue(s) that result in referrals being declined.

For all other grievances, providers must email a detailed grievance to Jill.carter@abccm.org within 10 days of the adverse action/decision. The veteran lead will schedule a hearing within 10 days of receiving the grievance and render a decision within 10 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 The SWHCRC Regional Lead, Marilyn Chamberlin
828-354-0999, VSC/ABCCM veteran lead Jill Carter, 828-398-6785, or The Coordinated Assessment Lead, Monica Frizzell
828-586-3965, either verbally or in writing, within 10 days of the attempted referral. Veteran lead will respond within 10 days. If the household does not agree with this local decision, an appeal will be submitted to the BoS CoC Veteran Subcommittee.