Coordinated Entry Pre-Screen

To best meet the housing needs of Rock and Walworth County residents Community Action Inc. participates in the Wisconsin Balance of State Coordinated Entry System.

What does this mean for me?

Coordinated Entry means “no wrong door.” If you are in need of housing assistance rather than apply at several places you can completed the attached pre-screen form to determine eligibility for multiple housing programs in Rock and Walworth Counties. Based on your current situation and responses your level of need is referred to the Rock/Walworth Prioritization list.

If/when a program has an available housing opportunity the person/family with the greatest level of need will be contacted by the program with the opportunity.

By completing this screening you are applying for shelter services at Twin Oaks Shelter for the Homeless and requesting to be placed on the prioritization list for other homeless housing opportunities.

*This screening DOES NOT place you on any subsidized, public housing or Section 8 waiting list. This screening is only for Community based housing programs in Rock and Walworth Counties which may include but is not limited to: Community Action Inc., ECHO, YWCA, Housing of Mercy and Salvation Army of Janesville and Beloit.

Once you have been referred to the prioritization list it is not possible for Community Action staff to estimate your placement on the list and/or an approximation of if/when you will receive services. Placement on the list is based on need not order of referral.
Wisconsin Balance of State Coordinated Entry System
Client Rights & Responsibilities

Please read the following notice and authorization (or ask to have it read to you) before signing.

This agency participates in the Wisconsin Balance of State Continuum of Care (BOSCOC) Coordinated Entry System. Agencies that participate in the Coordinated Entry System have agreed to follow a standard set of policies and procedures. Because you are requesting homelessness assistance, you have rights and responsibilities with respect to the BOSCOC Coordinated Entry System.

Your rights include:
1. To be treated with dignity and respect.
2. To receive equal access to the BOSCOC Coordinated Entry System without regard to race, color, national origin, ancestry, religion, actual or perceived gender identity, actual or perceived sexual orientation, familial status, marital status, disability status, source of income, age, status as a victim of domestic abuse, sexual abuse, or stalking, or other protected status. No eligible person or household will be denied access to the BOSCOC Coordinated Entry System or otherwise discouraged from obtaining access because of their status described above.
3. Having the Coordinated Entry process explained to you.
4. Placement on the prioritization list no matter which participating agency you contact. You have the option to be referred to any coalition’s Prioritization List in the BOSCOC.
5. Being served as a family (if requesting services as a family) regardless of your gender identity, marital status, family make-up, or sexual orientation. Your gender identity, marital status, sexual orientation will be accepted as you present them.
6. You and your family members will not be asked to provide proof related to your family status, gender identification and/or sexual orientation.
7. Referral to appropriate services for your individual situation.
8. Having your personal information kept confidential. You may ask to keep your name off the Coordinated Entry Prioritization List, and therefore not seen by other agencies. This will not impact your prioritization.
9. Staying on the Prioritization List, as long as you are still eligible, even if you choose to decline offered services or programs.
10. Removing your name from the Prioritization List for any reason.
11. Refusing to complete the VI-SPDAT/VI-F-SPDAT/TAY-VI-SPDAT screening assessment.
12. The option to file a grievance regarding the Coordinated Entry System (see next page for the Grievance Process).

Your responsibilities include:
1. Keeping your contact information up to date.
   - You should provide us with current email addresses, message numbers, & places you stay so we can let you know about housing & program that come available.
   - You should provide updated information about who is in your household.
2. Letting us know where you are staying or sleeping when that changes.
3. Connecting with staff within two (2) business days after you receive a call, email, or message from us.
4. Letting us know if you no longer need housing assistance.

How to reach us
Call: Click or tap here to enter text.
Text: Click or tap here to enter text.
Email: Click or tap here to enter text.

We will do our best to reach you. If we cannot get in touch with you, you may be passed over for housing assistance or removed from the Prioritization List.

Approved by BOS CE Committee 7-22-2020
Grievance Policy and Process
If an individual has a complaint or grievance regarding an agency or representative of that agency, it is recommended they follow that agency’s procedure for collecting and resolving complaints or grievances. An effort to resolve complaints locally should be made before filing a formal grievance with the WI BOSCOC. This can be done by contacting the Coordinated Entry Lead for your local Coordinated Entry System. The contact information for the Coordinated Entry Lead in every coalition can be found on the WI BOS web site at: https://www.wiboscoc.org/coordinated-entry.html

Policy
Individuals have the right to file a grievance regarding the BOSCOC Coordinated Entry System. A grievance is defined as a written expression of dissatisfaction with some aspect of Coordinated Entry service that has not been resolved despite attempts to do so by participants, agencies, or community members at the point of service. Any such written expression sent to the WI BOSCOC will be considered a grievance. The individual has the right to be assisted by an advocate of his/her choice (e.g., agency staff person, coworker, friend, family member, etc.) at each step of the grievance process.

Process
Step 1: Incident occurs
- A grievance can be filed within 60 calendar days from the date of the incident.
Step 2: Grievance filed
- WI BOSCOC staff will notify the agency identified in the grievance within 14 calendar days.
Step 3: Agency Response
- Agencies have 7 calendar days from receiving the notification to provide a response.
Step 4: Review and Decision
- WI BOSCOC staff will review the grievance and agency response and make a determination within 14 calendar days of the date the agency was notified of the grievance.
Step 5: Appeal
- An agency or individual can submit an appeal within 7 calendar days from the date marked on the determination letter.
Step 6: Response to Appeal
- The WI BOSCOC Board of Directors shall review and make a final decision within 14 calendar days from the date of the appeal letter.

Acknowledgment of Receipt:
I have been informed of my rights and responsibilities related to the BOSCOC Coordinated Entry System. I understand that it is my right as a service recipient to file a grievance if I have a complaint about the services I receive from participating agency in the Coordinated Entry System if it cannot be resolved through other means.

Service Recipient Signature ___________________________ Date ___________________________
Verbal Consent Given? ☐ Yes ☐ No Date ___________________________
Agency Staff Signature ___________________________ Date ___________________________

Copy given to service recipient: ☐ Provided directly ☐ Emailed ☐ Texted ☐ Directed to website 
☐ Sent to proxy ☐ Picked-up ☐ Other ___________________________ ☐ Client declined a copy

Approved by BOS CE Committee 7-22-2020
WI BALANCE OF STATE CoC
Pre-Screen Form

Are you a domestic violence victim or survivor? □ Yes □ No
If yes, would you like a referral to a local DV agency? □ Yes □ No
If yes, when last experience occurred? __________________________
If yes, are you currently fleeing a domestic violence situation? □ Yes □ No

Do you have a disability or need reasonable accommodations for us to provide services to you, including filling out this form? (this question is voluntary and does not affect your eligibility for services) □ Yes □ No
List Accommodations needed:

Do you need an interpreter? □ Yes □ No Language? ________________

Household members (List everyone living in your household, related & unrelated)

Head of Household __________________________

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<th>Last</th>
<th>First</th>
<th>Middle</th>
<th>Gender</th>
<th>□ Disabled</th>
<th>Race</th>
<th>Ethnicity</th>
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Current Address: ____________________________________________________________

<table>
<thead>
<tr>
<th>Street</th>
<th>Apt. #</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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Telephone No: ________________ Email: ________________________________________

Living situation last night

☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher
☐ Place not meant for habitation inclusive of “non-housing service site (outreach programs only)”
☐ Safe haven

When did this homelessness experience start (not necessarily when you entered shelter)? __/__/____

☐ Hotel or motel paid for without emergency shelter voucher
☐ Staying or living in a family member’s room, apartment or house
☐ Staying or living in a friend’s room, apartment or house
☐ Rental by client, no housing subsidy
☐ Rental by client, with VASH housing subsidy
☐ Rental by client, with other housing subsidy (including RRH)
☐ Jail, prison, or juvenile detention facility
☐ Transitional housing for homeless persons (including homeless youth)
☐ Permanent housing (other than RRH) for formerly homeless persons
☐ Psychiatric hospital or other psychiatric facility
☐ Substance abuse treatment facility or detox center

☐ Other __________________________________________________________
☐ Residential project or halfway house with no homeless criteria
☐ Long term care facility or nursing home
☐ Rental by client with GPD or TIP subsidy
☐ Foster care home or foster care group home
☐ Hospital (non-psychiatric)
☐ Owned by client, no housing subsidy
☐ Owned by client, with housing subsidy
Length of living situation in place marked above.
- One night or less
- 2-6 nights
- One week but less than a month
- One to three months

More than three months, but less than one year
- One year or longer

- Until shelter/housing is received
- Less than 3 months
- 3 months to a year

Estimate how much longer you expect to reside there.
- Can’t go back
- More than a year

Number of times you have been on the Street, in an Emergency Shelter, on a motel voucher, or in a Safe Haven in the past three years including today: _____ times

Number of months homeless on the Street, in an Emergency Shelter, on a motel voucher, or in a Safe Haven in the past three years: _____ (not exceeding 36 months)

Veteran Status
- Never in the Service
- Currently in the Service
- Veteran
- Currently not receiving
- Veteran Benefit Status
- Never received

Cause of homelessness (check all that apply).
- Divorce/Separation
- Domestic Violence
- Loss of job
- Low income
- Parole/incarceration
- Ran Away
- Eviction
- Mental illness
- Thrown out
- Run Away
- Exiting Foster care
- Substance abuse
- Rent increase

FUP Eligible Family
FUP Eligible Youth

*For public child welfare agencies only, FUP eligibility must be determined by the PCWA in your county

INCOME: (Please list all sources of income)
Source: ______________________  Gross monthly amount $ ____________
Source: ______________________  Gross monthly amount $ ____________
Source: ______________________  Gross monthly amount $ ____________

NO INCOME – Do you certify that you do not have any income from any source at this time?
- Yes
- No
- VERBAL

Do you give consent that this agency may share information with other agencies such as, but not limited to, your situation, household demographics, and any questions asked during this assessment for the purpose of providing a referral to Coordinated Entry Prioritization Lists?
- Yes
- No
- VERBAL

I understand that the information contained on this form is provided voluntarily. The information is true and correct to the best of my knowledge. I am aware that providing false information or not reporting pertinent information is fraud. If I provide any false information, I understand that services may be denied. I understand that completion of this form does not guarantee that I will receive assistance.

- VERBAL

Signature of Applicant_________________________________________ Date:__________________

Signature of CoC Agency Rep____________________________________ Date:__________________

v. 3 Approved by WI BOS CE Committee 4/2020
PERMISSION TO SHARE CONFIDENTIAL INFORMATION TO SECURE NECESSARY SERVICES

Please read the following notice and authorization (or ask to have it read to you) before signing.

This agency __________________________ participates in the Wisconsin statewide Homeless Management and Information System. Agencies that participate in the Wisconsin HMIS belong to an Internet-based network. This network is administered by the Institute for Community Alliances. The name of the software that stores this data is called WellSky Community Services, formerly known as ServicePoint.

<table>
<thead>
<tr>
<th>Benefits to Data Sharing for the Consumer</th>
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<tr>
<td>Eliminates Duplicate intakes</td>
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<tr>
<td>Reduces the amount of time spent answering basic questions regarding your situation</td>
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<tr>
<td>Reduces the amount of times you have to tell your story to service providers</td>
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</tbody>
</table>

*WellSky ensures the security of its system. Please see below for detailed information on security measures.*

Because this network is made up of many service providers in Wisconsin, you have the option to share your information with other service providers from whom you might be seeking services. Your identity and information collected in the WI HMIS will be shared, with your written consent, in the network. WI HMIS includes your demographic information and other essential personal information needed to best determine your service needs.

The computer program used for this purpose has industry standard security protocols and is updated regularly to meet these security requirements. The information you provide will only be shared with this agency, the network, and limited staff of the Institute for Community Alliances. No personally identifying information will be shared by our network with any department in the Federal Government, other than Federal departments that are providing services within our network (for example, Veterans Affairs). Personally identifying information will not be shared with any State or Federal department for the purposes of determining your eligibility in other State or Federal programs (for example, Food Share). Information collected is housed in a secure server owned and hosted by WellSky in Arizona. Limited WellSky staff have access to this server and the data for the purposes of network support and maintenance. Data collected for the network will be maintained for at least seven years from the last date of service.

The list of agencies participating in the network can be accessed on the ICA website here, [HMIS Release of Information](https://www.icains.com). This list may change.

Please note if you grant permission for your information to be shared, that agreement will be in effect until you revoke it in writing. You may end your agreement in writing and your personal and service information will no longer be shared from that date going forward. If you do not give permission for this agency to release your information, no other agency in the network will have access to it.

Maintaining the privacy and the safety of those using our services is very important. Your record will only be shared if you give permission. You cannot be denied services that you would otherwise qualify for if you choose not to share information. However, even if you choose not to share your information with other agencies, federal and state regulations may require limited data collection for funding purposes.

1 Updated 4/1/2019
Wisconsin HMIS
Client Informed Consent and
Release of Information

Type of information to be shared:
- Personal Identifying Information: Name (First, Middle and Last), Social Security Number, Date of Birth, Gender, Race Ethnicity, Last Residence Information, Military Status
- Housing/Program Specific: Program Eligibility, Entry/Exits, Agency Assessments, Services, Coordinated Entry, Case Notes, Referrals
- Assessment Specific: Income, Non-cash Benefits, Disability, Domestic Violence

*Please indicate your choice regarding data sharing*

Option 1: ☐ Verbal Consent
- By initialing here, I agree to share my and my child/children's above specified information and coordinate services with all participating agencies in the network.

Option 2: ☐ Verbal Consent
- By initialing here, I agree to limit sharing of my and my child/children's above specified information and coordination of services with this agency and the agencies listed below:

Option 3: ☐ Verbal Consent
- By initialing here, I agree I do not want to share my and my child/children's above specified information and coordinate services with other agencies.

I understand that signing below relates only to data sharing within the WI HMIS and does not guarantee I will receive assistance. Alternatively, I understand that I will NOT be denied services if I refuse to consent to data sharing.

Print Name: __________________________________________

Client Signature: ________________________________ Date: __________________________

Adult #2 Print Name: __________________________________

Adult #2 Client Signature: ________________________________ Date: __________________________

Agency Witness Signature: ________________________________ Date: __________________________

☐ Verbal Consent obtained by phone (Agency Staff Initials): __________ Date: __________________________

2 | Updated 6/16/2010
Program Description

Twin Oaks Shelter for the homeless, a Community Action Program, provides up to 60 days of emergency shelter and case management to qualified individuals and/or households. The goal of the program is for individuals/households to achieve housing stability as quickly as possible after shelter entry.

The program will attempt to accomplish these goals by: (1) providing shelter; (2) providing case management services; (3) assist participants in identify clear short and long-term goals that will lead to housing stability; including but not limited to housing, employment and budgeting and (4) identifying and/or coordinating access to mainstream resources.

The program is unable to accept individuals with a history of sexual offenses or violent criminal acts. Background will be verified.

Program Requirements

- Complete the Coordinate Entry Pre-Screen Form
- Head of household must be 18 years of age or older
- Complete background check notification
- Must be able to verify homelessness or imminent risk of homelessness upon program acceptance
- Must lack sufficient resources/support networks to assist in providing housing

Enrollment Process

Twin Oaks will contact you when a suitable room becomes available. Using the contact information provided in your referral, staff will make an attempt to contact you at the phone number(s) and/or email address(es). If you do not respond within 24 hours of the initial contact, the spot will be offered to the next person on the list. You will remain on the list and another attempt will be made when another room becomes available. If after the second attempt there has been no contact, your name will be removed from the list.

Once you are contacted for an opening, staff will work closely with you to determine your eligibility. At this time you will be asked to provide:

- Verification of Age (driver’s license or State ID)
- Verification of homelessness or imminent homelessness
- Last 30 days of income (check stubs, social security, child support, W-2 award letters, etc.)
- Social security numbers of all household members

Staff Contacts

Elizabeth Knapp-Spooner, Twin Oaks Shelter Manager  262-882-3662  eknapp@community-action.org
Jim Stahl, Twin Oaks Shelter Case Manager  262-882-4143  jstahl@community-action.org
Fax number  262-882-4142
TWIN OAKS SHELTER

BACKGROUND CHECK NOTIFICATION

Adult Household Member: __________________________________________ Birth Date: ________________ Please
Print

First Middle Last Name

Adult Household Member: __________________________________________ Birth Date: ________________ Please
Print

First Middle Last Name

Adult Household Member: __________________________________________ Birth Date: ________________ Please
Print

First Middle Last Name

I hereby authorize Community Action, Inc. and Twin Oaks Shelter to complete a background check for all adult members of my current household as part of the application process for services at Twin Oaks Shelter. I understand this authorization is for the purposes of determining eligibility for services and compliance with the policies and procedures of Twin Oaks Shelter.

I understand individuals convicted of a violent or sexual crime are not eligible for services at Twin Oaks and the background check is a required part of the intake process. I also understand failure to complete and return this document will result in an incomplete intake application for services and a delay in accessing services or being placed on the waiting list.

I further understand that if, as a result of this background check, I am not eligible for program services I will be notified.

___________________________  ________________________________
Adult Household Member PRINT & SIGN                  Today’s Date

___________________________  ________________________________
Adult Household Member Signature                  Today’s Date

___________________________  ________________________________
Adult Household Member Signature                  Today’s Date

___________________________
Staff Signature                  Date