North Dakota-500
Statewide Continuum of Care

Discharge Plan for the Emergency Solutions Grant and Continuum of Care Programs

CoC Board Approval: April 2025
CoC Membership Approval: May 2025

Next Review: April 2026

I. Overview

A. Purpose

The purpose of this policy is to inform Emergency Solutions Grant (ESG) and ND Continuum of Care (ND CoC) funded agencies guidance on creating discharge policies with the state's institutions and systems of care and to facilitate discussions with public facilities and systems of care to understand the resources available from ESG and CoC funded organizations.

B. HUD Definition of Homeless.

The U.S. Department of Housing and Urban Development (HUD)has four federally defined categories under which persons are defined as homeless.

1. Literally Homeless. Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:
    a. Has a primary nighttime residence that is a public or private place not meant for human habitation; or
    b. Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, and local government programs); or
    c. Is exiting an institution where they resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.
2. Imminent Risk of Homelessness. Individual or family who will imminently lose their primary nighttime residence provided that:
    a. Residence will be lost within 14 days of the date of application for homeless assistance; and
    b. No subsequent residence has been identified; and
    c. The individual or family lacks the resources or support networks needed to obtain other permanent housing.
3. Homeless Under other Federal statutes. Unaccompanied youth under 25 years of age or families with children and youth who do not otherwise qualify as homeless under this definition but who:
    a. Are defined as homeless under other listed federal statutes;
    b. Have not had a lease, ownership interest, or occupancy agreement in permanent housing during the 60 days prior to the homeless assistance application;
    c. Have experienced persistent instability as measured by two moves or more during the preceding 60 days; and
    d. Can be expected to continue in such status for an extended period due to special needs or barriers.
4. Fleeing/attempting to flee domestic violence. Any individual or family who:
    a. Is fleeing, or is attempting to flee, domestic violence; and
    b. Has no other residence; and
    c. Lacks the resources or support networks to obtain other permanent housing.

C. Guiding Principles

- Homelessness should be rare, brief, and one time.
- Individuals should not be discharged from a state or public facility without assistance to seek housing or shelter at an emergency shelter.
- Every effort should be made through careful discharge planning to work with the client to seek resources for adequate, permanent housing.
- Homeless program administrators should make efforts to continually share resource information with public facilities and systems of care.

II. Resource Sharing

Regional pocket resource guides created by Money Follows the Person (MFP) Housing Initiative are available to provide information to agencies about available regional resources including housing to assist the agency in developing a discharge plan. Housing resources will include information about public housing authorities, agencies that provide rental assistance, and as a last resort, shelter information.

Publicly funded institutions and systems of care will be invited to be a part of the ND CoC and/or attend housing service collaborative meetings coordinated by MFP Housing which offer an opportunity to collaborate with other agencies about housing issues and/or lack of housing.

III. Regional and Local Planning

Each local coalition should develop a regional plan to address discharge planning in their communities.

- The plan should include strategies to educate and engage local service providers and institutions that work with individuals experiencing homelessness.
- Each coalition will review the plan annually and make necessary revisions.

IV. CoC/ESG Administrative Responsibilities

- Provide technical assistance to regional coalitions to help create discharge planning action plans.
- Receive and review copies of the regional discharge planning, if available.
- Contact agencies to do outreach and education to make systems of care aware of the resources for housing in the community.
- Invite publicly funded institutions and systems of care to ND CoC meetings.
- Inform publicly funded institutions and systems of care to state and regional homeless coalition meetings.

V. Publicly Funded Institutions and Systems of Care Definitions and Agencies in Charge

The McKinney-Vento Act requires that State and local governments have policies and protocols in place to ensure that persons being discharged from publicly funded institutions or systems of care **Are Not** discharged immediately into homelessness.

A. Health Care.

Under 42 CFR 482.43(b) and (6) all hospitals must have in place a discharge planning process that applies to all patients and the discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and the

availability of those services. The hospital must include the discharge planning evaluation in the patient's medical record for use in establishing an appropriate discharge plan and the hospital must discuss the results of the evaluation with the patient or the person acting on the patient's behalf.

B. Skilled Nursing Facilities

MDS 3.0 Section Q is designed to engage nursing facility residents in their discharge planning goals. Department of Health and Human Services, Aging Services Division is charged with maintaining the policy. https://www.hhs.nd.gov/adults-and-aging/mds-30-section-q-local-contact-agency-referral-and-discharge-planning-process

- §483.15(c)(7) Orientation for transfer or discharge: A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.

C. Hospitals

ND Century Code Chapter 23-49 covers required hospital discharge policies.

- §482.43 Condition of Participation: Discharge Planning: The hospital must have in effect a discharge planning process that focuses on the patient goals and treatment preferences and includes the patient and his or her caregivers support person(s) in the discharge planning for post-discharge care. The discharge planning process and the discharge plan must be consistent with the patient's goals for care and his or her treatment preferences, ensure an effective transition of the patient from hospital to post-discharge care, and reduce the factors leading to preventable hospital readmissions.

D. Life Skills and Transitional Center

Person Centered Transition Planning for discharge of Life Skills and Transition center people supported policy II-4c.

E. Foster Care:

ND Health and Human Services (DHHS) Child and Family Services division is charged with the development of the discharge policy for youth existing the foster care system. A transition plan is required for all individuals and youth "aging out" of foster care and must be completed within 90 days prior to their 18th birthday. The transition plan must be developed and personalized at the direction of the child and made part of their foster care case plan (either attached or embedded in the case plan). Transition planning is also required 90 days prior to the 18th birthday for a child who is interested in remaining in the 18+ Continued Care program. The transition plan can be updated as needed.

North Dakota requires the use of SFN 494 "Transition Checklist" for all children aging out of foster care regardless of the length of time the child has been in foster care. For placements less than six months, custodians should make concerted efforts to gather required documentation noted on the Transition Checklist. This document will assist the Child and Family Team in developing transition goals and organizing all required information that must be provided to a child aging out.

All efforts must be made to ensure that foster youth are not discharged into homelessness.

F. Mental Health

The North Dakota State Hospital has a Discharge and Aftercare Policy/Procedure (Policy 7.6) to ensure individuals have adequate discharge and aftercare plans.

G. Department of Corrections

The ND Dept. of Corrections has a Release and Temporary Leave Policy (4G-01) to ensure planning and communication between the correctional institution and community corrections regardless of whether the inmate is being released on discretionary parole, mandatory release or maximum discharge from sentence. These procedures involve advanced communication and planning between the inmate and case management staff. The Residence Planning Guide requires the following to be addressed

1. Housing
2. Employment
3. Enrollment in JP3 program
4. Transportation
5. Medical and medication needs, including enrollment in Medicaid
6. Referrals to and appointments with human service centers and agencies
7. Referrals to Free through Recovery or Community Connect
8. Sex offender registration supervision issues, if applicable
9. Social security and disability
10. Vocation rehabilitation
11. Veterans' administration
12. Identification or driver's license
13. Educational needs
14. Legal issues, such as outstanding fines and child support
15. Spiritual needs
16. Family transition issues

Release housing: Unit management staff shall help adults in custody find appropriate permanent housing. Homeless shelters, while preferable to placing an adult in custody back into the community without any housing, may be used only as a last resort. When it is necessary to place an adult in custody into a homeless shelter, the case manager shall notify the adult in custody's assigned parole or probation officer and facilitate communication between the adult in custody and the field services officer and assist them in finding more permanent housing, as soon as possible, after placement into the shelter.