Durham, North Carolina Coordinated Entry System Policies and Procedures Manual

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January 14, 2018

Coordinated Entry Overview

In 2017, the City of Durham, North Carolina initiated a process to improve the delivery of housing and crisis response services and assistance to/for people experiencing homelessness or at imminent risk of homelessness by refining the community's process for access, assessment, eligibility determination and referrals across the Continuum of Care.

This process, the ***Coordinated Entry System***, institutes consistent and uniform access, assessment, prioritization, and referral processes to determine the most appropriate response to each homeless person's immediate housing needs. This system of Coordinated Entry is not only mandated by the U.S. Department of Housing & Urban Development (HUD) and many other funders, but is recognized nationally as a best practice. A Coordinated Entry System can improve efficiency within systems, provide clarity for people experiencing homelessness, and can help serve more people more quickly and efficiently with assistance targeted to address their housing needs.

Building upon the local expertise in Coordinated Entry implementation for families experiencing homelessness since 2012, the City of Durham formalizes and codifies the policies and procedures to ensure compliance with the mandate from the Department of Housing and Urban Development (HUD) that every Continuum of Care establish and operate a coordinated entry process (24 CFR 578). This Coordinated Entry System Policies and Procedures document is an operational manual, providing guidance and direction for the day to day operations, management, oversight, and evaluation of Durham's coordinated entry implementation. This manual will be updated and revised on an ongoing basis as the actual application and practical experience of Coordinated Entry System design principles are refined and improved.

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Introduction and Purpose of Coordinated Entry

In July 2012, HUD published the Continuum of Care (CoC) Program interim rule. The CoC Program interim rule requires that the CoC establish and consistently follow written standards for providing CoC assistance. The CoC Program interim rule (24 CFR 578) and the ESG interim rule (24 CFR 576) require the CoC to establish and operate a coordinated entry process and consistently follow written standards for providing CoC assistance, in consultation with recipients of the ESG program. As such, all programs operating in Durham, North Carolina that receive funding from either the Continuum of Care grant program or the Emergency Solutions Grant (either as a sub-grantee of the City of Durham or through the State of North Carolina) are required to participate in Durham's coordinated entry processes.

At a minimum, HUD requires these written standards to include:

- Policies and procedures for evaluating eligibility for assistance in the CoC Program
- Policies and procedures for determining and prioritizing which eligible people will receive assistance for permanent supportive housing assistance, transitional housing assistance, and rapid re-housing assistance

The goals of the written standards are to:

- Establish community-wide expectations on the operations of projects within Durham
- Ensure that the system is transparent to users and operators
- Establish a minimum set of standards and expectations in terms of the quality expected of projects
- Make the local priorities transparent to recipients and sub-recipients of funds
- Create consistency and coordination between recipients' and sub-recipients' projects within the CoC, including both CoC-funded and ESG-funded projects;
- CoC Program standards must be in accordance with Violence Against Women Act (VAWA) regulations

The Coordinated Entry System is Durham, North Carolina's approach to organizing and providing services and assistance to people experiencing a housing crisis throughout the Durham Continuum of Care (CoC). People who are seeking homeless or homelessness prevention assistance are directed to defined entry points, assessed in a uniform and consistent manner, prioritized for housing and services, and then linked to available interventions in accordance with the intentional service strategy defined by CoC Lead Agency staff. Each service participant's acuity level and housing needs are aligned with a set of service and program strategies that represent the appropriate intensity and scope of services needed to resolve the housing crisis.

Guiding Principles

The Durham CoC's Coordinated Entry System standardizes connection to the most critical resources in our community, and expedites permanent housing for people experiencing homelessness. The guiding principles for the Coordinated Entry System include:

- Housing First: When a person experiences homelessness the service priority shall be to reconnect them with housing, and then to other services in the community which will help them maintain their housing.
- Client-centered: Based on the identified needs of the household we will focus on connecting them with community resources designed to achieve housing stability.
- System-wide prioritization of limited supportive housing resources: Our community has a limited number of moderate to intensive housing supports including rapid re-housing slots, public housing units and vouchers, specialized housing vouchers for people experiencing homelessness and case management services. The CoC will help prioritize access to these limited resources on a community-wide basis.

Fair Housing, Tenant Selection and Other Statutory and Regulatory Requirements

All CoC projects in the Durham Coordinated Entry System must include a strategy to ensure CoC resources and Coordinated Entry System resources are eligible to all people regardless of race, color, national origin, religion, sex, age, familial status, disability, actual or perceived sexual orientation, gender identify, or marital status. Special outreach to people who identify with one or more of these attributes ensures the Coordinated Entry System is accessible to all people.

All CoC projects in Durham's Coordinated Entry System must ensure that all people in different populations throughout the geographic area, including people experiencing chronic homelessness, veterans, families with children, youth, and survivors of domestic violence, have fair and equal access to the coordinated entry process, regardless of the location or method by which they access the crisis response system.

All CoC projects in Durham's Coordinated Entry System must document steps taken to ensure effective communication with people with disabilities. Access points must be accessible to people with disabilities, including physical locations for people who use wheelchairs, as well as people in Durham who are least likely to access homeless assistance.

Providers must also take reasonable steps to offer Coordinated Entry process materials and instruction in multiple languages to meet the needs of minority, ethnic, and groups with Limited English Proficiency (LEP).

Coordinated Entry System Terms

Chronically Homeless (HUD Definition)

HUD defines a chronically homeless person as follows:

1. A homeless individual with a disability who lives either in a place not meant for human habitation, a safe haven, or in an emergency shelter, or in an institutional care facility if the individual has been living in the facility for fewer than 90 days and had been living in a place not meant for human habitation, a safe haven, or in an emergency shelter immediately before entering the institutional care facility. In order to meet the "chronically homeless" definition, the individual also must have been living as described above continuously for at least 12 months, or on at least four separate occasions in the last 3 years, where the combined occasions total a length of time of at least 12 months. Each period separating the occasions must include at least 7 nights of living in a situation other than a place not meant for human habitation, in an emergency shelter, or in a safe haven.

2. Families with adult heads of household who meet the definition of a chronically homeless individual. If there is no adult in the family, the family would still be considered chronically homeless if a minor head of household meets all the criteria of a chronically homeless individual. A chronically homeless family includes those whose composition has fluctuated while the head of household has been homeless.

Disability (HUD Definition)

HUD defines a person with disabilities as a person who:

1. has a disability as defined in Section 223 of the Social Security Act (42 U.S.C.423), or
2. is determined by HUD regulations to have a physical, mental, or emotional impairment that:
    a. is expected to be of long, continued, and indefinite duration;
    b. substantially impedes his or her ability to live independently; and
    c. is of such a nature that more suitable housing conditions could improve such ability, or
3. has a developmental disability as defined in the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 15002(8)), or
4. has the disease acquired immunodeficiency syndrome (AIDS) or any conditions arising from the etiologic agent for acquired immunodeficiency syndrome (HIV).

For qualifying for low income housing under HUD public housing and Section 8 programs, the definition does not include a person whose disability is based solely on any drug or alcohol dependence.

Literally Homeless (HUD Homeless Definition Category 1)

A person who lacks a fixed, regular, and adequate nighttime residence

a. An individual with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, camping ground; or
b. An individual living in a supervised 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, or local government program for low-income individual); or
c. An individual who is exiting an institution where he or she 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.

At imminent risk of homelessness (HUD Homeless Definition Category 2)

A person who will imminently lose their housing (within 14 days) and become literally homeless

Homeless under other Federal statutes (HUD Homeless Definition Category 3)

A person defined as "homeless" by other federal statute (e.g., Dept. of HHS, Dept. of Ed.)

Fleeing domestic abuse or violence (HUD Homeless Definition Category 4)

A person fleeing or attempting to flee domestic violence, stalking, dating violence, or sexual assault.

At Risk of Homelessness (HUD Definition)

1. Category 1: A person who:
    a. has an annual income below 30% of median income for the area; AND
    b. does not have sufficient resources or support networks immediately available to prevent them from moving to an emergency shelter or another place defined in Category 1 of the "homeless" definition; AND Meets one of the following conditions:
        i. Has moved because of economic reasons 2 or more times during the 60 days immediately preceding the application for assistance; OR
        ii. Is living in the home of another because of economic hardship; OR
        iii. Has been notified that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance; OR
        iv. Lives in a hotel or motel and the cost is not paid for by charitable organizations or by Federal, State, or local government programs for people with low-income; OR
        v. Lives in an "Single Room Occupancy" (SRO) or efficiency apartment unit in which there reside more than 2 persons or lives in a larger housing unit in which there reside more than one and a half persons per room; OR
        vi. Is exiting a publicly funded institution or system of care; OR

vii. Otherwise lives in housing that has characteristics associated with` instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan.

2. Category 2: A child or youth who does not qualify as homeless under the homeless definition, but qualifies as homeless under another Federal statute
3. Category 3: An unaccompanied youth who does not qualify as homeless under the homeless definition, but qualifies as homeless under section 725(2) of the McKinney-Vento Homeless Assistance Act, and the parent(s) or guardian(s) or that child or youth if living with him or her.

Homeless Management Information System

A Homeless Management Information System (HMIS) is an electronic web-based data collection and reporting tool designed to record and store person-level information on the characteristics and service needs of people experiencing homelessness throughout a CoC jurisdiction. Usage of the HMIS is mandated by (HUD) for any person experiencing homelessness, with the exception of survivors of domestic violence.

Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT)

The Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT), developed and owned by OrgCode and Community Solutions, is a triage tool that assists in informing an appropriate 'match' to a particular housing intervention to people based on their acuity in several core areas. Within those recommended housing interventions, the VI-SPDAT allows for prioritization based on presence of vulnerability across four components for unaccompanied individuals and five components for families: (a) history of housing and homelessness (b) risks (c) socialization and daily functioning (d) wellness - including chronic health conditions, substance usage, mental illness and trauma and (e) family unit. The Durham Coordinated Entry System currently utilizes Version 2 of the VI-SPDAT for both unaccompanied individuals and families, released May 2015 as the common assessment tool. The Durham Coordinated Entry System has agreed to use the VI-SPDAT as the universal assessment tool across the CoC for screening and matching people experiencing homelessness in Durham. Staff administering any of the SPDAT tools should be trained.

Planning, Staffing Roles and Participation Responsibilities

Coordinated Entry System Continuum of Care Lead Agency

The Executive Committee of the Homeless Services Advisory Committee (HSAC), serving as the Continuum of Care Governance Board, will conduct oversight and monitoring of Coordinated Entry functions to ensure consistent application of policies and procedures and high quality service delivery for people experiencing a housing crisis. City of Durham staff will be responsible for evaluating and reporting to the Executive Committee of the Homeless Services Advisory Committee for review.

Continuum of Care Providers Serving People Experiencing Homelessness

1. **Adopt and follow Coordinated Entry System policies and procedures.** Coordinated Entry System participating providers shall maintain and adhere to these policies and procedures for Coordinated Entry System operations, and as established by the Coordinated Entry System CoC Governance Board.

2. **Maintain low barrier to enrollment.** Providers serving people experiencing homelessness shall limit barriers to enrollment in services and housing. No person may be turned away from crisis response services or homeless designated housing due to lack of income, lack of employment, disability status, or substance use unless the project's primary funder requires the exclusion or a previously existing and documented neighborhood covenant/good neighbor agreement has explicitly limited enrollment to people with a specific set of attributes or characteristics. Providers maintaining restrictive enrollment practices must maintain documentation from project funders, providing justification for the enrollment policy.

   CoC providers offering Prevention and/or Short-Term Rapid Re-housing assistance (i.e. 0 – 24 months of financial assistance) may choose to apply some income standards for their enrollment determinations.

3. **Maintain Fair and Equal Access**. Coordinated Entry System participating providers shall ensure fair and equal access to Coordinated Entry System programs and services for all people regardless of actual or perceived race or ethnicity, color, religion, national origin, age, gender identity, pregnancy, citizenship, familial status, household composition, disability, veteran status, or sexual orientation.

   If a program participant's self-identified gender creates challenging dynamics among residents within a facility, the host program should make every effort to accommodate the person or assist in locating alternative accommodation that is appropriate and responsive to the person's needs.

   Coordinated Entry System participating providers shall offer universal program access to all populations as appropriate, including chronically homeless people, veterans, youth, transgender people and people fleeing domestic violence.

   Population-specific projects and those projects maintaining affinity focus (e.g. women only, veterans only, etc.) are permitted to maintain eligibility restrictions as currently defined and will continue to operate and receive prioritized referrals. Any new project wishing to institute exclusionary eligibility criteria will be considered on a case by case basis and receive authorization to operate as such on a limited basis from the Coordinated Entry System CoC Governance Board.

4. **Provide appropriate safety planning**. Coordinated Entry System participating providers shall provide necessary safety and security protections for people fleeing or attempting to flee family violence, stalking, dating violence, or other domestic violence situations. Minimum safety planning must include a threshold assessment for presence of participant safety needs and referral to appropriate trauma-informed services if safety needs are identified.

5. **Create and share written eligibility standards**. Providers must document eligibility criteria, which should be limited to that required by the funder. Criteria not required by the funder should be reduced or eliminated wherever possible. This may include characteristics, attributes, behaviors or histories used to determine who is eligible to be enrolled in the program. These standards will be shared with all providers that serve as access points for the Coordinated Entry System, the Coordinated Entry System CoC Lead Agency staff as well as funders.

6. **Communicate vacancies**. Homeless providers must communicate project vacancies, either bed, unit, or voucher, to the Coordinated Entry System CoC Lead Agency staff in a manner determined by and outlined in this document.

7. **Limit enrollment to participants referred through the defined Coordinated Entry System access point(s)**. Each bed, unit, or voucher that is required to serve someone who is homeless must receive their referrals through the prioritization criteria outlined below. Any agency filling homeless mandated units from alternative sources will be reviewed with funders for compliance. Coordinated Entry System access points mustbe informed of every opening and how and when they were filled.

8. **Participate in Coordinated Entry System planning**. CoC projects shall participate in Coordinated Entry System planning and management activities as defined and established by the CoC Governance Board.

9. **Contribute data to HMIS if mandated per federal, state, county, or other funder requirements.** Each provider with homeless dedicated units will be required to participate in HMIS. Providers should work with the Durham HMIS Lead Agency with funding sources to determine specific forms and assessments required for HUD compliance within HMIS.

10. **Ensure staff who interact with the Coordinated Entry System process receive regular training and supervision.** Each provider must notify Coordinated Entry System CoC Lead Agency staff to changes in staffing, in order to ensure employees have access to ongoing training and information related to the Coordinated Entry System.

11. **Ensure individual rights are protected and people are informed of their rights and responsibilities.** People shall have rights explained to them verbally and in writing when completing an initial intake. At a minimum, rights will include:
    - The right to be treated with dignity and respect;
    - The right to appeal Coordinated Entry System decisions;
    - The right to be treated with cultural sensitivity;
    - The right to have an advocate present during the appeals process;
    - The right to request a reasonable accommodation in accordance with the project's tenant/person selection process;
    - The right to accept housing/services offered or to reject housing/services;

- The right to confidentiality and information about when confidential information will be disclosed, to whom, and for what purposes, as well as the right to deny disclosure.

12. **Marketing.** Coordinated Entry policies, procedures and services shall be advertised on the CoC's website (www.DurhamOpeningDoors.org). Providers shall post on their premises in a location clearly visible to program participants a notice stating participation in the CoC's Coordinated Entry System. The script for administration of the coordinated assessment tool, the VI-SPDAT, shall state that the reason that participants are surveyed using the VI-SPDAT is to provide entry to the system of services in a coordinated manner.

Coordinated Entry System Workflow and Policies

I. Coordinated Entry Workflow Overview

All street outreach, emergency shelter, transitional housing staff, as well as day center, rapid re-housing and permanent supportive housing staff will work to ensure that as many of the people they engage with as possible:

- will be assessed with the VI-SPDAT,
- readily able to be located,
- motivated to pursue housing,
- in possession of the documentation required for potential housing options
- and successfully engaged by Continuum of Care providers seeking to resolve their crisis of homelessness.

II. Access Models and Accessibility – Comprehensive, Accessible and Understood

Durham, North Carolina utilizes a "no wrong door" access model for adults without children and unaccompanied youth, and a centralized access model for adults accompanied by children, households fleeing domestic violence, and people at risk of homelessness. Households who are included in more than one of these populations (for example, a parenting unaccompanied youth or an adult who presents both as unaccompanied and with children to different providers) will receive service at each of the access points for which they qualify as a target population. Regardless of initial access point(s), people experiencing homelessness or at risk of homelessness receive the same assessment approach, including standardized decision-making and assessment tool specific to each population (adults without children, adults accompanied by children, unaccompanied youth and people at risk of homelessness).

III. Safety Planning and Domestic Violence

Upon a household entering the homeless services system, providers shall conduct safety assessments to determine whether the household is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the household. The household should be processed in accordance with the following protocol:

a. If during the initial engagement, concerns are identified about the household's immediate safety, the client should be referred to local law enforcement (911) and to Durham's domestic violence shelter, through virtual access to the Durham Crisis Response Center's Domestic Violence 24 hour Crisis Line (919-403-6562 in English or 919-519-3735 for Spanish).

b. If the client needs a domestic violence or other form of a protective order, they should be referred to the Durham County Clerk of Court (919-808-3076 or 919-808-3123) to obtain such an order

If during the assessment, it is determined that the client presents an immediate safety risk to themselves or others, the individual performing the assessment should immediately contact 911 and/or Durham County Adult Protective Services (919-560-8000) to assist in determining the appropriate course of action to ensure the safety of the clients and those around the client.

IV. Non-Discrimination

All CoC providers must operate with as few barriers to entry as possible. People may access emergency services, such as emergency shelter, independent of the operating hours of the system's intake and assessment processes, by calling 211 or by accessing the Durham Network of Care website at http://durham.nc.networkofcare.org/mh/.

Physical locations must be accessible to people with disabilities, including accessible locations for people who use wheelchairs, with a particular focus on people experiencing homelessness who are least likely to access homeless assistance.

CoC providers must ensure effective communication with people with disabilities, including provision of appropriate auxiliary aids and services necessary to ensure effective communication (e.g. Braille, audio, large type, assistive listening devices, and sign language interpreters) at the person's request.

Providers must also take reasonable steps to offer Coordinated Entry process materials and instruction in multiple languages to meet the needs of minority, ethnic, and groups with Limited English Proficiency (LEP).

V. Initial System Access

During the shelter stay or street outreach engagement, when concerns are raised about the household's immediate safety, the client should be referred to local law enforcement and domestic violence shelters as described in Section III. Safety Planning and Domestic Violence.

When an emergency shelter or street outreach staff engages a person experiencing homelessness, they should update an existing HMIS record or create a new HMIS record and complete accompanying intake forms, including Releases of Information to disclose personally identifiable information. For families experiencing homelessness, the consent form should be signed by all adults in the household. The head of household or

authorized representative should also sign the consent forms on behalf of children in the household who are below the age of eighteen (18).

VI. Survey – Explaining What You're Doing and Why

The Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT), developed and owned by OrgCode and Community Solutions, is a triage tool that assists in informing an appropriate 'match' to a housing intervention for people based on their acuity in several core areas. Within those recommended housing interventions, the VI-SPDAT allows for prioritization based on presence of vulnerability across four components for unaccompanied individuals and five components for families: (a) history of housing and homelessness (b) risks (c) socialization and daily functioning (d) wellness - including chronic health conditions, substance usage, mental illness and trauma and (e) family unit. Durham's Coordinated Entry System has agreed to use the VI-SPDAT as the universal assessment tool across the CoC for screening and matching people experiencing homelessness in Durham, and is currently implementing Version 2 of the VI-SPDAT, released May 2015.

The VI-SPDAT should be completed as close to first engagement as possible with anyone residing in places not meant for habitation ("unsheltered"), and with people residing in an emergency shelter or transitional housing for at least seven days.

People engaged by providers representing the Coordinated Entry System should receive the same information regarding what that process involves. Assessors should communicate the survey process and its results clearly and consistently across the community. This ensures that the benefits to participating in a survey are described clearly to encourage people to participate. It is equally important to make sure that people understand that completing the VI-SPDAT does not guarantee (and may not result in) housing. It is also important that people receive a clear understanding of where their information will be shared. An example of what to standardize follows below, and is further described in Appendix B – Example Messaging:

- the name of the assessor and their affiliation (organization that employs them, volunteer as part of a Point in Time Count, etc.)
- the purpose of the VI-SPDAT being completed
- that it usually takes less than 10 minutes to complete
- that only "Yes," "No," or one-word answers are being sought
- that any question can be skipped or refused
- that the information is going to be stored in the Homeless Management Information System
- that other providers conducting assessments and the housing providers connected to the Coordinated Entry System will have access to the information so that the person does not need to complete the assessment multiple times, that housing providers can identify people to target for housing resources as they come available, and for planning purposes.
- that if the participant does not understand a question, clarification can be provided

- the importance of relaying accurate information to the assessor and not feeling that there is a correct or preferred answer that they need to provide, nor information they need to conceal

VII. Additional Population-Specific Considerations

Veterans:
Providers serving veterans may require a Health Insurance Portability Accommodations Act (HIPAA)-compliant Release of Information to enable representatives from the Department of Veterans Affairs, the State, and other relevant stakeholders to ensure veterans are able to access the full spectrum of housing resources available for this population.

Survivors of Domestic Violence:
A person who is or has been a victim of domestic violence, dating violence, sexual assault or stalking may not be denied access to the coordinated entry process if they are experiencing homelessness or are at risk of homelessness. The Violence Against Women Act (VAWA) prevents providers dedicated to serving survivors of domestic violence from inputting their personally identifiable information into a Homeless Management Information System (HMIS) because of the additional safety precautions specific for this population. While the VI-SPDAT is not a domestic violence-specific triage tool, providers dedicated to serving survivors of domestic violence can assess people who desire access to the broader range of housing options dedicated to people experiencing homelessness using the VI-SPDAT. Those results must be stored within a VAWA-compliant electronic system or in paper files secured according to the full requirements of the law.

VIII. Survey Refusals

For limited instances when staff encounter people who do not provide a response to any of the first questions, they should stop and acknowledge that the assessment will not provide useful information if the person receiving assessment does not want to participate. Staff should utilize continued progressive engagement and rapport building with these people until they are willing to be assessed. The surveyor may request verbal consent to ask additional questions in order to utilize their conversation with the person, observation, documentation and information from other professionals. The VI-SPDAT should be completed in one engagement (although not necessarily at first contact).

People who respond better to a conversational approach may benefit from the more comprehensive full SPDAT, further described in Appendix C – Full SPDAT Process.

IX. Survey – Concluding the Engagement

Upon completion of the VI-SPDAT, the Assessor may ask if the person is currently working with a provider to receive case management. If so, the person receiving the survey should be encouraged to continue to engage with their existing case management supports. If not, the Assessor should provide a brief description of the resources currently

available within the community and ask if the person is interested in specific forms of housing assistance.

Assessors should emphasize the importance of having reliable and comprehensive information regarding the best times and places to contact the person. Staff should collect information on whereabouts across a 24-hour period, beginning with where the person wakes up until they bed down at night, with notations for days when location patterns change, and record that information within the VI-SPDAT. This includes where meals are obtained, transportation methods and times to and from meal and shelter providers, cross streets of locations where they receive services, outside agency names and staff with whom they engage, etc.

Assessors may emphasize that, while completion of the assessment does not make them now the person's case manager, it remains critically important that the Assessor possesses the most reliable methods possible for locating the person being assessed, especially if that includes an outside agency or staff attempting to contact the person at a later date.

X. Next Steps – Collecting Documentation for Housing

Once the VI-SPDAT is completed, and/or as part of the initial engagements for people already assessed, staff should quantify which essential documents the person currently possesses, and begin working with them to begin collecting missing documents, as staff time and resources allow.

Assessors should emphasize that specific documentation is required for many programs, including but not limited to government issued photo identification, Social Security card, birth certificate, proof of income or lack of income, verification of homelessness, and DD-214 for people who have served in the United States Armed Forces (regardless of discharge status or length of service).

Prioritization of Referrals

Upon successful VI-SPDAT completion, CoC providers including homelessness prevention, street outreach, transitional housing, rapid re-housing and permanent supportive housing projects will fill their case load (for services only programs) and/or beds (for shelter and housing programs) from the Coordinated Entry System according to the following prioritization criteria.

Providers will identify the eligibility requirements for each of their programs that they will be dedicating to the Coordinated Entry process and will be able to run a By-Name List report of VI-SPDAT results from people experiencing homelessness from within the HMIS. Once a referral is made following the prioritization criteria outlined below, the provider may contact the person directly, and may coordinate contact with the VI-SPDAT interviewer for further support if necessary. The housing provider commits to working with the assessor to locate the person and engage with them to verify if the housing referral provides a good match. The housing provider commits to communicating in writing with

the CoC Lead Agency staff when 50% or more of matches do not lead to successful program entry in order to facilitate more successful referrals (further outlined below).

The Housing Provider will document any unsuccessful matches and provide both the (A) reason(s) why they were not housed, (B) date of unsuccessful match/"unassignment" and (C) name of the project being unassigned within HMIS so that the person can be reassigned to additional providers (further outlined below). The housing provider will also document when each match does lead to successful program entry and providing the date the person moves into housing within HMIS.

A. Homelessness Prevention Prioritization:

People experiencing homelessness may be referred to ***Homelessness Prevention*** according to the following prioritization criteria (the criteria must be met before proceeding to people who do not meet the priority category 1):

Priority Category 1:
Imminent risk of eviction with documentation

B. Street Outreach Prioritization

People experiencing homelessness may be referred to ***Street Outreach*** per the following prioritization criteria (the criteria must be met before proceeding to people who do not meet the priority category 1):

Priority Category 1:
People experiencing homelessness matched to transitional housing, rapid re-housing or permanent supportive housing

C. Emergency Shelter Prioritization

People experiencing homelessness may be referred to ***Emergency Shelter*** per the following prioritization criteria (the criteria must be met before proceeding to people who do not meet the priority category 1):

Priority Category 1:
People experiencing homelessness matched to transitional housing, rapid re-housing or permanent supportive housing

Priority Category 2:
People experiencing homelessness

D. Transitional Housing Prioritization
People experiencing homelessness may be referred to ***Transitional Housing*** per the following prioritization criteria (only proceeding to the next category when no one remains in the initial/previous category):

Priority Category 1:

People not experiencing chronic homelessness

Priority Category 2:
Highest VI-SPDAT score

E. Rapid Re-Housing Prioritization

People will be referred to ***Rapid Re-Housing*** per the following prioritization criteria (only proceeding to the next category when two or more people remain in the initial/previous category):

Priority Category 1:
Same as ***Permanent Supportive Housing*** when not available

Priority Category 2:
Highest ***Rapid Re-Housing*** recommended score (individuals: 4-7, families: 4-8)

Priority Category 3:
Chronic homelessness

Priority Category 4:
Length of time homeless

Priority Category 5:
Overall wellness (domain D score of the VI-SPDAT)

F. Permanent Supportive Housing Prioritization

People experiencing homelessness will be referred to ***Permanent Supportive Housing*** per the following prioritization criteria (only proceeding to the next category when no people remain in the initial/previous category):

Priority Category 1:
Highest VI-SPDAT score

Priority Category 2:
Chronic homelessness

Priority Category 3:
Length of time homeless

Priority Category 4:
Overall wellness (domain D score of the VI-SPDAT)

Connection to Mainstream Resources
People who may benefit from a connection to a mainstream service provider, such as Goodwill, Department of Social Services, Legal Aid, income based housing or other services may be provided a referral to connect to these mainstream providers. All

mainstream service referrals shall be documented in the HMIS and shall not prohibit the prioritization or matching into a supportive housing program for which the individual or household is eligible at the time a match is identified.

CoC Lead Agency staff shall engage key mainstream service providers to enhance and streamline the connection between their resources and CoC providers.

Unsuccessful Matches Process

By Person Experiencing Homelessness
People may reject a housing referral due to the health, safety or wellbeing of the person being compromised by the potential referral. Respecting choice and preference, people may also reject a housing referral due to not being willing to work with the housing provider to which they are referred. Rejections of housing referrals by people should be infrequent and must be documented in HMIS. Repeated rejections on behalf of staff, programs, and/or agencies may require case conferencing and additional consultation with or guidance from Continuum of Care Lead Agency staff.

By Housing Provider
Durham CoC providers and program participants may deny or reject referrals from the Coordinated Entry System, although service denials should be infrequent and must be documented in HMIS. The specific allowable criteria for denying a referral shall be published by each project and be reviewed and updated annually or as they change, whichever happens first. All participating projects shall provide the reason for service denial, and may be subject to a limit on the number of service denials.

Agencies who would like to deny a referral that is incompatible with their programming must include details about the reason for denial. Documentation should include communication attempts with the person, specific criminal or housing history that prevents acceptance of referral, or other similar details. Examples of denials that will need additional details or documentation include the following:

- Confirmed as doubled up/unhappily housed but not residing on streets/shelter
- Confirmed as relocating out of area
- Person unable to be located after multiple, documented attempts
- Ineligible for assigned provider
- Declined services from assigned provider
- Person confirmed as incarcerated
- Person confirmed as deceased

If the denial is the result of a third-party property management/landlord (private or partner of service provider) rejecting the person's application, the rejection will trigger a case conferencing meeting. If the household choose to appeal this decision, a new referral will not be provided to the housing program until the appeal process has reached its conclusion.

The Housing Provider will document any unsuccessful matches and provide both the (A) reason(s) why they were not housed and the (B) date of unsuccessful match/ "unassignment" within HMIS so that the person can be reassigned to additional providers. The housing provider will also document when each match does lead to successful program entry and providing the date the person moves into housing within HMIS.

Re-Screening

While people generally do not need to be surveyed multiple times with the VI-SPDAT, there are circumstances under which people who have been screened using the VI-SPDAT would qualify to be re-screened, including the following:

a. Someone has not had contact with the homeless services system for one year or more since the initial VI-SPDAT screening.
b. Someone has encountered a significant life change defined as one of the following items: an adult member added or removed to their household, re-unification with child, or SPMI identified by a credentialed professional.
c. In rare occurrences, someone who is screened and referred to a housing program may be eligible for re-screening if the program identifies after extensive efforts the person needs a higher level of support than can be offered in that level of intervention.
d. Someone who has known extensive history within the shelter and other emergency systems but whose acuity is not accurately depicted on their first screening.

Note: People who qualify under items C and D, listed above may benefit from the more comprehensive full SPDAT further described in Appendix C – Full SPDAT Process.

Coordinated Entry System Monitoring and Evaluation

Monitoring and Reporting of the Coordinated Entry System

When using an HMIS or any other data system to manage coordinated entry data, all participant information requires privacy protections according to the HMIS Data and Technical Standards at (CoC Program interim rule) 24 CFR 578.7(a) (8).

Providers may not deny services to people if they refuse to allow their data to be shared unless Federal statute requires collection, use, storage, and reporting of a participant's personally identifiable information (PII) as a condition of program participation.

HMIS users must understand and follow the privacy rules associated with the collection, management, and reporting of client data according to the State and CoC HMIS Policies and Procedures. The State-defined monitoring process will report on performance objectives related to Coordinated Entry System utilization, efficiency, and effectiveness.

HUD has developed the following seven system-level performance measures to help communities gauge their progress in preventing and ending homelessness:

1. Length of time persons remain homeless;
2. The extent to which persons who exit homelessness to permanent housing destinations return to homelessness;
3. Number of homeless persons;
4. Jobs and income growth for homeless persons in CoC Program-funded projects;
5. Number of persons who become homeless for the first time;
6. Homelessness prevention and housing placement of persons defined by Category 3 of HUD's homeless definition in CoC Program-funded projects;
7. Successful housing placement;

The purpose of these measures is to provide a more complete picture of how well a community is preventing and ending homelessness. The number of homeless persons measure (#3) directly assesses a CoC's progress toward eliminating homelessness by counting the number of people experiencing homelessness both at a point in time and over the course of a year. The six other measures help communities understand how well they are reducing the number of people who become homeless and helping people become quickly and stably housed.

Reductions in the number of people becoming homeless are assessed by measuring the number of people who experience homelessness for the first time (#5), the number who experience subsequent episodes of homelessness (#2), and homelessness prevention and housing placement for people who are unstably housed (Category 3 of HUD's homelessness definition) (#6). Achievement of quick and stable housing is assessed by measuring length of time homeless (#1), employment and income growth (#4), and placement when people exit the homelessness system (#7). The performance measures are interrelated and, when analyzed relative to each other, provide a more complete picture of system performance. For example, the length of time homeless measure (#1) encourages communities to quickly re-house people, while measures on returns to homelessness (#2) and successful housing placements (#7) encourage communities to ensure that those placements are also stable. Taken together, these measures allow communities to evaluate the factors more comprehensively that contribute to ending homelessness.

Ongoing Training and Feedback

The Durham CoC will consult with each participating project and project participants at least annually to evaluate the intake, assessment, case conferencing, prioritization and referral processes associated with the Coordinated Entry System. Feedback requests must address the quality and effectiveness of the entire Coordinated Entry experience for both participating projects and households experiencing homelessness.

Participants will be identified through their Continuum-wide feedback requests made directly to participating agencies, through case managers and through self-identification. Requests for modification/addition/removal from current Coordinated Entry processes will be provided to the Homeless Services Advisory Committee (HSAC), serving as the Continuum of Care Governance Board, for approval. The Durham CoC ensures adequate privacy protections of all participant information collected in the course of its annual evaluation, and no personally identifiable information will be included.

Appendices

Appendix A

Coordinated Entry System Program Component Definitions

Component definitions provide detailed descriptions of each CoC program type available through the Coordinated Entry System.

Street Outreach

Component Type	Essential Elements	Target Population
Emergency services and engagement intended to link unsheltered households who are homeless and in need of shelter, housing, and support services.	Low-demand, street and community-based services that address basic needs (e.g., food, clothing, blankets) and seek to build relationships with the goal of moving people into housing and engaging them in services over time. In addition, outreach staff should provide or link people with: case manager, assistance to develop a person-centered case management plan, housing placement and housing location support, on-site psychiatric and addictions assessment, medication, other immediate and short-term treatment, and assessment to other programs and services.	Homeless people on the streets, frequently targeting those living with mental illness(es), severe addiction(s), or dual-diagnoses As providers funded to end homelessness match people to their available housing resources, street outreach will target people connected to a housing resource through these providers in order to demonstrate Coordinated Entry participation

Prevention

Component Type	Essential Elements	Target Population
Prevention from homelessness includes financial assistance and services to prevent people and families from becoming homeless and help those who are experiencing homelessness to be quickly re-housed and stabilized. The funds under this program are intended to target people and families who would be homeless but for this assistance.	Programs can provide a variety of assistance, including: short-term or medium-term rental assistance and housing relocation and stabilization services, including such activities as mediation, credit counseling, security or utility deposits, utility payments, moving cost assistance, and case management.	People who are "at risk of homelessness."

Emergency Shelter

Component Type	Essential Elements	Target Population
Emergency Shelter programs providing stabilization and assessment; focusing on quickly moving all people to housing, regardless of disability or background. Short-term shelter that provides a safe, temporary place to stay (for those who cannot be diverted from shelter) with focus on initial housing assessment, immediate housing placement and linkage to other services.	Entry point shelter with: • showers, • laundry, • meals, • other basic services, • and linkage to case manager and housing counselor (on-site), with the goal of helping households move into stable housing as quickly as possible. Shelters include an array of stabilization options that allow for varying degrees of participation and levels of support based on needs and engagement at the time they enter the system (i.e., for those with	People experiencing homelessness As providers funded to end homelessness match people to their available housing resources, emergency shelters will target people connected to a housing resource through these providers in order to demonstrate Coordinated Entry participation

	chronic addictions, mental illness, and co-occurring disorders). On-site supportive services staff should conduct the ***VI-SPDAT*** of repeat people requesting such assessment **following 7+ shelter nights** to determine housing needs (e.g., unit size, rent levels, location), subsidy needs, and identify housing barriers, provide ongoing case management, and manage ongoing housing support and services that the person must remain stably housed	

Rapid Re-Housing

Component Type	Essential Elements	Target Population
Rapid re-housing is an intervention designed to help people and families exit homelessness quickly and return to permanent housing. Rapid re-housing assistance is offered without preconditions (such as employment, income, absence of criminal record, or sobriety) and the resources and services provided are typically tailored to the unique needs of the household. While a rapid re-housing	**Housing Identification** • Recruit landlords to provide housing opportunities for people and families experiencing homelessness. • Address potential barriers to landlord participation such as concern about short term nature of rental assistance and tenant qualifications. **Rent and Move-In Assistance (Financial)** • Provide assistance to cover move-in costs, deposits, and the rental and/or utility assistance (typically six months or	People experiencing homelessness with temporary barriers to self-sufficiency

program must have all three core components available, it is not required that a single entity provide all three services nor that someone would utilize them all.	less) necessary to allow people and families to move immediately out of homelessness and to stabilize in permanent housing. **Rapid Re-Housing Case Management and Services** • Help people and families experiencing homelessness identify and select among various permanent housing options based on their unique needs, preferences, and financial resources. • Help people and families experiencing homelessness address issues that may impede access to housing (such as credit history, arrears, and legal issues). • Help people and families negotiate manageable and appropriate lease agreements with landlords. • Make appropriate and time-limited services and supports available to families and people to allow them to stabilize quickly in permanent housing. • Monitor participants' housing stability and be available to resolve crises, at a minimum during the time rapid re-housing financial assistance is provided. • Provide or assist households with	

	connections to resources that help them improve their safety and well-being and achieve their long-term goals. This includes providing or ensuring that the person has access to resources related to benefits, employment and community-based services (if needed/appropriate) so that they can sustain rent payments independently when rental assistance ends. • Ensure that services provided are person-directed, respectful of people' right to self-determination, and voluntary. Unless basic, program-related case management is required by statute or regulation, participation in services should not be required to receive rapid re-housing assistance. • Assist households to find and secure appropriate rental housing.	

Transitional Housing

Component Type	Essential Elements	Target Population
Safe, temporary apartments located in project-based or scattered-site housing that focuses on housing planning, addictions treatment, stabilization, and recovery for people	Safe units located in site-based or scattered site housing that focuses on housing planning, addictions treatment, stabilization, and recovery for people and families with temporary barriers to self-	• People experiencing homelessness contemplating recovery or newly in recovery, • youth, • ex-offenders, • veterans (choosing GPD) • People who are

and families with temporary barriers to self-sufficiency.	sufficiency. Recognizing that a zero tolerance approach does not work for all people, transitional housing programs employ a harm reduction, or tolerant, approach to engage people and help them maintain housing stability Housing assistance may be provided for up to two years, including rental assistance, housing stabilization services, landlord mediation, case management, budgeting, life skills, parenting support, and child welfare preventive services. Housing plan within two weeks. Average stay is six months. Could stay up to two years. All programs provide follow up case management post exit. Expectation of six months of post placement tracking to assess success	actively fleeing domestic violence

Permanent Supportive Housing

Component Type	Essential Elements	Target Population
Project-based, clustered and scattered site permanent housing	Permanent housing with supports that help people maintain housing and	People experiencing long-term homelessness, living with disabilities, and

linked with supportive services that help residents maintain housing.	addresses barriers to self-sufficiency. PSH programs should provide subsidized housing or rental assistance; tenant support services Recognizing that relapse is part of the recovery process, PSH programs should hold units open for 30 days while people are in treatment or in other institutions. If a person returns to a program after 30 days and their unit was given to someone else, staff should work with that person to keep them engaged and place them in a unit when one is available. Some PSH programs should have a tolerant, or harm reduction, approach to engage people with serious substance abuse issues. While in PSH, people should receive supportive services appropriate to their needs from their case manager and/or the ACT multidisciplinary team.	significant barriers to self-sufficiency.

Permanent Housing – Market Rate

Component Type	Essential Elements	Target Population
Housing where people may stay indefinitely with temporary or long-term rental assistance and/or supportive	Broad range of clustered or scattered-site permanent housing options for people with temporary barriers to self-sufficiency, including	People who were formerly homeless

services.	group living arrangements, shared apartments, or scattered-site apartments. People can receive rental subsidies (transitional or permanent, deep, or shallow) and supportive services. Both length and intensity of housing subsidy and services are defined on a case-by-case basis depending on their needs. Once people are housed, a multi-disciplinary case management team (lead by the primary case manager of an assigned PH provider) should conduct a comprehensive assessment and develop a long-term case management plan based on their needs. People should maintain the same primary case manager for as long as they are in the homeless system, but members of the multi-disciplinary team may change as the person's needs change.	

Appendix B

Example Messaging When Conducting VI-SPDATs

"My name is [ ] and I work for a group called [ ]. I have a 10 minute survey I would like to complete with you. The answers will help us determine how we can go about providing supports. Most questions only require a "yes" or "no." Some questions require a one-word answer. All that I need from you is to be honest in responding, so that there isn't a "correct" or preferred answer that you need to provide, or information you need to conceal. We can come back to or skip any question you don't feel comfortable answering, and I can explain what I mean for any question that's unclear.

The information collected goes into the Homeless Management Information System, which will ensure that instead of going to agencies all over town to get on waiting lists, you will only have to complete this survey once. If you have a case manager who is helping you apply for housing, you should still work with them once you have finished this survey.

After the survey, I can give you some basic information about resources that could be a good fit for you. I want to make sure you know, though, that there are very few housing resources that are connected to the survey, so it's possible but unlikely that you would be housed through this process. The primary benefit to doing the survey is that it will help give you and me a better sense of your needs and what resources I can refer you to.

Would you like to take the survey with me?"

Appendix C

SPDAT Process

While the VI-SPDAT is a pre-screen or triage tool that looks to confirm or deny the presence of more acute issues or vulnerabilities, the SPDAT (or "full SPDAT") is an assessment tool looking at the depth or nuances of an issue and the degree to which housing may be impacted.

To provide a safety net for people that are presumed to be highly vulnerable but score too low on the VI-SPDAT to qualify for permanent supportive housing (i.e., 7 or below), those people may be recommended for full SPDAT assessment. The primary reason for recommending a SPDAT are when the person is assessed under or over-reports what the Assessor observes or knows through outside observation.

By allowing for assessors to spend the time to complete this more in-depth analysis, the small set of people whose full depth of vulnerability may not be reflected within their VI-SPDAT assessment may still be considered for street outreach or housing assignments. In a subset of these very limited instances, it is possible for a full SPDAT to produce different results than the VI-SPDAT because it is a multi-method assessment that incorporates more comprehensive outside information than the primarily self-reported information collected through the VI-SPDAT. Those who have received a full SPDAT assessment will periodically be reviewed through case conferencing and housing match processes.

In instances where people have both a full SPDAT and VI-SPDAT assessment, whenever possible, referral for housing placement will prioritize the full SPDAT and not solely the VI-SPDAT score.