NORTHEAST FLORIDA COC FL-510 COORDINATED ENTRY SYSTEM

COORDINATED ENTRY SYSTEM
POLICIES & PROCEDURES

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TABLE OF CONTENTS

Overview……2

HUD Guidance and Regulation……..4

Key Terms……...5

Coordinated Entry System Roles and Responsibilities…….11

CoC Lead Agency…….11

CES Agency……..11

Providers……11

Applicants & Clients……..12

Coordinated Entry: CoC & ESG Program Requirements……..13

CES Operation Protocols……...14

Access……14

Assessment……15

Prioritization……..18

Referral……..23

By Name List/Housing Prioritization List…….24

Special Populations……25

Domestic Violence Survivors…….25

Unaccompanied Youth…….. 26

Program Evaluation……... 27

OVERVIEW

Coordinated Entry- "Coordinated Entry" is defined as a process designed to coordinate program participant intake, assessment, and provision of referrals. It covers the geographic area, is easily accessed by individuals and families seeking housing and services, is well advertised, and includes a comprehensive and standardized assessment tool.

The process of Coordinated Entry can be implemented regardless of geography, housing stock, service availability, or unique community makeup. Almost any model of Coordinated Entry applied to any community or situation with patience, persistence, testing, and tweaking, can be successful.

The terms "Coordinated Access", "Centralized Intake", "Coordinated Intake", "Coordinated Entry" and "Coordinated Assessment" are often used interchangeably, and with the exception of "Centralized Intake", more or less mean the same thing: transitioning from a "first come, first served" mentality to a mentality that says "now that you are here, let's determine, together, what might be your next step". ***The Northeast Florida Continuum of Care will refer to the system as "Coordinated Entry."***

Coordinated Entry, when implemented correctly, can help to prioritize individuals and families who need housing the most across communities. Coordinated Entry can create a collaborative, objective environment across a community that can provide an informed way to target housing and supportive services to:

1. Divert people away from the system who can solve their own homelessness.
2. Quickly move people from street to permanent housing.
3. Create a more defined and effective role for emergency shelters and transitional housing.
4. Create an environment for less time, effort, and frustration on the part of case managers by targeting efforts.
5. End homelessness across communities, versus program by program.

<u>The intention of Coordinated Entry is to:</u>

1. **Target** the correct housing intervention to the correct individual (family), particularly for those with high acuity and high need.
2. **Divert** people away from the system who can solve their own homelessness.
3. **Greatly reduce the length of homelessness** by moving people quickly into the appropriate housing.
4. **Greatly increase the possibility of housing stability** by targeting the appropriate housing intervention to the corresponding needs.

Traditionally, the system of entry and referral to housing and service supports was based on a "first-come, first-served" basis and in some places still is. But years of research, re-thinking, and a commitment to moving away from the linear approach to housing placement and moving toward quickly placing people into appropriate housing, has shifted the way we do business.

Historic Practice is **Program** Centric	Coordinated Access/Entry/Assessment is **Client** Centric
Should we accept this family into our program?	What housing and service intervention is the best fit for each family and individual?
Unique entry and assessment forms for each individual program.	Standard forms, assessment, and entry processes across all programs.
Uneven knowledge about existing programs, eligibility, and purpose in communities.	Accessible information about housing and service options in the CoC.

Applying Coordinated Entry to a community or region brings together the strength of programs across a community, offering a menu of services across programs. When communities come together to implement a Coordinated Entry model, each program realizes success in a myriad of ways:

- Programs Receive Eligible Clients: Programs receive referrals for participants whose needs and eligibility have already been determined. The autonomy and unique nature of programs, as they operate within a coordinated framework become a strength, not a hindrance.
- Case Managers can concentrate on Case Management: With every program in a community providing assessment, case managers often share the burden of intake and assessment.
- Communities readily see what additional resources they need most: Lots of clients with mid-level acuity signal a need for more Rapid Re-housing resources. Lots of clients with high-level acuity signal a need for more permanent supportive housing/housing first.
- Time, red tape, and barriers are significantly reduced: When different programs in a community follow the same process across and are aware of one another, workload is significantly reduced.
- Community success in ending homelessness is significantly increased: Targeting limited resources as a community in a laser-like way leads to very fast and effective interactions that lead to long-term housing stability.

HUD GUIDANCE AND REGUALTION

The U.S. Department of Housing and Urban Development (HUD) published the Continuum of Care (CoC) Program Interim rule in the Federal Register on July 31, 2012. The rule, governing the CoC Programs, is designed to assist individuals (including unaccompanied youth) and families experiencing homelessness, and to provide the services needed to help such individuals move into transitional and permanent housing, with the goal of long-term stability. The program promotes community-wide planning and strategic use of resources to address homelessness; improved coordinated and integration with mainstream resources and other programs targeted to people experiencing homelessness; improved data collection and performance measurement; and allows each community to tailor its program to the particular strengths and challenges within that community.

In the Homeless Emergency Assistance and Rapid Transition to Housing: Continuum of Care Program 24 CFR 578.7(a)(8) HUD mandates that "In consultation with recipients of Emergency Solutions Grants program funds within the geographic area, establish and operate either a centralized or coordinated assessment system that provides an initial, comprehensive assessment of the needs of individuals and families for housing and services. The Continuum must develop a specific policy to guide the operation of the centralized or coordinated assessment system on how its system will address the needs of individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking, but who are seeking shelter or services from non-victim service providers"[1].

HUD uses the terms *coordinated entry* and *coordinated entry process* instead of *centralized* or *coordinated assessment* to help avoid the implication that CoC's must centralize the assessment, and to emphasize that the process is easy for people to access, that it identifies and assess their needs, and makes prioritization decisions based upon needs[2].

The policy and procedures for Northeast Florida's Coordinated Entry System have been revised to reflect and act in accordance with the following HUD Regulations:

- 24 CFR Part 578 [Docket No. FR-5476-I-01] Rin 2506-AC29 Homeless Emergency Assistance and Rapid Transition to Housing: Continuum of Care Program
- 24 CFR Part 576 [Docket No. FR-5476-I-01] Rin 2506-AC29 Homeless Emergency Assistance and Rapid Transition to Housing: Continuum of Care Program
- Notice CPD 14-012 Issued July 28, 2014
- Notice CPD 17-01 Issued January 23, 2017

[1] Department of Housing and Urban Development 24 CFR Part 578 [Docket No. FR-5476-I-01] Rin 2506-AC29 Homeless Emergency Assistance and Rapid Transition to Housing: Continuum of Care Program https://www.hudexchange.info/resources/documents/CoCProgramInterimRule_FormattedVersion.pdf

[2] HUD Coordinated Entry Policy Brief February 2015 https://www.hudexchange.info/resources/documents/Coordinated-Entry-Policy-Brief.pdf

KEY TERMS

Acuity - When utilizing the VI-SPDAT Prescreens (triage tool), acuity speaks to the presence of a presenting issue based on the prescreen score. In the context of the Full SPDAT assessments, acuity refers to the severity of the presenting issues. In the case of an evidence- informed common assessment tool like the VI-SPDAT (Single), Family VI-SPDAT, Full SPDAT, acuity is expressed as a number with a higher number representing more complex, co-occurring issues that are likely to impact overall housing stability.

Access Points – For the purpose of this document, Access Points are designated areas located within our continuum where individuals or families can go to for intake and assessment of homeless prevention and housing services for which they may qualify.

Common Assessment Tool - A comprehensive and standardized assessment tool used for the purposes of housing prioritization and placement within a CoC Coordinated Entry System. The Northeast Florida Continuum of Care (Fl-510) has adopted the VI-SPDAT (Vulnerability Index Service Prioritization Decision Assistance Tool) as the Common Assessment Tool in April 2014 when we initially launched our Coordinated Entry System.

Chronic Homelessness (Final Definition 24 CFR 578.3, effective January 15, 2016) -

> (1) A "homeless individual with a disability," who: (i) lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and (ii) has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least 12 months or on at least 4 separate occasions in the last 3 years where the combined occasions must total at least 12 months
>
> >Occasions separated by a break of at least 7 nights
>
> >Stays in an institution of fewer than 90 days do not constitute a break
>
> (2) An individual who has been residing in an institutional care facility for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
>
> (3) A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraphs (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Disability is described as: substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000 (42 USC 15002)), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability 24 CFR 578.3.

Coordinated Entry - "A centralized or coordinated process designed to coordinate program participant intake, assessment, and provision of referrals across a geographic area. The system covers the geographic area (designated by the CoC), is easily accessed by individuals and families

seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool." 24 CFR Section 578.7. It is the responsibility of each CoC to implement Coordinated Entry in their geographic area.

Coordinated Entry Committee - Entity responsible for implementation and upper level management of Coordinated Intake System. Members of the Board are representatives from community providers within the service area.

Coordinated Systems – Within our community, coordinated systems is defined as interconnected network of systems that services homeless and at risk households, and consists of coordinated intake and assessment, diversion, prevention, rapid re-housing, transitional housing, permanent supportive housing and other tailored programs and services, and linkages to mainstream resources.

Cultural and Linguistic Competency – All persons administering assessments shall us culturally and linguistically competent practices. Assessment shall include trauma-informed culturally and linguistically competent questions for first-generation-subpopulations; youth; persons fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking; and LGBTQ+ persons.

Disabling Condition - (1) a condition that: (i) is expected to be long-continuing or of indefinite duration; (ii) substantially impedes the individual's ability to live independently; (iii) could be improved by the provision of more suitable housing conditions; and (iv) is a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury; or (2) a development disability, as defined above; or (3) the disease of Acquired Immunodeficiency Syndrome (AIDS) or any conditions arising from the etiologic agent for Acquired Immunodeficiency Syndrome, including infection with the Human Immunodeficiency Virus (HIV). 24 CFR 583.5.

Diversion - Diversion is a strategy that prevents homelessness for people seeking shelter by helping them identify immediate alternate housing arrangements and, if necessary, connecting them with services and financial assistance to help them return to permanent housing. Diversion programs can reduce the number of families becoming homeless, the demand for shelter beds, and the size of program prioritization lists. The main difference between diversion and other permanent housing-focused interventions centers on the point at which intervention occurs. Prevention targets people at imminent risk of homelessness, diversion targets people as they are applying for entry into shelter, and rapid re-housing/permanent supportive housing targets people who are already homeless.

Fair and Equal Access – All people in the CoC's geographic area shall have fair and equal access to the Coordinated Entry process, regardless of where or how they present for services. Fair and equal access means that people can easily access the Coordinated Entry process in person at the Urban Rest Stop, by phone, or some other method, and that the process for accessing help is well known.

Family - includes, but is not limited to the following, regardless of actual or perceived sexual orientation, gender identity, or marital status: (1) A single person, who may be an elderly person, displaced person, disabled person, near-elderly person, or any other single person; or (2) A group of persons residing together, and such group includes, but is not limited to: (i) A family with or without children (a child who is temporarily away from the home because of placement in foster care is considered a member of the family); (ii) An elderly family; (iii) A near- elderly family; (iv) A disabled family; (v) A displaced family; and (vi) The remaining member of a tenant family. 24 CFR 5.403.

Fiscal Agent – For the purpose of this document, the entity that coordinates funding and provides oversight to the coordinated intake and assessment system. The fiscal agent for this community will be Changing Homelessness, Inc. This agent is also known as the "Lead Agency"

Emergency Transfer Plan – Provides for emergency transfers for DV survivors receiving rental assistance or residing in units subsidized under a covered housing program (including CoC and Emergency Solutions Grant (ESG) funded programs).

a. **External Emergency Transfer –** An emergency relocation of a tenant to another unit where the tenant would be categorized as a new applicant (i.e., tenant must undergo an application process to reside in the new unit.)
b. **Internal Emergency Transfer –** An emergency relocation of a tenant to another unit where the tenant would not be categorized as a new applicant. (i.e., tenant may reside in new unit without having to undergo an application process.)

HEARTH – The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) act of 2009 that includes Emergency Solutions Grant (ESG) and Continuum of Care (CoC) grants.

HMIS – Homeless Management Information System; a centralized data base designated to create an unduplicated accounting of homelessness that includes housing and services. Client Track is the HMIS system for this CoC.

Homeless – definition by category:

1. Category 1: Literally Homeless- An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:

> (i) an individual or family 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, or camping ground;

> (ii) an individual or family 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 programs for low- income individuals);

> or (iii) 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;

2. Category 2: Imminent Risk of Homelessness- An individual or family who will imminently lose their primary nighttime residence, provided that:

> The primary nighttime residence will be lost within 14 days of the date of application for homeless assistance;

> (ii) No subsequent residence has been identified; And

> (iii) The individual or family lacks the resources or support networks, e.g., family, friends, faith-based or other social networks, needed to obtain other permanent housing;

3. Category 3: Homeless Under Other Statues- 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:

> (i) Are defined as homeless under section 387 of the Runaway and Homeless Youth Act (42 U.S.C. 5732a), section 637 of the Head Start Act (42 U.S.C. 832), section 41403 of the Violence Against Women Act of 1994 (42 U.S.C. 14043e 2), section 330(h) of the Public Health Service Act (42 U.S.C. 254b(h)), section 3 of the Food and Nutrition Act of 2008 (7 U.S.C. 2012), section 17(b) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)), or section 725 of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a);

> (ii) Have not had a lease, ownership interest, or occupancy agreement in permanent housing at any time during the 60 days immediately preceding the date of application for homeless assistance;

> (iii) Have experienced persistent instability as measured by two moves or more during the 60-day period immediately preceding the date of applying for homeless assistance; and

> (iv) Can be expected to continue in such status for an extended period of time because of chronic disabilities; chronic physical health or mental health conditions; substance addiction; histories of domestic violence or childhood abuse (including neglect); the presence of a child or youth with a disability; or two or more barriers to employment, which include the lack of a high school degree or General Education Development (GED), illiteracy, low English proficiency, a history of incarceration or detention for criminal activity, and a history of unstable employment; or

4. Category 4: Fleeing or Attempting to Flee Domestic Violence- Any individual or family who:

> 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 individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence;

> (ii) Has no other residence; and

> (iii) Lacks the resources or support networks, e.g., family, friends, and faith-based or other social networks, to obtain other permanent housing.

Housing First - An approach to quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to program/housing entry, such as sobriety, treatment or service participation requirements. Supportive services such as housing-focused case management are offered to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to permanent housing entry.

HUD – The Department of Housing and Urban Development; the United States federal department that administers federal program dealing with homelessness. HUD oversees HEARTH and CoC funded programs.

Lead Agency – The agency identified as the primary administrator of coordinated intake and assessment. For the purpose of this document that agency is the Changing Homelessness, Inc. or its sub-grantee who has been contracted to provide the Coordinated Intake and Assessment Services.

Linkage or Access to Mainstream Resources – An approach to help people stabilize their housing for the long term by linking them to resources for which they are eligible within their community.

Permanent Supportive Housing (PSH) - means community-based housing without a designated length of stay, and includes both permanent supportive housing. Permanent supportive housing means long term permanent housing in which supportive services are provided to assist homeless persons with a disability to live independently. 24 CFR 578.3. The definition of rapid re-housing appears below.

Prioritization List - The prioritization List is thought of as a universal registry within the CoC for purposes of prioritization and housing placement. CoC and ESG funded agencies must make and take referrals off of this list for their programs.

Navigator – A certified intake worker whose responsibility is to provide coordinated intake and assessment for individuals or families seeking homeless prevention or housing services.

Rapid Re-Housing (RRH) -An intervention designed to help individuals and families exit homelessness as quickly as possible, return to permanent housing, and achieve stability in that housing. Rapid re-housing assistance, operating in a Continuum of Care and/or Housing First model, 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. The core components of a rapid re-housing program are housing identification and relocation, short-and/or medium term rental assistance and move-in (financial) assistance, and case management and housing stabilization services. This assistance is subject to the definitions and requirements set forth in 24CFR§576.2 "Homeless" paragraph (1) and paragraph (4) who are residing in a place set forth in (1), 24CFR§576.105, 24CFR§576.106 and 24CFR§576.400. (24CFR§576.104 & Core Components of Rapid Re-Housing, National Alliance to End Homelessness).

SPDAT - (Service Prioritization Decision Assistance Tool) the evidence-based assessment utilized by all trained CoC providers in either enacting more detailed determinations of acuity for housing placement and/or ongoing use in case management to ensure housing stabilization. This is an ongoing case management tool suggested for your use. The SPDAT (or "Full SPDAT") has an individual and family tool. Staff must be trained by OrgCode Consulting prior to administering the tool. The SPDAT can be completed on paper or in HMIS and attached to a client record.

Severity of Service Needs –

(a) For the purposes of Notice (CPD-16-11), this means an individual for whom at least one of the following is true:

i. History of high utilization of crisis services, which include but are not limited to, emergency rooms, jails, and psychiatric facilities; and/or

ii. Significant health or behavioral health challenges, substance use disorders, or functional impairments which require a significant level of support in order to maintain permanent housing.

iii. For youth and victims of domestic violence, high risk of continued trauma or high risk of harm or exposure to very dangerous living situations.

iv. When applicable CoCs and recipients of CoC Program-funded PSH may use an alternate criteria used by Medicaid departments to identify high-need, high cost beneficiaries.

(b) Severe service needs as defined in paragraphs i.-iv. above should be identified and verified through data-driven methods such as an administrative data match or through the use of a standardized assessment tool and process and should be documented in a program participant's case file. The determination must not be based on a specific diagnosis or disability type, but only on the severity of needs of the individual. The determination cannot be made based on any factors

that would result in a violation of any nondiscrimination and equal opportunity requirements, see 24 C.F.R. § 5.105(a)

Transitional Housing (TH) - housing to facilitate the movement of individuals and families experiencing homelessness into permanent housing within 24 months. 24 CFR 578.3.

VI-SPDAT - (Vulnerability Index-Service Prioritization Decision Assistance Tool) the evidence- based Common Assessment or Prescreen Triage Tool utilized by all projects in the Northeast Florida Continuum of Care to determine initial acuity (the presence of an issue) and utilized for housing triage, prioritization and housing placement. Note there are two versions of VI-SPDAT, the Individual and Family, both of which are available in HMIS. There is a Youth VI-SPDAT that was recently released for use specifically with youth and is available on the OrgCode website, with anticipation of HMIS release in the near future.

> PLEASE NOTE the VI-SPDAT is a different tool than the Full SPDAT; do not use these terms interchangeably as they are different

> The VI-SPDAT is the Common Assessment Tool, or Prescreen Triage Tool

> The Full SPDAT can be used as an ongoing case management tool

COORDINATED ENTRY SYSTEM ROLES AND RESPONSIBILITIES

As a system-level process, coordinated entry requires intensive coordination and communication among all the projects and agencies in the CoC and, ideally, all of those otherwise available in the community to serve individuals and families experiencing homelessness, including programs that can serve that population but may not be targeting it.

CoC Lead Agency:

- It is the lead agency's responsibilities to:
    - Ensure proper data systems and management protocols are established to support CES operation
    - Regularly update CES Policy & Procedures to ensure most up to date operational information is available to the community
    - Regularly report CES implementation updates, problems, and/or suggestions to the CoC Governance Board
    - Oversee provision of homeless diversion, prevention and housing services for eligible clients.
    - Plan and conduct annual CES Evaluation

CES Lead Agency:

- It is the CES Lead agency's responsibilities to:

- Manage the day-to-day operation of coordinated entry
- Update and maintain information on program vacancies/opening. To be completed on a weekly basis regardless of whether there are new openings to report.
- Regularly update and make current all programs eligibility guidelines and program contact information so that Navigators can make the best referrals possible.
- Ensure that when a referral is made, the Navigators confirms within two business days whether the referral is accepted, declined by provider, declined by client, or pending, or the provider is unable to contact the client.
- Bring problems and suggestions to the monthly Data Committee meeting and/or Coordinated Entry meeting.
- Ensure that all points of entry will use the same screening and assessment tool, data collection forms, policies on eligibility verification and referral/information-sharing systems.

Providers:

- Participation Requirement.
    - All providers receiving funding through HEARTH or a HUD funded program are required to participate in the coordinated intake and assessment process.
    - Providers must be live on the HMIS system and must maintain data which is inputted no later than within 24 hours of a service or outcome being achieved or rendered.
    - Providers must provide written documentation to the Coordinated Entry Board within 3 business days on why an applicant was denied entry into a program.

Applicants and Clients:

- Clients who are in need of homeless prevention or housing services can access information and eligibility criteria through one of the Access Points. Applicants seeking assistance must be screened at one of the Access Points or by a Navigator prior to being referred to an agency for assistance. Applicants not eligible for services will be referred to other appropriate community resources.
- Eligibility. Individuals and families that are **"Literally Homeless"** (meeting HUD's Category 1 definition of homelessness) or at **"Imminent Risk of Homelessness"**. For purposes of eligibility for coordinated intake and assessment, "imminent risk of homelessness" means individuals and families that are able to document that they must leave their current nighttime residence within 72 hours, and include household that;
    - Have received a court notice of eviction or foreclosure.

- Are staying with family or friends AND can document that they must leave within 72 hours. Documentation must include a third party verification of violation. (For example, a lease that states that anyone other than occupants in the lease constitutes a lease violation.)
- Other, as determine by a provider or by the Northeast Florida CoC

- Participation Requirement. All households (with the exception of households in domestic violence situations) must be assessed prior to program entry; or , in the case of households in emergency shelters that admit same day, the assessment must occur as soon as possible after entry, and before being referred to another program

- Applicants/Clients can expect:
  - To be treated with respect and dignity
  - Their initial phone call for assistance to be answered live or returned within two business days
  - To be scheduled for an in-person, intake and assessment within two to five business days
  - To be matched to an appropriate program based upon their unique needs, and referred based on their priority status to opening in a program
  - To wait until the system has the capacity to assist them, and to get help from through diversion or other resource available to them.
- Responsibilities:
  Client must:
  - Answer all questions truthfully and to the best of their ability
  - Bring all required documentation
  - Keep their contact information current in order to be notified of available opening, and referred in a timely manner.

NOTE: *This system acknowledges that the needs of a household fleeing or attempting to flee, domestic violence, dating violence, sexual assault or stalking, may be different than the needs of non-victims. Navigators will be trained on sensitivity in regards to victim's assistance, and referrals will only be made to domestic violence providers. In addition, the HMIS data of victims will continue to be treated with the highest level of confidentiality and victims' data not shared with other Providers (except those designated as Domestic Violence Providers).*

COORDINATED ENTRY: COC & ESG PROGRAM REQUIREMENTS

All HUD CoC & ESG programs will be an active member of the Northeast Florida CoC Coordinated Entry system as it is locally implemented via the Coordinated Entry Committee. The HUD CoC & ESG programs will have minimal entry requirements to ensure the most vulnerable

of the population are being served. HUD CoC & ESG programs will ensure active client participation, client-center practices and informed consent. All HUD CoC & ESG programs will receive referrals from the Prioritization List for housing referral and placement with available HUD CoC & ESG housing resources via Coordinated Entry/Master List Committee Meetings.

STEPS:

1. All adult program participants must meet the ***program*** eligibility requirements and properly document this eligibility as required (HUD funded ESG and CoC Programs are required to use the HUD CoC & ESG Toolkits by appropriate program) for housing placement.

2. Programs may require participants to meet additional program eligibility requirements as they relate specifically to federally and state-guided eligibility in writing. For example, if your Grant Agreement states that you will serve specific populations. Programs are strongly encouraged to create or amend program standards to Low-Barrier standards for client entry.

3. Programs may disqualify registered sex offenders from the program if the location of housing will place the client in violation of Florida statute 775.215 which prohibits registered sex offenders from living near schools, daycare facilities and publicly owned playgrounds. These offenders are prohibited from living within 1,000 feet of a high school, middle school, elementary school, preschool, publicly owned playground, or licensed day care facility. The measurement is taken in a straight line from the nearest property line of the school to the nearest property line of the registrant's place of residence. Additionally, under 24 CFR 578.93 (b)(4), if the program housing has in residence at least one family with a child under the age of 18, the housing may exclude registered sex offenders and persons with a criminal record that includes a violent crime from the project so long as the child resides in the housing.

4. Additionally, programs **may not** disqualify an individual or family from program entry for lack of income or employment status.

5. Programs **cannot** disqualify an individual or family because of evictions or poor rental history.

6. The program explains the services that are available and encourages each adult member to participate in program services, but does not make service usage a requirement or the denial of services a reason for disqualification or eviction. Please note that it is acceptable to require your program participants to participate in housing- focused case management, but it is not acceptable to require participation in any other supportive services. It is important to note that the purpose of any required housing- focused case management should be to engage the program participant to assist them in **maintaining** their housing.

7. The program will maintain an annual Release of Information and annual income verification, Case notes, and all pertinent demographic and identifying data in HMIS, or a

comparable database. Paper files can also be kept as long as they are stored in a secure location.

COORDINATED ENTRY OPERATION PROTOCOLS

This system is focused on providing a continuum of care including prevention, diversion and rapid re-housing approaches. The Plan requires each Navigator to assess household's eligibility for services. Prevention services target people at imminent risk of homelessness, while diversion services target people as they are applying for entry into shelter, and rapid re-housing services target people who are already homeless. If they client is considered chronically homeless the assessment will be made to a permanent supportive housing program or permanent housing program such as the Jacksonville Housing Authority.

ACCESS:

Duval, Nassau and Clay counties are located in Northeast Florida and span over 2,286 square miles of diverse geographic and demographic landscape. Duval County is a populated metropolitan area, Nassau County consists of both rural and beaches community and Clay County is mostly rural with pockets of suburban neighborhoods. In order to meet the need of our community we will utilize a hybrid approach incorporating Access Points such as the Urban Rest Stop, Outreach Navigators, and web based components to provide a variety of avenues in which all segments of our community can access housing and service supports.

ASSESSMENT:

Applicants and Clients:

- Each applicant is evaluated on a variety of criterion, including rental history, criminal history, domestic violence, mental health challenges, disabling conditions, language barriers, educational attainment, employment status, and length of homelessness. Services are then assigned based on the client level determination.
- The Assessment tool provides a procedure for determining which applicants are eligible and appropriate for the variety of housing and support services available in the community. For example, applicants for permanent supportive housing must have a disabling condition and lack the resources to obtain housing.
- Clients will be allowed to submit a survey for improvement changes and suggestions on the Coordinated Intake and Assessment process.

Providers:

- Each applicant who is referred for housing or services will be evaluated through an assessment of their current barriers to obtaining and successfully maintain permanent housing.
- The assessment is heavily focused on the applicant's immediate housing challenge and includes questions regarding household composition, current housing situation, homelessness history, evictions, criminal history and/or active warrants, physical and mental health, and domestic violence issues.
- The Assessment will be used as a guide, with the understanding that each applicant has a unique set of circumstances.
- Generally speaking, the assessment tool ensures that protocols are applied consistently throughout the three county region (Duval, Nassau and Clay County), and that each Provider is engaging in responsible assessments protocol.

CES Lead Agency:

- The Vulnerability Index- Service Prioritization Decision Assistance Tool (VI-SPDAT) is the assessment tool utilized for this system.
- The VI-SPDAT will determine an acuity score that will help inform Navigators and Providers about the following :
    - ✓ People who will benefit most from Permanent Supportive Housing
    - ✓ People who will benefit most from Rapid Re-Housing
    - ✓ People who are most likely to end their own homelessness with little to no intervention on your part
    - ✓ Which areas of the person's life that can be the initial focus of attention in the case management relationship to improve housing stability.
    - ✓ How individuals and families are changing over time as result of case management process.
- The Lead Agency will provide a system of care that allows clients to give feedback on suggestions and improvements of the Intake and Assessment Process. This process will be posted in common areas of "Access Points" and made available on-line as part of the Web-based system.
- The Lead Agency will ensure that the VI-SPDAT is not used to :
    - ✓ Provide a diagnosis
    - ✓ Assess current risk or be a predictive index for future risk
    - ✓ Take the place of other valid and reliable instruments used in clinical research and care

COMMUNITY ASSESSMENT TOOL: VI-SPDAT

The VI-SPDAT is a pre-screening, or triage tool that is designed to be used by all providers within a community to quickly assess the health and social needs of homeless persons and match them

with the most appropriate support and housing interventions that are available. A triage tool like the VI-SPDAT allows homeless service providers to similarly assess and prioritize the universe of people who are homeless in their community and identify who to treat first based on the acuity (severity) of their needs. It is a brief survey that service providers, outreach workers, and even volunteers can use to determine an acuity score for each homeless person who participates. The scores can then be compared and used to identify and prioritize candidates for different housing interventions based upon their acuity. Using the VI-SPDAT, providers can move beyond only assisting those who present at their particular agency and begin to work together to prioritize all homeless people in the community, regardless of where they are assessed, in a consistent and transparent manner.

Sometimes the VI-SPDAT is confused with or used interchangeably with the Full SPDAT. Whereas the VI-SPDAT is a triage tool (also referred to as a pre-screen tool), the SPDAT is an assessment tool. The Full SPDAT digs deeper into the context, history, environment and severity of an issue in a more nuanced manner than the VI-SPDAT. To return to the metaphor of a hospital emergency department, the VI-SPDAT is the triage station asking a series of questions to confirm what is occurring and to understand a particular patient's needs in comparison to all other patients; the Full SPDAT is what happens when the doctor sees the patient, rounds out the understanding of the issue, and advises the appropriate treatment protocol for that individual. The VI-SPDAT is designed to determine the presence and acuity of an issue and identify clients to refer for assessment for specific housing interventions, but it is not intended to provide a comprehensive assessment of each person's needs.

It is recommended that the VI-SPDAT be used together in a community with the Full SPDAT, as they are complementary tools. However, communities may start with using only the VI-SPDAT and referring clients directly to different housing interventions based on their VI-SPDAT scores, although this approach is less precise than using a more comprehensive assessment. Please note, use of the Full SPDAT is not mandated under the Northeast Florida Continuum of Care Coordinated Entry System for housing referral.

VI-SPDAT AND COORDIANTED ENTRY CONSENT

An individual **must** provide informed consent prior to the VI-SPDAT being completed, (Client HMIS Agreement and Release of Information Form). You **cannot** complete a VI-SPDAT with a client without that person's knowledge and explicit agreement. You also **canno**t complete the VI-SPDAT solely through observation or using known information within your organization.

- **Client HMIS Agreement**: This agreement allows the Northeast Florida CoC Homeless Management Information System (**HMIS**) User listed to enter and store client data as, or on behalf of, the agency listed below and/or to report on behalf of the agency.

- **Release of Information Form**: The Release of Information is utilized by all providers to input VI-SPDAT assessments within the HMIS. Individuals who do not sign the release of information do not complete the assessment. Individuals who are not able to complete either a VI-SPDAT or full SPDAT may be referred to the Coordinated Entry Committee.

ASSESSMENT IN PRACTICE

STEPS:

1. Providers will obtain a Northeast Florida HMIS Release of Information and Consent (or comparable document for VSPs)

2. Providers will utilize the VI-SPDAT as the Common Assessment Tool, to screen individuals and families experiencing homelessness.

3. There is a specific VI-SPDAT for Individuals and Families in HMIS. Providers should use the most up to date version available in HMIS (currently, Version 2 is available for both Individuals and Families).

4. The assessment takes approximately 7 minutes to administer, and can be conducted by any provider who has been introduced to the tool through a 30 minute video (or attended a training by its creator, OrgCode Consulting, Inc.), see below for more training details.

5. The VI-SPDAT, as a first assessment at entry, provides each program with the ability to determine, across dimensions, the acuity of an individual or family.

6. In the case of an evidence-informed common assessment tool like the VI-SPDAT, acuity is expressed as a number with a higher number representing more complex, co-occurring issues that are likely to impact overall housing stability. The VI-SPDAT score shows the ***presence*** of these issues, and indicates the potential best fit for housing and service intervention, based on scores across the following dimensions:

- ✓ Wellness: Chronic health issues and substance use.
- ✓ Socialization and Daily Functioning: Meaningful daily activities, social supports, and income.
- ✓ History of Housing and Homelessness: Length of time experiencing homelessness, and cumulative incidences of homelessness.
- ✓ Risks: Crisis, medical, and law enforcement interdictions. Coercion, trauma, and most frequent place the individual has slept.
- ✓ Family Unit (Family VI-SPDAT Only): School enrollment and attendance, familial interaction, family makeup, and childcare.

7. Based upon the Prescreen Acuity Score of the VI-SPDATs, programs and communities can arrive at best possible housing intervention that applies, as follows:

VI-SPDAT Version 2 Individuals

Intervention Recommendation	VI-SPDAT Prescreen Score for **Individuals**
Permanent Supportive Housing/Housing First	8+
Rapid Re-Housing	4-7
Community Resources/Diversion	0-3

VI-SPDAT Version 2 Families

Intervention Recommendation	VI-SPDAT Prescreen Score for **Families**
Permanent Supportive Housing/Housing First	9+
Rapid Re-Housing	4-8
Community Resources/Diversion	0-3

8. Scores on the VI-SPDAT populate the local Prioritization List once entered into HMIS, and at weekly Local Prioritization Committee meetings all the partners and others with housing resources decide who enters available housing (RRH and PSH) next by acuity and HUD priorities.

PRIORITIZATION PROCEDURES & PROTOCOL:

One of the main purposes of a Coordinated Entry System is to ensure that people with the most severe service needs and levels of vulnerability are prioritized for housing and homeless assistance. As indicated by HUD guidelines individuals and families experiencing chronic homelessness should be prioritized for permanent supportive housing.

The following represents the uniform process to be used across the community for assessing individuals, matching them to an appropriate housing intervention (PSH & RRH), and within each category, prioritizing placement into housing. This will eliminate the need to complete multiple assessments with individuals, which is burdensome both for the person being assessed and those conducting the assessment.

The VI-SPDAT will be the ONLY tool used to assess individuals at the point of entry. The VI- SPDAT scores will be used to triage individuals into the appropriate category of intervention.

The following represents the uniform process utilized across the community for prioritizing placement into permanent supportive housing for single individuals and/or families experiencing chronic homelessness. The VI-SPDAT and SPDAT will be the ONLY tools used to assess individuals at the point of entry.

1. Assessment Score: The first prioritization criteria will expedite placement into housing for individuals with the most severe medical and service needs who are at greater risk of

death. This score would be based on questions 1-27 of the VI-SPDAT version 2, with a maximum score of 17.

2. Unsheltered Sleeping Location: The second prioritization criteria is the location where the individual sleeps based on the HUD universal data element 3.19 Living Situation and/or question 1 of the VI- SPDAT version 2. Unsheltered individuals will be given priority over sheltered individuals.

3. Length of Time Homeless: The third prioritization factor is the length of time an individual has experienced homelessness, giving priority to the person that has experienced homelessness the longest, based on homelessness history present within HMIS and/or question 2 of the VI-SPDAT version 2.

4. Overall Wellness: The second prioritization factor targets individuals with similar medical needs as criteria number 1, who will be prioritized when they have behavioral health conditions or histories of substance use, which may either mask or exacerbate medical conditions. This score will be based on questions 15 through 27 of the VI-SPDAT version 2 (i.e., the "Wellness Domain"), and/or the combined responses to the "Mental Health & Wellness & Cognitive Functioning," "Physical Health & Wellness," "Substance Use," "Medication" and "Experience of Abuse and/or Trauma" domains of the SPDAT.

5. Date of VI-SPDAT Assessment: The final prioritization criteria will be the date of the individual's assessment, giving priority to the earliest date of assessment.

PERMANENT SUPPORTIVE HOUSING

For individuals that score 8 or above on the VI-SPDAT version 2, signals a recommendation for permanent supportive housing, prioritizations will be based on the following criteria *(only going to the next level as needed to break a tie between two or more individuals):*

HUD has released specific guidance for the prioritization of chronically homeless individuals and families, which was adopted by the Continuum of Care upon its release is outlined in the following notice: Notice CPD 16-11: Notice on Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing. This Notice supersedes Notice CPD-14-012 and provides guidance to Continuums of Care (CoC) and recipients of Continuum of Care (CoC) Program (24 CFR part 578) funding for permanent supportive housing (PSH) regarding the order in which eligible households should be served in all CoC Program-funded PSH. This Notice reflects the new definition of chronically homeless as defined in CoC Program interim rule as amended by the Final Rule on Defining "Chronically Homeless" (herein referred to as the Definition of Chronically Homeless final rule) and updates the orders of priority that were established under the prior Notice.

The goal of this notice is to ensure that homeless individuals and families with the most severe

service needs within a community are prioritized in PSH, eventually ending chronic homelessness.

In order for a household to qualify for PSH interventions they must meet the definition of chronically homeless as defined by HUD. The definition of "chronically homeless" currently in effect for the CoC Program is that which is defined in the CoC Program interim rule at 24 CFR 578.3, which states that a chronically homeless person is:

(a) An individual who
    a. Is homeless and lives in a place not meant for habitation, a safe haven, or in an emergency shelter
    b. Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions in the last three years
    c. Currently diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments resulting from brain injury or chronic physical illness

(b) An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility for fewer than 90 days and met all the criteria outlined in section (a)

(c) A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all the criteria in section (a), including a family whose composition has fluctuated while the head of household has been homeless.

In accordance with HUD Notice CPD-014-12, households scoring in the permanent supportive housing range will be prioritized in the following manner:

- **First Priority- Chronically Homeless Individuals and Families with the longest history of homelessness and with the most severe service needs**
    - Household's length of time homeless will be determined by length of time as reported by homeless household during the VISPDAT assessment in combination with a review of their HMIS record. Households must be able to demonstrate history of homeless by producing required documentation.
    - Service needs will be identified by the acuity captured in the VISDPAT assessment. When applicable, portions of the SPDAT targeting the use of crisis services will be administered to the head of household if the household's needs are not accurately captured by the VISPDAT.

- **Second Priority- Chronically Homeless Individuals and Families with the longest history of homelessness**

- The chronically homeless individual or head of household of a family has been homeless and living in a place not meant for human habitation, a safe haven, or in an emergency shelter for at **least 12 months either continuously or on at least four separate occasions in the last 3 years, where the cumulative total length of the four occasions equals at least 12 months** and the **CoC or CoC program recipient has NOT identified** an individual or a head of household, who meets all the criteria of the definition for chronically homeless, of the family as having severe service needs
- Household's length of time homeless will be determined by length of time as reported by homeless household during the VISPDAT assessment in combination with a review of their HMIS record. Households must be able to demonstrate history of homeless by producing required documentation

- **Third Priority- Chronically Homeless Individuals and Families with the most severe needs**
  - The chronically homeless individual or head of household of a family has been homeless and living or residing in a place not meant for habitation, a safe have or an emergency shelter **on at least four separate occasions in the last 3 years, where the total length of those separate occasions equals less than one year**, and the **CoC or CoC recipient has identified ta chronically homeless individual or head of household**, who meets all of the criteria of the definition for chronically homeless, of the family **as having severe service needs**.
  - Service needs will be identified by the acuity captured in the VISDPAT assessment. When applicable, portions of the SPDAT targeting the use of crisis services will be administered to the head of household if the household's needs are not accurately captured by the VISPDAT.

- **Forth Priority- All other chronically Homeless Individuals and Families**
  - The chronically homeless individual or head of house household has been homeless and living in a place not meant for human habitation, a safe haven or in an emergency shelter for at **least 12 months either continuously or on at least four separate occasions in the last 3 years where the cumulative total length of the four occasions is less than 12 months** and the CoC or CoC program recipient has **NOT identified a chronically homeless individual or head of household** who meets all the criteria of the definition for chronically homeless as having severe service needs.

RAPID REHOUSING

The following represents the uniform process utilized across the community for prioritizing placement into rapid rehousing for single individuals and/or families. Individuals and/or families

and/or between 4 and 7 on the VI- SPDAT version 2 Individuals, and/or 4-8 on the VI- SPDAT version 2 Families, will be prioritized through the process described below. Assessors should describe the core components to rapid rehousing through the following standardized messaging:

- Designed to facilitate movement into market rate housing as quickly as possible while providing the support needed to achieve that goal
- Assistance that does not provide a voucher
- Time-limited support and financial assistance to pay rent so that when the program ends, participants are able to pay the full rent independently. The length of rental assistance and support depends on each person's individual needs.
- Financial assistance provided is on a case-by-case basis
- Assistance in identifying and accomplishing other short term goals outside of housing, such as employment, connection to benefits, legal assistance/referrals, personal financial planning services, transportation services, etc.
- Able to connect participants with longer term community resources to help maintain housing as well.

Among rapid rehousing referrals, the following process will be used to prioritize for placement *(only going to the next level as needed to break a tie between two or more individuals):*

1. Date of VI-SPDAT Assessment: The first prioritization criteria will be the date of the individual's assessment, giving priority to the most recent date of assessment.

   Unsheltered Sleeping Location: The second prioritization criteria is the location where the individual sleeps based on the HUD universal data element 3.19 Living Situation and/or question 1 of the VI- SPDAT version 2. Unsheltered individuals will be given priority over sheltered individuals.

2. Length of Time Homeless: The third prioritization factor is the length of time an individual has experienced homelessness, giving priority to the person that has experienced homelessness the longest, based on homelessness history present within HMIS and/or question 2 of the VI-SPDAT version 2.

Based on the quantity of available units, rapid rehousing will be targeted through an equal distribution of VI-SPDAT and/or SPDAT scores. If 4 rapid rehousing openings become available, 1 individual scoring 7, 1 individual scoring 6, 1 individual scoring 5 and 1 individual scoring 4 would be referred for placement.

The equal distribution of rapid rehousing placements will prioritize by scores recommending that intervention. If 3 rapid rehousing openings become available, 1 individual scoring 7, 1 individual scoring 6, and 1 individual scoring 5 would be referred. Similarly, if 5 openings became available,

2 individuals scoring 7, 1 individual scoring 6, 1 individual scoring 5 and 1 individual scoring 4 would be referred for placement.

For veterans served through SSVF, SSVF will continue to prioritize placements from the universal registry for all eligible individuals with military service history recommended for rapid rehousing 4-7 on VI-SPDAT version 2. Due to the amount of funding currently available for the program, a limited number of direct referrals may be made.

REFERRAL:

The following process describes how CES will be administered to community housing programs.

Step 1:

- Individuals and families seeking services will go to MHRC or visit a Mobile Outreach hot spot to be assessed for services.

Step 2:

- Intake Navigators complete Intake Workflow and collect Universal Client data in Client Track
- Intake Navigators will complete VISPDAT to assess housing needs
- Based on Client Information and VISPDAT scores, Navigators will refer client to appropriate Agency, Programs, and resources
- Navigators will gather all available supporting documentation needed
- Navigators will submit referral to agency or program

Step 3:

- Agency or Program Supervisor receiving referral will review information within 2 business days upon receipt and assign to appropriate Case Manager
- Case Manager will make contact with family to schedule a program intake appointment within 2 business days of receiving referral
- If Case Manager is unable to make contact after 3 documented attempts they will notify Program Supervisor who will contact Navigators within 1 business day. Navigators will place referral back on waitlist and reach out to outreach teams to assist with locating referral. **At this point a new referral will be issued to program to fill vacancy.**
- Case Manager will meet with individual and/or family and complete program enrollment to begin services.
- If referral is appropriate for program, Case Manager will notify Program Supervisor of program enrollment. Program supervisor will notify Intake Navigators of program enrollment.

- If referral is NOT appropriate for program, Case Manager will notify Program Supervisor immediately and Program Supervisor will refer back to Navigator within 24 hours.
- For housing programs, Case Manager will work to house individual and/or family within 30 days upon receipt of referral

Step 4:

- Individual and/or family receives services based on identified needs. And completes program as appropriate.

BY-NAME LIST/HOUSING PRIORITIZATION LIST

A by name registry and/or Housing Prioritization List is a report run through the Homeless Management Information System (HMIS) that generates client records whom have been screen by the CES team. This list is reviewed and updated weekly to ensure all recent client additions and client housing placements are captured accordingly.

This list includes an active and inactive list.

Active List

People who stay longer than one night at a shelter and are currently enrolled in a program or have been within the last 90 days are part of the active list. Clients engaged in with CES and Street Outreach teams are also considered to be actively homeless and will be included on the By Name List.

Inactive List

The Inactive Policy is a critical component of maintaining a real-time by-name master list as well as a robust coordinated entry system. To ensure an efficient assessment and referral process, it is important to ensure that the Coordinated Entry System Navigators and Outreach teams have the ability to contact and connect with households as soon as a housing opportunity is available. Without this policy, the Coordinated Entry System can experience delays in its referral procedures due to the time spent searching for households in the community who they have not been able to reach through multiple attempts, often for many months. Due to this loss of contact it is hard for the system to determine whether these households are still in need of housing. In some situations these households may have self-resolved their housing crisis or relocated to another area.

If a household has had no contact with any Coordinated Entry Access points, System Navigators and/or Community Outreach for 180 days, AND they have had no services or shelter stays in HMIS for the past 3 months, the household will be removed from the Active Homeless List and placed on the Inactive List.

For our Veteran population, the no contact threshold to remove a client form the active list is 90 days. We coordinate with our VA team members to access their HOMES and Remote Data Systems to see if the veteran has relocated or has accessed any other VA services locally. If a signed ROI was in place at the time the Veteran was moved to the Inactive List, our local VA team will provide any pertinent information available.

If a household on the inactive list makes contact with the homeless system including outreach workers, drop-in centers, shelters, meal lines, etc., they are moved from the inactive list to the active list and can be referred to housing openings once they have fully re-engaged with the system which may include re-assessment of their vulnerability.

SPECIAL POPULATIONS

DOMESTIC VIOLENCE SURVIVORS

People who are currently fleeing domestic violence and human trafficking along with those who have previously experienced domestic violence and/or human trafficking require a path through the CES that promotes and protects their confidentiality and safety. The following policies and procedures are incorporated into the Northeast Florida CES to protect the safety of every person and household impacted by domestic violence.

The first set of protocols relates to DV providers serving survivors of domestic violence and the second set of protocols relates to mainstream, non-DV providers serving survivors of domestic violence.

Domestic Violence Provider Protocols

There are several Domestic Violence (DV) Shelters in Northeast Florida. Survivors of Domestic Violence in current danger who are entering a DV shelter are screened using a tool specific to the single agency providing that service in Clay, Duval or Nassau counties. Shelter and outreach staff are familiar with their respective DV shelter's referral process; DV staff in turn provide safe access to their own intake process.

For the safety of those individuals and/or families who are fleeing or attempting to flee domestic violence, referrals are made to programs identified as victim service providers for assistance whenever those services are immediately available and desired by the household.

A client fleeing or attempting to flee domestic violence, dating violence, and/or human trafficking must be offered a choice to have their personally identifiable data entered into the HMIS conventionally or have it entered anonymously. Existing entries can be de-identified if a clients' status changes to fleeing and they are already in the HMIS.

Privacy and Safety

DV Providers which are primarily "victim services providers" are prohibited from contributing client-level data into HMIS. However these programs must record client-level data within a comparable database and be able to provide aggregate data for reporting.. When a household working with a DV provider is attempting to flee or experiencing literal homelessness having already fled domestic violence, the applicant shall be connected to a trained staff member (someone proficient with the VI-SPDAT or Family VI-SPDAT triage assessments).

DV Provider/DV Coordinated Entry System Roles

DV Provider

- Request consent to participate from the applicant. If the applicant has an HMIS record, do they want their information de-identified?
- Link Applicant to a trained staff member to review all consent options and complete the Coordinated Entry Assessment.
- Follow protocol regarding not using names of DV programs the Applicant participates in within the Standardized Housing Assessment
- All communication about the assessment should be conducted through the service provider to maintain client confidentiality.
- Match households as appropriate.

Housing Providers

- Accept referrals from the DV Coordinated Entry System and follow up with DV provider contact
- Follow up with DV provider contact and linked providers within two business days.
- Follow CES protocols including protecting the confidentiality of the household such as not disclosing to an emergency contact any information shared in the Standardized Housing Assessment.

Non-Domestic Violence Provider Protocol

If a non-victim service provider becomes aware that a household being served is fleeing or attempting to flee violence, the provider should:

1. Offer the household a warm handoff/referral to a victim services provider; and
2. Check HMIS to see if there is an existing record. Follow safety protocols and client choice.

CES Staff Member

- Review all HMIS consent options with the Applicant
- Complete Coordinated Entry Assessment and follow protocol to lock the file
- Follow protocol regarding not using names of DV programs the Applicant participates in within the Standardized Housing Assessment
- Match households as appropriate.
- Communicate with housing providers and DV providers to foster a linkage for households by e-mail after the match has been made via HMIS.

Housing Providers

- Accept referrals from the Coordinated Entry System and follow up with Applicant
- Follow up with Applicant and linked providers if the applicant shared contact information to request support with a linkage to the household within two business days.
- Follow CES protocols including protecting the confidentiality of the household such as not disclosing to an emergency contact any information shared in the Standardized Housing Assessment.

Non-DV providers may use HMIS and directly enter information while following protocol to lock the Applicant's file and other measures in place for safety and confidentiality. HMIS files of all Applicants presenting as survivors of domestic violence are locked in HMIS so that they can only be seen by the Coordinating Entities for the purpose of matching the household to a housing and/or service intervention.

Safeguards for Domestic Violence Survivors

All staff conducting DV providers or non-DV providers will be trained on the complex dynamics of domestic violence, trauma-informed care, privacy and confidentiality, safety planning and how to handle emergency situations.

UNACCOMPANIED YOUTH AND YOUNG ADULTS

The Department of Health and Human Services Administration for Children, Youth and Families emphasizes that youth who run away from home are often mistakenly portrayed as juvenile delinquents. In contrast, such behaviors often reflect society's failure to develop adequate support which includes homeless services. Unaccompanied youths are one of the fastest growing and most underserved sub- populations, in our community. In addition, it is important to note that Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex, as well as African American youth and young adults are disproportionately impacted when compared to other groups.

Clients:

Unaccompanied Youth and Young Adults are defined as youth (ages 13-17) and young adults (ages 18-24) who are unaccompanied by a parent or guardian and are without shelter where appropriate care and supervision are available, whose parent or guardian is unable or unwilling to provide shelter and care, or who lack a fixed , regular and adequate nighttime residence. Undocumented unaccompanied youth and young adults may also be served under these provisions except where exclusions are noted

Providers:

Providers of services for unaccompanied youth and young adults should be able to provide safe and high quality housing and supportive services (scattered-site independent apartments, host homes, and shared housing) to youth and young adults experiencing homelessness that involve an integrated constellation of affordable housing, intensive strengths-based case management, self-

sufficiency services, trauma informed care, and positive youth development approaches.

CES Lead Agency:

All housing service referrals for unaccompanied youth and young adults must be screened and assessed at a centralized intake hotspot. The Lead Agency is responsible for overseeing and ensuring that:

- Unaccompanied youth and young adults willingly engage with coordinated entry for a screening and an in person comprehensive assessment.
- Whenever possible, unaccompanied youth should be re-housed within the catchment area of their school of origin.
- Low barriers of entry for this highly vulnerable population are created.
- Navigators consult with expert providers of this population when conducting intake to properly match clients and providers, and reduce the risk of flight for this highly vulnerable population.

PROGRAM EVALUATION

The Coordinated Entry is one of many projects within our community that addresses the needs of individuals and families that are at risk or experiencing homelessness within our communities. The Lead Agency will evaluate the effectiveness as well as required HEARTH Act outcomes by utilizing data from HMIS. As recommended by the National Alliance to End Homelessness, the Lead Agency will track progress in the following areas to evaluate the Coordinated Intake and Assessment process:

- Length of stay, particularly in shelter: If consumers are referred to the right interventions and those interventions have the necessary capacity, fewer individuals and families should be staying in shelter waiting to move elsewhere. Also if clients are referred immediately to the right provider, over time, clients will likely spend less time jumping from program to program looking for help, which could reduce their overall length and/or repeated episodes of homelessness.

- New entries into homelessness: if every individual and family seeking assistance is coming through the front door to receive it and the front door has prevention and diversion resources available, more people should be able to access these resources and avoid entering a program unnecessarily.
- Repeat episodes of homelessness: If clients are sent to the intervention that is the best suited to meet their needs on the first time, families are more likely to remain stably housed.

To track the outcomes summarized above, the Lead Agency will analyze the following

Performance Measures annually.

1) Duval, Nassau and Clay County will reduce the number of person experiencing homelessness.
    a. Reduction in the total number of person experiencing homelessness
    b. Reduction in the total number of persons experiencing first time homelessness.
2) Duval, Nassau and Clay County will reduce the length of homelessness episodes
    a. Reduction in the mean length of homelessness episode for individuals
    b. Reduction in the mean length of homelessness episode for families with children
    c. Reduction in the men length of homelessness episode for youth
3) Duval, Nassau and Clay County will reduce the number of persons returning to homelessness.
    a. Reduction in return to homelessness within two years following exit
    b. Increase in exits to permanent housing
    c. Increase in income at exit

Measuring of the success of this system and transparency with the community and providers will be a key to the success of this project. The Lead Agency will summarize the data annually in conjunction with the annual Point in Time homeless census data report.

Moving forward, the Lead Agency will expand the evaluation of outcomes by establishing mechanisms to monitor the quality of service through system-wide monitoring. For example, once a client enters shelter an assessment is to be completed within 72 hours. Procedures will be built into the monitoring system to determine how often this goal is met. This will allow for ongoing monitoring of the quality of services and how the program and Providers are able to follow through with this goal.

As part of the evaluation process, as recommended by the National Alliance to End Homelessness, the Lead Agency will set a goal to establish an integrated feedback loop that involves using information gained from these assessments to make any necessary adjustments to the system. For example, if families are being referred to the right program, but the program cannot serve them due to capacity issues while other program types have an increasing number of empty beds, it may be appropriate to make system-wide shifts in the types of programs and services offered. Additionally, the Lead Agency will continue working to develop data tools to ensure overall system efficiency.