THE MAHONING COUNTY HOMELESS CONTINUUM OF CARE

Coordinated Entry Policies and Procedures

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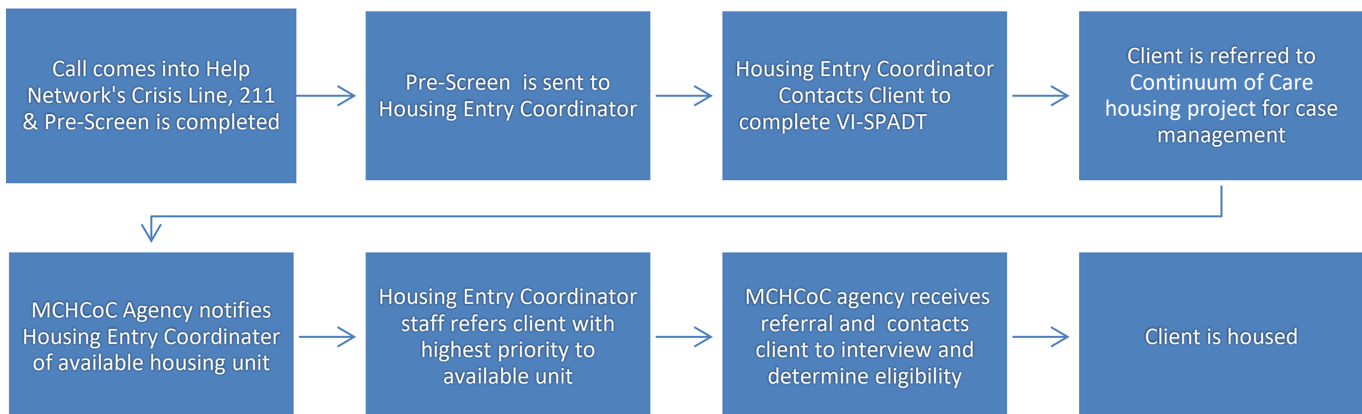
Overview Coordinated Entry Process

The goal of Coordinated Entry is to focus on the most vulnerable people within our community and move them into housing quickly. The goal of this program is to have a person housed within 60 days of entering Coordinated Entry.

To be entered into Coordinated Entry, a person will call Help Network's Crisis Line, 211 and a crisis worker will complete a short prescreen assessment (Appendix I) to determine if the person meets the criteria for Coordinated Entry. At that time the crisis worker will also make a referral to an emergency shelter, as well as other emergency services the person may need. After the prescreen is completed, the crisis worker will forward the prescreen to the Housing Entry Coordinator. The Housing Entry Coordinator will follow up with the person experiencing homelessness, confirm that the person will be able to verify their homelessness and complete the appropriate VI-SPDAT assessment. After gathering this information, the person will be entered into HMIS and added to the prioritization list and if appropriate, the information will be forwarded to a housing project for case management (Appendix III). At a Case Management meeting that occurs every other week people that have been entered into Coordinated Entry within the past two weeks will be reviewed on status and any complications. . The Continuum of Care housing project assists the person with getting the documentation needed to move into housing and to give the person a point of contact to call with any questions and update any information that changes such as phone number. The person will then be referred to a Continuum of Care housing project when an opening occurs.



Definitions

HMIS Homeless Management Information System

Housing Entry Coordinator person employed by Help Network of Northeast Ohio, who is a part of the Coordinated Entry Team who completes VI-SPDAT, prioritizes people looking for housing, issues referrals to participating agencies and keeps current/ updated information in HMIS for homeless people.

MCHCoC Mahoning County Homeless Continuum of Care

VI-SPADT Vulnerability Index-Service Prioritization Decision Assistance Tool

FVI-SPDAT Family Vulnerability Index-Service Prioritization Decision Assistance Tool

TAYVI-SPDAT Transition Aged Youth Vulnerability Index-Service Prioritization Decision Assistance Tool

Standard Assessment Tool

The MCHCoC has chosen to use the VI-SPDATs created by Community Solutions. This standard tool will be used to assess all people that would like to go through the Coordinated Entry process. While this is a standardized tool, all people that call into Coordinated Entry are made aware that they do not have to answer a question or a question can be re-phrased. Any person or professional that the person is working with can call to update information in the VI-SPDATs, in order to assist in getting a clearer picture of the person and their needs.

The VI-SPDATs is primarily completed by the Housing Entry Coordinator. However, in occasional circumstances where a person does not have a phone or is difficult to maintain contact with, the PATH Homeless Outreach Team will complete a paper VI-SPDATs and it will be entered in HMIS. All persons completing the VI-SPDATs follow the same script (Appendix II) and complete training on the tool at least annually.

Release of Information

Prior to completing the VI-SPDAT the HMIS end user asks for verbal consent from the person to be entered into HMIS. If a person cannot have their information entered in HMIS for safety concerns, they can be entered as "anonymous". Once a person is referred to a MCHCoC Housing Project, the project then has the person review and sign the HMIS Release of Information form for ongoing information to be entered into HMIS. Signatures on form should be obtained by Case Manager upon in person visit. See HMIS Policies regarding forms.

Accessibility

The Housing Entry Coordinator, is the primary person entering people into Coordinated Entry through HMIS. All MCHCoC housing projects have the ability to enter a person into Coordinated Entry so the person does not need to be transferred to another organization. Coordinated Entry project operates in a building that is open to the public and is accessible to all populations. The building is on the local bus line and it is around other community resource programs. If a person has limited mobility, the Housing Entry Coordinator can meet the person at a mutually agreed upon location.

Hours of Operation

The Help Network's Crisis Line, 211 is available 24 hours a day, 365 days a year. The Housing Entry Coordinator is available Monday through Friday, 8:00 am to 4:00pm. TDD (Telephone Device for the Deaf) is available at 330-744-0579 or 1-800-750-0750. Translators are also available.

Eligibility

MCHCoC Housing Projects must notify the Housing Entry Coordinator of their program requirements and update those requirements if they change. Once a person is referred to a MCHCoC Housing Project, the project is responsible for gathering information documenting homelessness and obtain other paperwork/ documentation required for project entry. At the different steps of Coordinated Entry, homelessness is assessed and if a person is not currently residing in an emergency shelter, the PATH Homeless Outreach Team

is able to follow up with the person to verify homelessness. If a Veteran calls, they will be entered into the Coordinated Entry program, but also referred to the local VA at 1-877-424-3838.

Referrals to Projects

A MCHCoC Housing project will notify the Housing Entry Coordinator if there is an opening within their project. The MCHCoC Housing project will specify if the opening is for a single or a family.

The Housing Entry Coordinator will run a report in HMIS, with the following order: Referral Ranking, VI-SPDAT score and referral date. The Housing Entry Coordinator will follow Prioritization Standards, which has been approved by the MCHCoC Executive Board (see below).

The first person on the prioritization list that meets the projects' requirements is referred to the project within HMIS. The Housing Entry Coordinator contacts the person before the referral is made, to confirm that the person is still homeless and would like the project where they are being referred. The Housing Entry Coordinator also emails the project for notification of the referral.

Once the person is accepted into the housing project, the project will notify the Housing Entry Coordinator, who will then exit the person from the Coordinated Entry Program in HMIS.

If the person is outside of the county check the following link for locations (includes SSVF locations): https://cohhio.org/boscoc/

See "Denying a Referral" section regarding a person being unreachable.

Prioritization Standards

First Priority–Homeless Individuals and Families with a Disability with Long Periods of Episodic Homelessness and Severe Service Needs
An individual or family that is eligible for CoC Program-funded PSH who has experienced fewer than four occasions where they have been living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter but where the cumulative time homeless is at least 12 months **and** has been identified as having severe service needs.

Second Priority–Homeless Individuals and Families with a Disability with Severe Service Needs.
An individual or family that is eligible for CoC Program-funded PSH who is residing in a place not meant for human habitation, a safe haven, or in an emergency shelter and has been identified as having severe service needs. The length of time in which households have been homeless should also be considered when prioritizing households that meet this order of priority, but there is not a minimum length of time required.

Third Priority—Homeless Individuals and Families with a Disability Coming from Places Not Meant for Human Habitation, Safe Haven, or Emergency Shelter without Severe Service Needs.
An individual or family that is eligible for CoC Program-funded PSH who is residing in a place not meant for human habitation, a safe haven, or an emergency shelter where the individual or family has not been identified as having severe service needs. The length of time in which households have been homeless should

be considered when prioritizing households that meet this order of priority, but there is not a minimum length of time required.

Fourth Priority–Homeless Individuals and Families with a Disability Coming from Transitional Housing.
An individual or family that is eligible for CoC Program-funded PSH who is currently residing in a transitional housing project, where prior to residing in the transitional housing had lived in a place not meant for human habitation, in an emergency shelter, or safe haven. This priority also includes individuals and families residing in transitional housing who were fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking and prior to residing in that transitional housing project even if they did not live in a place not meant for human habitation, an emergency shelter, or a safe haven prior to entry in the transitional housing.

The score range associated with the assessments for housing resources of Rapid Re-Housing (RRH), Transitional Housing (TH) or Permanent Supportive Housing (PSH) is as follows:

1. Households will be referred to **RRH** based on the availability of resources and the client's VI-SPDAT score.

- Referrals made outside of the specified VI-SPADT score range will be reviewed case by case and made based on the case conference between the Housing Entry Coordinator and the RRH provider.

2. Households will be referred to **TH** based on the availability of TH units, the client's VI-SPDAT score.

3. Households will be referred to **PSH** based on the VI-SPDAT score and the following specific criteria:
    - Chronic Homelessness as defined by HUD
    - Longest history of homelessness
    - Most severe Service Needs as determined by the VI-SPDAT

Housing Matching Prioritization Process for Permanent Supportive Housing (PSH)
The following represents the uniform process to be used across the community within the MCHCoC for assessing individuals and matching them to an intervention. Within each category, prioritization of placement into housing is paramount.

Individuals who score an eight (8) or above on the VI-SPDAT or a score of twelve (12) or above on the F VI-SPDAT, which signals the need for Permanent Supportive Housing will be prioritized based on the following criteria:

1. **<u>Length of Time Homeless</u>**: Priority is given to individuals or families that have experienced homelessness consecutively for the at least twelve (12) months or longer OR have been homeless more than four (4) times within the last three (3) years and with a disabling condition of long duration.

2. **<u>Medical Vulnerability</u>**: Homeless individuals with severe medical needs who are at greater risk of death will receive expedited placement. This determination is based on questions 22-34 of the VI-SPDAT with a maximum score of five (5).

3. **<u>Overall Wellness</u>**: Individuals with similar medical needs as criteria #1, will be prioritized when the individual has behavioral health conditions or histories of substance use, which may either mask or

exacerbate medical conditions. This score will be based on questions 21-50 of the VI-SPDAT (i.e., the "Wellness Domain").

4. **Unsheltered Sleeping Location**: Unsheltered individuals will be given priority over sheltered individuals.

5. **Age**: The age of the individual or Head of Household, giving priority to elderly clients.

6. **Veterans**: Veterans who score an eight (8) or above on the VI-SPDAT or those veterans who are identified as chronically homeless and clinically appropriate for Grant Per Diem (GPD), VA contracted housing or community shelter in the interim are referred to HUD VA Supported Housing (VASH). Veterans not accepted into HUD-VASH who scored eight (8) or above on the VI-SPDAT are then placed on the priority list in HMIS to engage in other permanent housing options.

Housing Matching Prioritization Process for Transitional Housing (TH) and Rapid Re-Housing (RRH)
The following process will be used to prioritize for Transitional Housing or Rapid Re-Housing Placement:

Scores of 4-7 on the VI-SPDAT for individuals or 5-11 on the F VI-SPDAT for families will be referred to Transitional Housing (TH).

Scores below 8 on the VI-SPDAT for individuals or below 12 on the F VI-SPDAT for families will be referred to Rapid Re-Housing (RRH).

Individuals that score 4-7 on the VI-SPDAT, or families that score 5-11 on the F VI-SPDAT will be prioritized based on the following criteria:

1. **Date of Assessment**: The date of the individual's assessment (giving priority to the oldest date of assessment).

2. **Unsheltered Sleeping Location**: Unsheltered individuals will be given priority over sheltered individuals.

3. **Length of Time Homeless**: The length of time an individual has experienced homelessness, giving priority to the person that has experienced a longer period of homelessness.

4. **Overall Wellness**: Homeless individuals with medical needs will be prioritized when they have behavioral health conditions or histories of substance use, which may either mask or exacerbate their medical conditions.

5. **Medical Vulnerability**: Homeless individuals with severe medical needs who are at greater risk of death will receive expedited placement into housing.

Any person referred to a project can decline the referral. It will be explained to the person, they will remain on the community queue, but the community queue is based on who presents with the most severe need and someone may present with a more severe need than them.

Transfer Process

Permanent supportive housing (PSH) project participants may request a transfer to another MCHCoC Housing Project when the person(s) no longer meets the eligibility criteria for the project that currently houses them or when their current housing unit no long satisfies their needs. Appropriate reasons for granting a transfer include the following:

1. Circumstance in which the participants qualify for emergency transfers as victims of domestic violence under 24 CFR Part 5, Subpart L, or circumstances that justify the participants' belief on their housing project's belief that the participants' continued residence in their current unit poses an imminent danger to themselves or other;
2. The existence of verified disabilities that cannot be reasonably accommodated in the participant' current unit; and
3. Changes in the size or composition of a participants' household.

To request a unit transfer, the project or person may call Coordinated Entry and explain the reason for the request. If the request meets the above listed criteria, information will be updated in Coordinated Entry as needed and the person will move to the top of the prioritization list for housing.

Denying a Referral

Before a client can be deemed "unreachable" the project will make three separate attempts to contact the person within seven (7) working days. The project will also contact the local emergency shelters, as well as the PATH Homeless Outreach Team, to see if these programs have had contact with the person. After these attempts and there is no contact, the project will notify the Housing Entry Coordinator. The Housing Entry Coordinator will call the person and give them two (2) business days to call back. If the person does not call back, the person can be denied in HMIS and a new referral will be made.

Each contact the project attempts should be documented in HMIS. The calls will be entered in "Client Notes" section within the "Client Profile" tab. Then, when the client is declined, the "Notes" will be updated within the referral from Coordinated Entry.

A project can make three denials for a reason, outside of homeless status or disability verification. After they have denied the third person, the Housing Entry Coordinator will notify the MCHCoC Coordinator. The MCHCoC Coordinator will review the information, then a meeting occurs with the project if necessary.

60 Day Policy

If a Continuum of Care housing project cannot find a person that was referred to them, the person will remain on the prioritization list for 60 days. The purpose of this policy is to allow this person who may no longer have a working number, make contact with another services, such as the emergency shelter or PATH Homeless Outreach. At 60 days the Housing Entry Coordinator will attempt to call the person again to determine if they are in need of housing, if the person does not call back within 2 business days they will be removed from the community queue and exited from coordinated entry in HMIS.

Exceptions to Coordinated Entry

Due to the nature of their programs, the following agencies do not receive referrals through Coordinated Entry: Sojourner House, Daybreak Youth Crisis Center, Merici Shelter, Voice of Hope Shelter, Catholic Charities Regional Agency: Homeless Prevention Program, and Mahoning Valley Dispute Resolution Services.

Advertising Plan

All agencies that receive referrals through Coordinated Entry will have a link to the MCHCoC website on their website, which describes the Coordinated Entry process. Flyers are given to Community Organizations to display at their Offices to call 211 if looking for housing. The Housing Entry Coordinator and/or MCHCoC Coordinator will speak at public meetings with service providers about the Coordinated Entry process and provide brochures and flyers for the program.

Privacy Protections

Coordinated Entry staff must abide by the defined privacy protections in the HMIS End User Agreement. Client consent protocols, data use agreements, data disclosure policies and other privacy protections offered to program participants upon entry into Coordinated Entry. Privacy protections are contained in the HMIS End User Agreement which is completed on line and signed by the registrant. All agencies must post the Data Collection Notice where visible and point it out to the client.

Program participants have the right to refuse to answer any questions, though that may impact their assessment score and appropriate referrals. Participants will not be denied services for refusal to provide certain information. Participants are not required to disclose their specific disability or diagnosis for the Coordinated Entry process.

Appeal Process

A person will be notified at the time of assessment with the Housing Entry Coordinator of their right to appeal their placement on the prioritization list. A participant can appeal their placement at any time and can do so by, notifying the Housing Entry Coordinator. The Housing Entry Coordinator will arrange a meeting or phone call to occur with the person(s) and the MCHCoC Coordinator. A final determination will be given to the participant via a follow up phone call or letter, depending on the participant’s preference.

Evaluation of Coordinated Entry

At least annually, people that went through the Coordinated Entry will have the opportunity to complete an evaluation of the program.

Surveys are sent to people that received housing with a MCHCoC housing project, people that were entered into the project but found other housing and people that are still waiting for housing. Surveys are also placed at the local emergency shelters for people to complete and send in throughout the year.

The information gathered will be used to improve the Coordinated Entry process, as well as update the Policies and Procedures if necessary.

Meetings

The Coordinated Entry Committee meets once quarterly to review the current process and to update policies and procedures as needed.

Case Management meetings are held once every two weeks with all agencies that receive people through Coordinated Entry.

APPENDIX I:

MCHCoC Coordinated Entry Initial Engagement Prescreen

Time: ____________________ HMIS ____________________

Date: ____________________ VISPDAT ____________________

Clients Name: ____________________

Contact Phone Number: ____________________

1. Where did you sleep last night? How long have you been there?

Shelter, Transitional Housing or Street ________ ________

Home or Family/Friend Home ________ ________

Inpatient Program ________ ________

2. Where was client prior to above? Shelter or Street ________

Home ________

Family/Friend Home ________

3. Does client qualify as literally Homeless? ________ Yes - Continue with Screen

________ No- STOP Give Referrals

PLEASE NOTE: Staying with a friend or family member is not considered homeless.

Even though the caller may not have a place of their own, they have a safe place to stay.

Birthdate ________

Are you fleeing Domestic Violence? ________ Are you a Veteran: ________

Household size: ________ Income? ________

What caused you to be homeless? ________

How long have you been homeless? ________ Date homelessness began ________

How many times have you been homeless in the past 3 yrs? ________

Do you have a disability? ________ Substance abuse? ________

Do you have documentation of your disability? ________

Type? ________

Does Client have Current ID, Original SS Card & Birth Certificate? ________

If not accessible by phone, where is best place to find you? ________

Counselor Contact information: ________

Does client give permission to share this information with other agencies? ________

Are you interested in housing that requires sobriety/drug testing? ________

Emergency Shelter and other Social Service referrals given/other notes: ________

Please fax this form to Coordinated Entry -Housing Entry Coordinator

330-746-3042

Screeners Initials ________ Agency ________

APPENDIX II:

VI-SPADT Script

I have a 15 minute survey to get you entered into Coordinated Entry. The answers you provide will help to determine how we can go about supporting and housing you. Most questions only require a yes or no answer. A handful of the questions require a one-word answer. Some of the questions are personal, so if you feel uncomfortable with any question, please let me know and you do not need to answer. The information I collect will be entered into our Homeless Management Information System/Coordinated Entry.

If there is a question you don't understand, just let me know and I can explain a little better. There are no right or wrong answers so please answer the questions as honestly as you can.

If any of your information changes, (phone #, income), it is very important that you let me know as soon as possible. If an agency does not have the most up-to-date information, it will be more difficult to meet your needs. You can give me a relative's phone number if you're worried about running out of minutes.

APPENDIX III:

Case Management

The purpose of the case management process is to keep in touch with people while they are waiting to be housed. We have found that the people with the most severe service needs, do not update Coordinated Entry when they have a change in contact information, then when a referral is made for housing, the person cannot be found. The intent of the case management process is for someone from a housing project to stay in contact with a person while they wait for housing and assist them with any housing related problems.

Any person experiencing homelessness scoring 10 or higher on the VI-SPDAT will be assigned to a Continuum of Care housing project for Case Management via email after the person is entered into HMIS by the Housing Entry Coordinator. The Continuum of Care housing project will contact the person at least weekly. Any changes to contact information should be updated in HMIS. The Continuum of Care housing project will add notes in HMIS under Client Profile, Client Notes.

If a Continuum of Care housing project is working with a person, that moves out of the county or into non CoC funded housing the Continuum of Care housing project will contact the Housing Entry Coordinator and the person will be exited from the Coordinated Entry program.

When a person is referred to a Continuum of Care housing project for case management, this does **not** mean the person will move into that housing project, however the Housing Entry Coordinator assigns people to project who meet the project criteria. When there is an opening for housing in a project, the list will be sorted as described in Prioritization Standards.

Meetings for Case Management will be once every two weeks.