2018 Policies and Procedures

For

Coordinated Entry System (CES)

Continuum of Care: FL-507

Orange, Osceola, and Seminole Counties

JANUARY 2018

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Coordinated Entry System: Overview

CES Mission Statement

A person-centered process that, through real-time data and evidence-based practices, streamlines and standardizes access to the most appropriate housing interventions for the most vulnerable family, veteran, transitional aged youth, or individual experiencing homelessness in our community.
CES is solutions focused.
CES is hyper-collaborative.
CES is person-centered and provider-centered.

The Coordinated Entry System (CES) is a way for all Central Florida homeless services providers to work together with a "no wrong door" approach to provide services to our homeless neighbors. The main goal of CES is to create a real time list of individuals experiencing homelessness in our community, then quickly and efficiently match those people to case management services, available housing, and other resources. We use evidence-based tools to systematically end homelessness. Within that process we are using universal tools and forms that will help ensure that those who are most vulnerable will get housed as quickly as possible.

CES is partnering with community agencies like health care providers, the public school systems, correctional facilities, homeless services providers, and many others to better prioritize those with the greatest needs. Persons experiencing homelessness can be assessed by going to community access points, community HUBs, calling 2-1-1, meeting with outreach workers on the streets, or by seeking services at other agencies participating in CES in the tri-county area.

Core Components

The CES is made up of seven key components;

1. Use of "The Big 3"—Release of Information, Entry Assesment in HMIS, and the VI-SPDAT (Vulnerability Index – Service Prioritization and Decision Assistance Tool)
2. Community Navigation to assist folks in getting "document ready" for a housing program
3. Referrals in HMIS, Eligibility Review (record keeping review), and Matching to appropraite housing programs
4. Referrals to Partner Agencies for approved participants to gain a Housing Stability Case Manager
5. Housing Search and Match, based on Participant Choice and Housing First
6. Housing Stability and re-entry into the Community
7. Data Sharing and Partner Communication

Target Populations

The *Coordinated Entry System* is open to all who meet the HUD definition of homeless, as outlined in the new HEARTH Act regulations, and have incomes below 50% of the Area Median Income. The system uses the person's level of vulnerability (described in Definitions) and length of homelessness to determine priority for housing and supportive services. The person with the highest priority is offered housing and supportive services first.

More directly, applicants may be offered housing regardless of vulnerability score, but the more vulnerable persons will likely be offered housing before the non-vulnerable.

CoC prioritized sub-populations include;

1. Chronically homeless individuals
2. Veterans
3. Families, with children under the age of 18
4. Transitional-Aged Unaccompanied Youth

Disclaimer:

The Coordinated Entry System is designed to assess eligibility for housing programs targeted to homeless persons. It is not a guarantee that the individual will meet the final eligibility requirements for - or receive a referral to - a particular housing option.

The CES is not a stand-alone solution to end homelessness or a solution to the shortage of affordable housing. The CES supports the purpose of 507 CoC: to facilitate a comprehensive and integrated system of services in Central Florida designed to ensure that any experience of homelessness is rare, brief, and singular. Orange, Osceola and Seminole Counties are committed to ending homelessness through sharing expertise, using data to inform practice, monitoring system performance, and using our collective voice to advocate for our homeless neighbors.

Workflow:

Access

Homeless persons can gain access into the Coordinated Entry System through Street Outreach workers, Shelters, participating community partners serving as Access Points, Community HUBS, or by calling 211. Currently the tri-county area is fully covered with HUBs, 1 in Seminole County, 3 in Orange County, and 2 in Osceola County. HUB information is advertised to all community partners via website, meetings, and e-blasts. 211 covers the tri county area 24/7. Partnering with 211 is critical to ensure emergency access to those in need of services when the CES is not operating. Street Outreach teams are located in each county as well, to ensure access to those living on the streets who are least likely to access services or seek out assistance.

Assess

Participating service providers gather information on people's needs, preferences, and the barriers they face to regaining housing by administering a standardized assessment, referred to as The Big 3. This standard assessment includes consent via the Release of Information, gathering basic household data via the HMIS CoC Entry, and gauging the vulnerability through administering the VI-SPDAT.)

Navigation

Once the assessment has identified the most vulnerable people with the highest needs, they are prioritized on a by-name list or registry. Service Providers meet weekly to review the by-name registry, where Community Navigators are assigned to the most vulnerable based on length of homelessness and VI-SPDAT score. Navigators then work with persons to discuss housing goals, and to verify eligibility for persons interested in housing. Navigators help persons secure the needed documents for Housing Program eligibility (i.e.: ID, social security card, etc.) as well as refer out to other community resources.

Referral

Once the person has all documents in order, the Community Navigator will make a referral in HMIS to CES Match.

CES Match

The CES team reviews the referral and person's eligibility. CES team will make a determination on eligibility and what program would best fit the client's needs, using the VI-SPDAT to guide the matching process.

Once client is approved for a Housing Program, they are reviewed weekly at Provider meetings to be prioritized for programs that have capacity. Participants are referred to programs with capacity, again prioritized based on length of time homeless and VI-SPDAT score. They are connected to a Housing Stability Case Manager who begins working with the participant on housing goals.

Housing Search

The participant and their Housing Case Manager complete a Housing Needs form to guide housing match process and to identify housing barriers. CES sends a referral to the Housing Locator Team to begin the search for a unit that meets the needs of the household.

Glossary of Terms

CES	Coordinated Entry System: *A person-centered process that, through real-time data and evidence-based practices, streamlines and standardizes access to the most appropriate housing interventions for the most vulnerable family, veteran, transitional aged youth, or individual experiencing homelessness in our community.*
CoC	Continuum of Care, official body of service providers and advocates representing a community plan to organize and deliver housing and services to meet the specific needs of people who are homeless as they move to stable housing and maximum self-sufficiency.
Community Navigator	Assigned in CES weekly meetings, this is typically a case manager or outreach worker who is tasked with following up with a person experiencing a housing crisis. The Navigator serves as the primary liaison between the person and the homeless system, up until the person is matched to a Housing Case Manager.
Data Element Fields	The specific fields required for collection by all projects participating in HMIS, regardless of project type or funding source.
DV	Domestic Violence; can include physical, verbal, emotional, economic, or sexual abuse by a partner, spouse, or family member.
EDA	Enter Data As: The specific program you have been authorized to enter data as for your agency. This must be accurately assigned once you log into HMIS or switch to different programs within your agency.
Housing First	A philosophy that emphasizes stable, permanent housing as a primary strategy for ending homelessness. HSNCFL has incorporated the ‘‘Housing First’’ approach in addressing and ending homelessness. Housing First establishes housing stability as the primary intervention in working with homeless persons. The Housing First approach is informed by research demonstrating that a homeless individual or household’s first and primary need is to obtain stable housing, and that other issues impacting the household can and should be addressed as housing is obtained. Research supports this approach as an effective means to end homelessness. Under Housing First, housing is not contingent on compliance with support services. Instead, participants must comply with a standard lease agreement and are provided with the services and supports that are necessary to help them do so successfully..
Housing Locator Team	Team of Homeless Services Network (HSN) employees who locate housing units and assist with matching participants to appropriate units.

HMIS	Homeless Management Information System: Federally mandated database used to collect unduplicated information on homeless individuals and families within our CoC.
HUD	Housing and Urban Development: a Federal organization aiming to increase homeownership, support community development and increase access to affordable housing free from discrimination.
LOH	Length of Homelessness: The cumulative amount of time of one's current episode of homelessness on the streets or shelters. LOH is one of our CoC's prioritization factors.
MOU	Memorandum of Understanding: a formal agreement between HSN and other participating CES agencies to establish an official partnership and understanding of the CES process.
PH	Permanent Housing: Household is in a safe, adequate housing whether they are receiving a subsidy or paying rent on their own.
PIT	Point in Time (Count): a snapshot of the homeless population on a given day. Since 2005, HUD requires all CoC applicants to complete this count every other year in the last week of January.
PSH	Permanent Supportive Housing: long term, community-based housing with intensive case management for as long as the participant needs the services.
Recordkeeping Review (RKR)	Stage where person's documentation is reviewed for completeness and eligibility for available programs.
Registry	The By Name list of all homeless persons who have been assessed for housing. The list is populated on a weekly basis and can be filtered by items such as; VI-SPDAT score, currently in an Emergency Shelter, veteran status, etc.
ROI	Release of Information, a person's informed consent for service providers to enter their data into HMIS, to share personal relevant information with other service providers, and general consent to engage with the housing system.
RRH	Rapid Re-Housing: short and\or medium term (3-9 months) rental assistance as necessary to help individuals or families living in shelter or places not meant for human habitation to move as quickly as possible into permanent housing and achieve stability in that housing.
Safe Haven	Emergency Shelter that serves hard to reach homeless individuals with severe mental illness and other debilitating behavioral conditions that are on the street and have been unable or unwilling to participate in housing or supportive services.

Shelter Plus Care (S+C)	A program that provides rental assistance for homeless individuals with disabilities through four component programs: Tenant, Sponsor, Project, and Single Room Occupancy (SRO) Rental Assistance, also offering intensive case management.
SSVF	Supportive Services for Veteran Families: Program providing supportive services to very low-income Veteran families living in or transitioning to permanent housing.
TH	Transitional Housing: housing that offers wrap around services (such as; childcare, job training, case management, etc.) while an individual or family is able to stabilize, can be up to 24 months.
Third-Party	Besides participant & Case Worker, another party who is a witness to the homeless person's situation. Ex: a separate agency who housed the person or provider homeless services.
UDE	Universal Data Elements: Data required to be collected from all persons serviced by homeless assistance programs using HMIS. These UDE include; date of birth, gender, race, ethnicity, veteran status, and social security number. These elements are needed for CoC's to understand the basic dynamics of homelessness within our community and for HUD to meet the Congressional directive to support the Annual Homeless Assessment Report (AHAR; HUD's report to Congress on the nature and extent of homelessness nationwide on an annual basis).
VASH	Veterans Affairs Supportive Housing: Program providing rental assistance to veterans and their families with case management and clinical services provided by the VA.
VI-SPDAT	Vulnerability Index & Service Prioritization Decision Assistance Tool: vulnerability tool that helps determine level of vulnerability of an individual experiencing homelessness. The VI-SPDAT is a tool used to guide decision making for program matching and to triage who receives services first. It is not the only decision-making factor.
VI-SPDAT (F)	Family Vulnerability Index & Service Prioritization Decision Assistance Tool: vulnerability tool that helps determine level of vulnerability of a family who is experiencing homelessness. The VI-SPDAT is a tool used to guide decision making for program matching and to triage who receives services first. It is not the only decision-making factor.
VI-SPDAT (TAY)	Transitional Aged Youth (18-24) Vulnerability Index & Service Prioritization Decision Assistance Tool: vulnerability tool that helps determine level of vulnerability of a youth who is experiencing homelessness. The VI-SPDAT is a tool used to guide decision making

for program matching and to triage who receives services first. It is not the only decision-making factor.

HUD Definitions

Terms used throughout these policies and procedures are defined below:

Chronically Homeless:

(1) An individual who:

(i) Is homeless and 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 one year or on at least four separate occasions in the last 3 years; and

(iii) Can be diagnosed with one or more of the following conditions: 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 U.S.C. 15002)), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability;

(2) 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 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 paragraph (1) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Disability:

A Physical, Mental or Emotional Impairment, including impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury that is expected to be long-continuing or of indefinite duration, substantially impedes the individual's ability to live independently, and could be improved by the provision of more suitable housing conditions; includes:

Developmental Disability Defined in §102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 USC 15002). Means a severe, chronic disability that Is attributable to a mental or physical impairment or combination AND Is manifested before age 22 AND Is likely to continue indefinitely AND reflects need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. An individual may be considered to have a developmental disability without meeting three or more of the criteria listed previously, if Individual is 9 years old or younger AND has a substantial developmental delay or specific congenital or acquired condition AND without services and supports, has a high probability of meeting those criteria later in life.

HIV/AIDS Criteria Includes 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).

Literally Homeless (Category 1):

Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) Has a primary nighttime residence that is a public or private place not meant for human habitation; (ii) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or (iii) Is exiting an institution where(s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution

At imminent risk of homelessness (Category 2)

Individual or family who will imminently lose their primary nighttime residence, provided that: (i) 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 needed to obtain other permanent housing

Homeless under other Federal statutes (Category 3)

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 the other listed federal statutes; (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 due to special needs or barriers

Fleeing domestic abuse or violence (Category 4)

Any individual or family who: (i) Is fleeing, or is attempting to flee, domestic violence; (ii) Has no other residence; and (iii) Lacks the resources or support networks to obtain other permanent housing

1.1 Access Fundamentals

1.1.1 Full Coverage

Written policies and procedures must describe the relationship of the CoC(s) to the coordinated entry process, addressing at a minimum how the core elements of ensuring access, standardizing assessments, and implementing uniform referral will operate in situations where the geographic boundaries of the CoC(s) and the boundaries of the crisis response system do not exactly align.

The 507-FL-CoC ensures that the crisis response system for those experiencing homelessness is accessible throughout its geographic area; Orange, Osceola, and Seminole counties. It uses multiple points of access, with a "no wrong door" approach, to achieve full coverage. Forms of access vary from in person assessments to over the phone assessments. Locations of access points vary from participating agencies, drop in centers, street outreach teams, shelters, HUBs, and a hotline; 2-1-1.

If an individual or family is not able to get to an access point due to mobility or transportation issues, they are able to access a CES assessment by contacting 2-1-1 and scheduling a time that works best for them to complete the CES assessment.

All access points and 507-FL-CoC CES partnering agencies utilize the same standardized assessment tools, and all individuals administering the CES assessment have been fully trained in the CES process. The standard assessment tool used by those mentioned above is commonly referred to as "The Big 3." This consists of; a release of information (ROI), an intake assessment (HMIS Entry Assessment), and completion of the vulnerability index (VI-SPDAT, F-VI-SPDAT, or TAY-VI-SPDAT). Individuals and families are then prioritized based on vulnerability and length of time homeless onto a by-name list called the registry. The registry is separated into specific population groups, such as; individuals, youth, families, and Veterans. The CES process prohibits the screening out of people from the process due to perceived barriers related to housing or services, including, but not limited to; too little or no income, active or a history of substance use, domestic violence, resistance to receiving services, the type nor extent of disability-related services or supports that are needed, evictions or poor credit, or criminal record (with exceptions for state or local restrictions that prevent projects from servicing people with certain convictions.) The CES process is available to all eligible persons regardless of race, national origin, religion, sex, age, familial status, disability, actual or perceived sexual orientation, gender identity, or marital status. All people in different populations and subpopulations in the 507-FL-CoC's geographic area, including people experiencing chronic homelessness, veterans, families with children, youth, and survivors of domestic violence, have fair and equal access to the CES process, regardless of the location or method by which they access the system. All access points, especially HUBs are advertised in monthly 507-FL-CoC meetings, for providers and community members alike, to ensure that those experiencing homelessness have access to a CES assessment and\or are offered other community resources, if found ineligible for CES related services.

1.1.2 Outreach

Written policies and procedures must detail a process by which street outreach staff ensure that persons experiencing a housing crisis who are encountered on the streets are prioritized for assistance in the same manner as any other person who accesses and is assessed through coordinated entry.

Street outreach efforts are part of the CES process. There are different teams designated to specific geographic areas covering the entire 507-FL-CoC. They are able to reach homeless individuals and families wherever they may be for those least likely to access services on their own. They are trained to complete an assessment in the field with individuals and families experiencing homelessness and act as a liaison to CES and other homeless services in the community. By completing the standardized assessment, they are prioritized in the same manner as any other access point or HUB. The standard assessment tool used by street outreach team members are commonly referred to as "The Big 3." This consists of; a release of information (ROI), an intake assessment (HMIS Entry Assessment), and completion of the vulnerability index (VI-SPDAT, F-VI-SPDAT, or TAY-VI-SPDAT). Individuals and families are then prioritized based on vulnerability and length of time homeless onto a by-name list called the registry. The registry is separated into specific sub-populations, such as Chronically Homeless, youth, families, and Veterans. A street outreach team member is able to continue creating rapport with persons living on the streets, eventually navigating them into housing when an opportunity becomes available for that individual or family, as well as connecting that individual or family to other community resources on an as needed basis.

1.1.3 Emergency Services

Written policies and procedures must document how persons are ensured access to emergency services during hours when coordinated entry intake and assessment processes are not operating. Additionally, written policies and procedures must describe the process by which persons will be prioritized for referrals to homelessness prevention services.

The CES process allows for people experiencing a housing crisis to access emergency services with as few barriers as possible. Emergency access point service providers include; homeless prevention assistance, domestic violence and emergency services hotlines, drop-in centers, emergency shelters, and other short-term crisis programs. Individuals and families are able to access these emergency services independent of the operating hours of the CES for intake and assessment. By calling their specific hotline number or regular office number, they are able to speak to a representative of the agency who is able to discuss in detail about the specific services they provide and the information that is needed to access those services. Some emergency shelters in the community use the CES process to prioritize families coming into the shelters based on their vulnerabilities and length of time homeless. The matching to beds portion is done internally after carefully looking at the by-name registry list to review which family is most vulnerable, in need of shelter, and matched the bed composition for the referring shelter. The

assessment also works in prioritizing them for housing programs available for them in the community. Other service providers have their own protocol and prioritization guidelines based on the available services that they have. 2-1-1 acts as a 24\7 crisis hotline where individuals and families experiencing any type of crisis can call for assistance and emergency services.

1.1.4 Standardized Access and Assessment

Required: Written policies and procedures must detail the CoC's standardized assessment process, including documentation of the criteria used for uniform decision-making across access points and across staff conducting assessments. If the CoC is differentiating access points for any of the HUD-designated subpopulations listed above, written policies and procedures must separately document the criteria for uniform decision-making for each subpopulation.

The CES process uses the same assessment process at all access points. Access points are general locations where individuals and families can complete a full intake assessment for the CES. The populations that are able to complete a full assessment are chronically homeless individuals, homeless families with minor children, homeless transitional aged unaccompanied youth, households fleeing domestic violence, and veterans. The VA Medical Center has 2 locations that target specifically the veteran population and act as an access point to the CES. The standardized assessment is completed at these sites as well, which allow entry to the CES process.

1.1.5 Marketing and Non-Discriminatory Access

Written policies and procedures must include guidelines for how the CoC will ensure that all populations and subpopulations in the CoC's geographic area have non-discriminatory access to the coordinated entry process. This applies to people experiencing chronic homelessness, veterans, adults with children, youth, and survivors of domestic violence, and regardless of the location or method by which they access the crisis response system. Written policies and procedures must also document steps taken to ensure that access points are accessible to people with disabilities as well as those people in the CoC who are least likely to access homeless system assistance.

The 507-FL-CoC ensures that the crisis response system for those experiencing homelessness is accessible throughout its geographic area; Orange, Osceola, and Seminole counties. It uses multiple points of access, with a "no wrong door" approach, to achieve full coverage. Forms of access vary from in person assessments to over the phone assessments. Locations of access points vary from participating agencies, drop in centers, street outreach teams, shelters, HUBs, and a hotline; 2-1-1.

If an individual or family is not able to get to an access point due to mobility or transportation issues, they are able to access a CES assessment by contacting 2-1-1 and scheduling a time that works best for them to complete the CES assessment.

The CES process prohibits the screening out of people from the process due to perceived barriers related to housing or services. These barriers might include, but are not limited to; too little or no income, substance use, domestic violence, resistance to receiving services, disability, disability-related services or supports that are needed, evictions or poor credit, lease violations or history of not being a leaseholder, or criminal record-with exceptions for state or local

restrictions that prevent projects from servicing people with certain convictions. The CES process is available to all eligible persons regardless of race, national origin, religion, gender, age, familial status, disability, actual or perceived sexual orientation, gender identity, or marital status. (If a program participant's self-identified gender or household composition creates challenging dynamics among residents within a facility-based or shelter setting, the host program should make every effort to accommodate the family or individual to assist in locating alternative accommodations or creating accommodations in which the individual or family feel safe at the current location, that is appropriate and responsive to the individual's or family's needs.) All people in different populations and subpopulations in the 507-FL-CoC geographic area, including people experiencing chronic homelessness, veterans, families with children, youth, and survivors of domestic violence, have fair and equal access to the coordinated entry process, regardless of the location or method by which they access the system. All access points, especially HUBs are advertised in monthly 507-FL-CoC meetings to service providers and community members alike, to ensure that those experiencing homelessness have access to a CES assessment and or are offered other community resources, if found ineligible for CES related services.

1.1.6 Safety Planning

> Written policies and procedures must establish protocols that ensure at a minimum that people fleeing, or attempting to flee, domestic violence have safe and confidential access to coordinated entry and that data collection conforms to the applicable requirements of the Violence Against Women Act, CoC Program, and/or HMIS Data Standards. Written policies and procedures must also describe the CoC's protocol for extending coordinated entry safety planning and protections to victims of domestic violence who are staying at non victim service provider projects. In addition, written policies and procedures for coordinated entry must include protocols that ensure at a minimum that people fleeing, or attempting to flee, domestic violence and victims of trafficking have safe and confidential access to the coordinated entry process and victim services, including access to the comparable process used by victim service providers, as applicable, and immediate access to emergency services such as domestic violence hotlines and shelters.

CES participating providers shall provide necessary safety and security protections for families and individuals fleeing or attempting to flee family violence, stalking, dating violence, or other domestic violence situations. Minimum safety planning must include a threshold\lethality assessment for presence of participant safety needs and referral to appropriate trauma-informed services, if safety needs are identified. The CES is connected with all domestic violence shelters in the 507-FL-CoC to ensure that if an individual or family presents at an access point they can immediately complete a threshold\lethality assessment over the phone for potential shelter, as well as create a safety plan. All data collection conforms to the requirements of the Violence Against Women Act (VAWA) and Homeless Management Information System (HMIS) Data Standards, thus protecting the confidentiality of the individuals and families who are fleeing. Alternative methods for data collection and storage are in place, ensuring confidentiality of all survivors and their family members.

1.1.7 Privacy

Written policies and procedures must include protocols for obtaining participant consent to share and store participant information for purposes of assessing and referring participants through the coordinated entry process. Written policies and procedures must also ensure participants can freely abstain from disclosing and sharing information without fear of denial of services resulting from the refusal. Certain funders might require disclosure of certain pieces of information for purposes of establishing or documenting program eligibility.

All Coordinated Entry System partner agencies within the 507-FL-CoC are trained in the Homeless Management Information System (HMIS) and agree to HMIS Agency Partner and User Agreements, ensuring confidentiality, data sharing, and general agency responsibilities are adhered to and understood. Release of Information (ROI) forms must be signed by all persons to authorize the entry and/or sharing of their personal information electronically with other 507-FL-CoC Participating Agencies through the HMIS where applicable, and are active for 3 years. A person has the right to appeal his or her individual issues related to HMIS in accordance with Agency dictated grievance policy. If no grievance procedure is in place as it relates to HMIS, it may be appealed by the following progression: 1. Agency Case Worker, 2. Agency Case Workers Supervisor, and finally, 3. Agency Executive Director. Individuals and families can freely abstain from disclosing and sharing information without fear of denial of services resulting from the refusal of wanting their information added to the HMIS. If a person declines their personal information from being entered into the HMIS, services will still be offered and alternative means of data collection and storage will be offered.

Homeless Management Information System (HMIS) protocols include standards for the privacy and security of information entered into the HMIS system. These standards were developed by HUD based on Health Insurance and Portability and Accountability Act (HIPAA) standards for securing and protecting information. Some communities have elected to adopt additional laws, protocols or policies to further enhance the privacy and security of information collected through HMIS. Users of HMIS products must comply with the baseline HUD standards and must also comply with any additional federal, state and local laws that require additional confidentiality protections

2.1 Assessment Fundamentals

2.1.1 Assessment Requirements

Privacy Protections

CoCs must include written policies and procedures for obtaining participant consent to share and store participant information for purposes of assessing and referring participants through the coordinated entry process. Participants must also be free to decide what information they provide during the assessment process. The assessment and prioritization process cannot require disclosure of specific disabilities or diagnoses. Specific diagnosis or disability information may only be obtained for purposes of determining program eligibility to make appropriate

referrals. Further requirements on the collection of disability information for the purposes of prioritization is described in II.B.3(a) of this Notice.

507-FL-CoC uses a Homeless Management Information System (HMIS) Release of Information (ROI) that guidelines the use of a shared database to store participant information for the purpose of entering the CES process and being referred to available programs. The participant provides consent to having their information entered into the HMIS and having their personal information shared with other HMIS authorized providers. Participants have to right to choose what information they would like to share and they have the ability to freely decide if they prefer to keep certain information private. 507-FL-CoC is prohibited from denying assessment or services to a participant if the participant refuses to provide certain pieces of information, unless the information is necessary to establish or document program eligibility per the applicable program regulation. 507-FL-CoC is also prohibited from denying services to participants if the participant refuses to allow their data to be shared unless federal statute requires collection, use, storage, and reporting of a participant's personally identifiable information (PII) as a condition of program participation. Participants are not to be denied access to the CES process on the basis that the participants is or has been a victim of domestic violence, dating, violence, sexual assault, or stalking. If the participant is or has been a victim of domestic violence, dating, violence, sexual assault, or stalking and does not consent to having their information entered into HMIS, then an alternate process for data collection and storage will take place without any PPI entered into the HMIS.

Standardized access and assessment tool

Written policies and procedures must detail the standardized assessment process, including documentation of the criteria used for uniform decision-making across access points and staff. If the CoC is differentiating access points and assessment tools for any of the five HUD-designated subpopulations, written policies and procedures must separately document the criteria for uniform decision-making for each subpopulation. The criteria must be based on the prioritization standards adopted by the CoC that are used for its different access points and assessment processes

The forms of access vary from in person assessments to over the phone assessments. Locations of access points vary from participating agencies, drop in centers, street outreach teams, shelters, HUBs, and a hotline; 2-1-1.

If an individual or family is not able to get to an access point due to mobility or transportation issues, they are able to access a CES assessment by contacting 2-1-1 and scheduling a time that works best for them to complete the CES assessment.

All access points utilize the same standardized assessment tools, and all individuals administering the CES assessment have been fully trained in the CES process. The standard assessment tool used by those mentioned above are commonly referred to as "The Big 3." This consists of; a release of information, an intake assessment, and completion of the VI-SPDAT, F-VI-SPDAT, or TAY-VI-SPDAT. It is important to note that all parties reserve the right to self-identify during the intake process without interrogation; one should not be asked for anatomical information, documentation, physical or medical evidence to prove their gender identity. Afterwards,

Individuals and families are then prioritized based on vulnerability and length of time homeless onto a by-name list called the registry. The registry is separated into specific population groups, such as' individuals, youth, families, and Veterans. All people in different populations and subpopulations in the 507-FL-CoC geographic area, including people experiencing chronic homelessness, veterans, families with children, youth, and survivors of domestic violence, have fair and equal access to the CES process, regardless of the location or method by which they access the system. All access points, especially HUBs are advertised in monthly 507-FL-CoC meetings to service providers and community members alike, to ensure that those experiencing homelessness have access to a CES assessment and or are offered other community resources, if found ineligible for CES related services.
Assessed persons populate onto a single prioritized list, referred to as The Registry, if "The Big 3" has been completed. Based on their length of homelessness and severity of service needs, prioritized persons are assigned a Navigator, if provider completing the assessment is not already assigned, to verify eligibility and obtain documents required by permanent housing projects. A Navigator's main role is to help homeless persons navigate the homeless system to find the most appropriate service intervention(s) needed to end their homelessness. This can include referring to a variety of community resources, relocation to natural supports, or working to refer a person to a supportive housing program. If a supportive housing program is needed, Navigators help get person get "document ready," typically obtaining ID, Social Security card, homeless verification, and income verification, as defined by HUD. Once the person is "document ready" Navigators submit a referral to CES Match.

Once the CES Match team receives a referral from a Navigator in HMIS, a record keeping review of the HMIS profile is completed to check for eligibility documents. . Once Approved for a supportive housing program, participants will populate on an Approved List, much like The Registry mentioned above. Participants are prioritized based off of HUDs guidance; first, length of homelessness and second, severity of needs based off of the VI-SPDAT tool. Prioritized participants are then matched to a Housing Stability Case Managers, and are referred using HMIS. Providers finalize housing placement with the Housing Locator Team and provide ongoing voluntary Case Management services in compliance with Housing First. Housing Providers are required to ensure that barriers remain low in partnership with the CES process, that housing is accessed rapidly, and that participant choice is prioritized during housing search and participation in services.

Participant autonomy

Written policies and procedures must outline a process whereby necessary information may be obtained when a person being assessed refuses to answer one or more assessment questions.

The CES process allows people presenting to the crisis response system to refuse to answer assessment questions and to reject housing and service options offered without their suffering retribution or limiting their access to assistance. CES staff and community providers always engage with participants in an appropriate and respectful manner to collect only necessary assessment information. However, participants might choose not to answer some questions or could be unable to provide complete answers in some circumstances. Since the lack of a response to some questions can limit the variety of referral options, the CES staff makes sure to

communicate to those participants the impact of incomplete assessment responses. The unresponsiveness of a participant does not affect future assessment or referral options. A participant may have the option to be re-assessed if they think that their assessment answers did not accurately reflect their current situation. Extended engagement is also used as a means to complete the assessment in full, but over an extended period of time, giving the staff more time to engage and build a relationship with the individual or family. Extended engagement is an encouraged process especially for those individuals or families dealing with mental health and are hard to engage with.

Assessor training

After staff receive initial training on the CoC's assessment protocols, further training is required once annually.

CES along with the 507-FL-CoC provides annual refresher trainings to community providers. These trainings cover CES assessment protocols and topics such as; how to complete the "Big 3", using the Vi-SPDAT, Motivational Interviewing, Trauma Informed Care, Person Centered Care, Cultural Competency, and other related person-centered topics.

3.1 Prioritization Fundamentals

3.1.1 Prioritization Requirements

Written policies and procedures must document the uniform referral process for all participating projects, including allowable entry requirements and protocol for a project rejecting a referral. *(Similarly, during referral, there also must be a policy that allows the person to maintain his or her place in the priority list after rejecting service options that are offered. See Section 4.5.4.)*

Written policies and procedures must include the process by which the CoC staff will make prioritization decisions for each project type (e.g., PSH, RRH) and the criteria used for prioritization decisions.

General Overview- Permanent Supportive Housing Projects

CES supports many 507-FL-CoC funded and non-funded agencies in Permanent Supportive Housing (PSH) Projects. These PSH Projects are intended to target homeless individuals and families who are the most vulnerable and have expereinced chronic homelessness, as defined by HUD Notice CPD-16-11 Issued 7-25-16. Homeless persons can access CES via 2-1-1, Emergency Shelters, Outreach, HUBs, and other HMIS homeless providers participating in the CES. Homeless persons are screened for diversion or prevention. Homeless persons are assessed using a comprehensive, standard assessment tool called "The Big 3" (Release of Information, HMIS Entry Assessment and VI-SPDAT). The VI-SPDAT is the standard assessment tool utilized to evaluate vulnerability. Data match resources can also be utilized, such as jail records, medical discharge records, etc.

Prioritization for Assignment to Navigation

Assessed persons populate onto a single prioritized list, referred to as The Registry. Based on their length of homelessness and severity of service needs, prioritized persons are assigned a Navigator to verify eligibility and obtain documents required by PSH projects. A Navigator's main role is to get homeless persons "document ready," typically for PSH Programs an ID, social, income verification, disability verification, and verified chronic homelessness, as defined by HUD. Once person is "document ready" Navigators submit a referral to CES Match.

Eligibility and Record Keeping Review

In order for the person to be eligible for a program, the criteria must be met and proper documentation must be provided. The chronic definition of homelessness and a certified disability are the main two criterions for eligibility. The person must have 12 consecutive or cumulative months of homelessness within the past 3 years (staying in the streets or in shelters) which must be verified through HMIS or a third-party service provider. In addition, the person's disability must be severe and verified by a licensed medical provider or by using a copy of the SSI/SSDI letter if receiving assistance due to a disabling condition. The proper identification documentation must be provided as well. Once a Navigator has uploaded all required documents needed for program eligibilty, they submit a referral in HMIS to the CES Match team. The CES Match team reviews each person's HMIS profile to verify eligibilty documents are valid and to match persons to the most appropriate housing program for which they are eligible for.

VI-SPDAT Requirement for Assignments to Permanent Supportive Housing Projects

Please refer to the "Glossary of Terms" for the definition of VI-SPDAT and the different versions it entails. During the eligibility verification and the Record Keeping Review process, the VISPDAT score should be a 10 or above to be considered an ideal recipient of Permanent Supportive Housing. If the score does not reflect a 10 or above one must provide substantial documents and an explanation as to why they believe this candidate is better suited for Permanent Supportive Housing as opposed to other programs available. For more information please review the "Extenuating Circumstances Checklist" listed below.

Prioritization for Assignment to Case Management and Housing

Once approved and matched to PSH Programs, persons will populate on an Approved List, much like The Registry mentioned above. Persons are prioritized based off of HUDs guidance; first, length of homelessness and second, severity of needs, based off of the VI-SPDAT toolPrioritized persons are then matched to PSH Housing Stability Case Managers based on program capacity, and are then referred to the PSH providers using HMIS. PSH providers finalize housing placement with the Housing Locator Team and provide ongoing voluntary Case Management services in compliance with Housing First. Providers are required to ensure that barriers remain low in partnership with the CES process, that housing is accessed rapidly, and that participant choice is prioritized during housing search and with regards to participation in services.

More on Prioritization Policy for Assignment to Case Management for PSH

1. General Concepts
    a. Approved List

    The Approved List is the subset of the full Chronic Registry consisting of the individuals (and households[1]) who are currently eligible for one or more of the PSH housing programs to which individuals may be matched through the Chronic Registry Management process. Upon use of the methods described in this section, the Approved List serves as the single prioritized list for all PSH programs participating in the Coordinated Entry System (CES).

    b. Assignment to Case Management

    The fact that an individual has been selected for matching to a housing program through the Chronic Registry Management process is formalized by the assignment of the individual to receive case management at a Chronic Registry Management meeting.

2. Additions to the Approved List

    a. An individual is added to the Approved List by CES staff upon completion of the PSH eligibility determination process (Recordkeeping Review). The Approved List, as well as The Registry is fluid, as the population we serve is constantly changing.

    c. An individual who has previously been removed from the Approved List but who is still within his or her PSH eligibility period may be re-added by CES staff upon request of a Chronic Registry Management participant with justification (e.g., outreach re-establishment of contact, participant returns from out-of-town and CES-approved termination of participant from project).

3. Removals from the Approved List

An individual may be removed from the Approved List by CES staff under any of the following circumstances:

a. The individual was assigned for case management at a Chronic Registry Management meeting;

b. The individual is otherwise housed or has reliably indicated that he or she no longer is in need of PSH housing;

c. No contact has been made with the individual for a period of at least 90 days, no further information is available about the individual's whereabouts, and no outreach worker or navigator has specifically requested that the individual remain on the Approved List; or

[1] For the remainder of this section, the term "individuals" refers to both individuals and households.

d. More than 12 months have elapsed since the individual has completed the navigation process, and efforts to complete the PSH eligibility re-determination process have proven unsuccessful.

4. Assignment to Case Management to be based on Initial Prioritization of the Approved List

a. Generally

Prior to each Chronic Registry Management meeting, the Approved List will be initially prioritized for assignment to case management by CES staff. This prioritization is based on an algorithm that factors in first, total length of time homelessness (LOH), and second, severity of need where the VI-SPDAT is used to determine severity.

b. Specifically

i. Length of homelessness (LOH) is estimated using the currently available LOH proxy. If two individuals have the same severity of need (as indicated by VI-SPDAT score), an individual with a longer LOH will have a higher initial priority than an individual with a shorter LOH.

ii. Severity of need for initial prioritization purposes is indicated by the most recent score on the VI-SPDAT instrument. An individual with a higher VI-SPDAT score will have a higher initial priority than an individual with a lower VI-SPDAT score.

iii. Under no circumstances will prioritization be based upon diagnosis or disability type, nor otherwise be determined in any manner that would violate the non-discrimination requirements of federal civil rights laws.

5. Bypassing Individuals for Assignment

The following individuals may be bypassed for assignment in the Chronic Registry Management process, regardless of their initial priority level:

a. The individual remains on the Approved List, but his or her whereabouts are currently unknown.
b. The individual remains on the Approved List, but is currently in jail or other institutional setting for at least seven (7) and not more than 90 days (with status updates to be provided by the assigned Navigator whenever possible.)
c. An outreach worker has identified the individual as currently unwilling to accept housing and indicated that he or she is a target for extended engagement efforts.
d. There is consensus among participants in the Chronic Registry Management meeting that one or more individuals should not be selected for assignment to case management for a specifically identifiable reason.

6. Exceptions to Assignment Based on Initial Prioritization

After the initial prioritization process has been completed, an individual may only be

selected for assignment to case management in the Registry Management process over another individual with a higher initial priority under one of the following conditions:

a. The individual is the highest priority individual eligible to access a specific, available case management or housing slot, particularly with respect to county of homelessness (i.e., from Seminole or Osceola Counties) or household composition (i.e., families with children).

b. The individual is determined by a consensus of participants in the Chronic Registry Management meeting to have a greater severity of need than one or more individuals despite their higher initial priority, by virtue of the fact that they meet one or more criteria listed on the Extenuating Circumstances Checklist described in section below. Individuals who meet more than one of the criteria will be prioritized over individuals who meet a single criterion.

7. Extenuating Circumstances Checklist

The following criteria are considered extenuating circumstances that would allow an individual with a lower initial priority to be assigned to case management before one or more individuals with higher initial priority, as described in section above:

a. An outreach worker or navigator has reported within the past week or reports at the Registry Management meeting that the individual is at considerable, imminent risk of suffering irreparable harm or death due to health conditions arising from their homelessness.

b. An outreach worker or navigator has reported that the assessment (VI-SPDAT) does not accurately reflect the vulnerability of the individual due to barriers to completing the assessment, such as cognitive impairments, severity of mental illness, memory loss, or other conditions that make it difficult for service users to answer assessment questions accurately.

c. An outreach worker or navigator has reported within the past week or reports at the Registry Management meeting that the individual is at considerable, imminent risk of violence or victimization arising from their homelessness.

d. A participant in the Chronic Registry Management process has reported or reports at the Registry Management meeting that the individual has previously been bypassed for assignment due to short-term incarceration or institutionalization, is expected to be discharged to homelessness within the next 7 days, and will remain PSH-eligible upon discharge.

Extenuating circumstances are discussed during registry meetings. Outreach workers or navigators are given an opportunity to present a case for extenuating circumstances for an individual to be considered for prioritization regardless of current assessment score.

General Overview- Rapid Rehousing Projects

Coordinated Entry System sustains a structured arrangement for many COC funded and non-funded agencies involved in Rapid Rehousing Projects. This program addresses the needs of households who are struggling with homelessness which include residing in a vehicle, on the streets, or in an emergency shelter. Its intentions are to aid those families with the assistance necessary to transition them back to housing. Households in a literally homeless situation are able to access CES through 211, emergency shelters, outreach teams, HUBs, or other HMIS homeless providers participating in HMIS. Homeless households that meet the program criteria are assessed using a comprehensive standard assessment tool called "The Big Three." This consists of the Release of Information, HMIS Entry Assessment with HUD required questions, and the VI-SPDAT. The VI-SPDAT is a vulnerability index tool used to prioritize households on the basis of their needs.

VI-SPDAT Requirement for Assignments to Rapid Rehousing Projects

Please refer to the "Glossary of Terms" for the definition of VI-SPDAT and the different versions it entails. During the eligibility verification and the Record Keeping Review process, the VI-SPDAT score should be a 5 or above to be considered an ideal recipient of Rapid Rehousing. If the score does not reflect a 5 or above one must provide substantial documents and an explanation as to why they believe this candidate is better suited for Rapid Rehousing as opposed to other programs available. (Should we include this for rapid rehousing also?)

Prioritization for Assignment to Navigation

Once households are assessed and the "Big Three" is completed, they populate onto The Registry, where they are prioritized based on their length of homelessness and their vulnerability. A Navigator is then assigned to the household and their primary role is to obtain the required documentation for the RRH program. They are responsible for verifying household's eligibility as well as getting them "document ready." Documents that are usually gathered consist of an ID, social security card, and a birth certificate for any child under 18. Once the Navigator has uploaded all necessary documents into HMIS, they submit a referral to CES Match.

There are two routes in which a client may move forward to navigation.

Funded Provider Navigation: Providers funded through CoC funding who provide navigation services can only accept clients who have been assigned through CES. Prioritization for navigation is based on vulnerability and length of homelessness.

Non Funded Provider Navigation: Non funded providers can navigate clients they are working with at their agencies. These providers, typically already working with vulnerable populations such as DV survivors and families with DCF involvement, prioritize clients internally.

Eligibility Process and Record Keeping Review

Once a household has been referred to CES Match, the CES team will review the referral for eligibility. There must be evidence of the household's current housing status in HMIS whether it being a shelter entry or service provider verification form. The household must consist of minor children and they must be literally homeless; for instance, in their car, on the streets, or in a shelter. Proof of income must be uploaded in addition to all necessary identification documents such as an ID and social security card for all adults and birth certificates for any minor children. The CES team will review each household profile based on program eligibility and availability. The referral will be approved if the household is deemed to be a good fit for the program and once the required criteria are met.

Prioritization for Assignment to Case Management and Housing

After a referral has been approved for RRH, households will populate on an Approved List that is similar to the Registry. Households are prioritized based on length of homelessness and their vulnerability index, which is measured using the VI-SPDAT measurement tool. Families will be referred through HMIS with an RRH Housing Stability Case Manager to ensure a successful transition into housing. The RRH case managers will ensure that the housing placements are finalized with the Housing Locator Team and that the household's choice is taken into consideration. They will provide case management services throughout the duration of the program's assistance period. The purpose is for the household to be given support in order to stabilize and ensure they retain their housing for a long term. Providers are required to ensure that barriers remain low in partnership with the CES process and that housing is accessed rapidly.

4.1 Referral Fundamentals

CES Referrals to Supportive Housing Provider

Once a participant has been prioritized for a RRH/PSH project, CES submits a referral in HMIS to the supportive services provider. The assigned Case Manager should begin making contact within 3 business days with the navigator or Outreach worker who has been working with the participant to coordinate a warm hand off. The warm hand off should take the participant's conditions and preferences into account (ex: mutually agreed upon location that is convenient and safe for all parties.) Intake and program enrollment can begin once the initial meeting between the participant and Case Manager has taken place.

Declining Referrals

CES and Housing First Programs may not screen participants out due to lack of income or perceived employability, current or past history of substance use, criminal history (except for state or federally-mandated restrictions) poor credit, type of disability, sexual orientation/gender identity, or general behaviors that are interpreted as indicating a lack of "housing readiness."

Any agency declining a referral submitted by CES must document in writing the reason for decline, either by uploading a written explanation in HMIS profile or by documenting via case

notes on HMIS profile. CES will review the reason for decline to ensure it is in line with Housing First and the Supportive Housing Provider's contract. (For example, some projects will accept sex offenders while others are not able to accept this background.)

In the event that a referral is rightfully declined, CES will prioritize participant for next available supportive housing space for which they are eligible to be referred to.

Contact Information

Martha Are, Executive Director // martha.are@hsncfl.org

Brian Postlewait, Deputy Director for 507-FL-CoC // brian.postlewait@hsncfl.org

Allison Nye, CES Operations Manager // allison.nye@hsncfl.org

Tino Paz, HMIS Operations Manager // tino.paz@hsncfl.org

Kerri Barglof, Housing Location Operations Manager // kerri.barglof@hsncfl.org

507 CoC Website // https://www.centralfloridacoc.org