# WV Balance of State Continuum of Care
# Coordinated Entry Guidance

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The Balance of State Continuum of Care developed the following Coordinated Entry standards to ensure:

- program accountability to promote equal access for all population groups experiencing homelessness; specifically, those who are experiencing chronic homelessness or are high-need/high-acuity.
- program compliance with HUD Rules and guidance.
- fairness and ease of access to resources across the entire CoC geographic area.
- standardization of assessment, prioritization, and housing placement consistency.
- coordination among federal partners serving persons experiencing homelessness, including integration of mainstream service providers into the system.
- adequate program staff competence and training to create an environment, locally and CoC-wide, of coordination, consistency and speed in housing placement.

## INTRODUCTION TO COORDINATED ENTRY

Coordinated Entry is defined as a process designed to coordinate program participant intake, assessment, and provision of referrals. It covers the entire geographic area served by the CoC, is easily accessed by all population groups 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 can be applied to any community or situation, and with patience, persistence, testing, and tweaking, can be successful.

Coordinated Entry, when implemented correctly, can help to prioritize individuals and families who need housing the most across communities. Beyond program confinement, and beyond silos, 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 of less time, effort, and frustration on the part of case managers by targeting efforts.
5. End homelessness across communities, versus program by program.

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.

The intention of Coordinated Entry is to:

1. Target the appropriate housing intervention to each population group particularly for those with high acuity and high need.
2. Divert people away from the system who can solve their own homelessness.
3. Ensure all population groups have the same assessment criteria applied utilizing an evidence-based assessment tool through the or identified access "entry" point in each region. If a particular population group(s) shows up at the wrong place, there must be a process identified in each region for getting them linked to the right place.
4. Greatly reduce the length of homelessness by moving people quickly into the appropriate housing.
5. Greatly increase the possibility of housing stability by targeting the appropriate housing intervention to the corresponding needs.

Applying coordinated entry to a community brings together the strength of programs across a community, offering a menu of services across programs. When communities come together to implement a coordinated access 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 share the burden of intake and assessment. When working across case managers in a community, real efficiencies can be realized in housing placement and case management when a common assessment is employed and agencies share the workload.
- Communities readily see what additional resources they need most: Lots of clients with mid-level acuity (definition of *acuity* below) 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 homelessness is significantly decreased: Targeting limited resources as a community in a laser-like way leads to very fast and effective interdictions that lead to long-term housing stability.

Prioritization for Chronic Homelessness: HUD has released (updated from the July 2014 document) guidance for the prioritization of chronically homeless individuals and families, which is outlined after the "definitions" section of this document. For a look at the full notice, please go here: https://www.hudexchange.info/resources/documents/notice-cpd-16-11-prioritizing-persons-experiencing-chronic-homelessness-and-other-vulnerable-homeless-persons-in-psh.pdf

And the HUD Updated Guidance on Coordinated Entry (January 23, 2017): https://www.hudexchange.info/resources/documents/Notice-CPD-17-01-Establishing-Additional-Requirements-or-a-Continuum-of-Care-Centralized-or-Coordinated-Assessment-System.pdf

On the WVCEH website there is a list of resources for CoC-funded programs, and all other homeless programs, to utilize in their staff trainings, strategic planning, and goal setting, while continuing to follow best practices and new developments within the field. Please note that these resources are here as a guide and not an exhaustive list or intended to replace existing documents at your organization which already capture all required information. As a reminder, all participating providers should be utilizing the WV BoS CoC forms for the following three components: documentation of homelessness status, documentation for length of time homeless (chronic verification) and verification of disabling condition, which can all be found below which can be found here: https://wvceh.org/continuum-of-care/bos-coc-monitoring.html

## DEFINITIONS

Access – The engagement point for persons experiencing a housing crisis. Also refers to how a person enters the Coordinated Entry System.

Assessment – Progressive gathering of information at various phases in the coordinated entry process, for different purposes, by standardized, trained assessors.

Balance of State (BoS) **–** Geographical areas designated by HUD throughout a state that are not covered by other metropolitan continuums.

Acuity – When utilizing the VI-SPDAT Prescreens, 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 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.

Chronically Homeless – An individual who:

1) Is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter;
2) 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 totaling 12 months or more in the last 3 years; and
3) 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;
4) 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 (*listed above)* of this definition [as described in 24 CFR Parts 91 & 578 of the CoC Final Rule], before entering that facility;
5) 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 (*listed above)* of this definition [as described in 24 CFR Parts 91 & 578 of the CoC Final Rule], including a family whose composition has fluctuated while the head of household has been homeless.

Comparable Database – HUD-funded providers of housing and services (recipients of ESG and/or CoC funding) who are not permitted, by law, to enter into HMIS (only victim service providers as defined under the Violence Against Women and Department of Justice Reauthorization Act of 2005) must operate a database that is comparable to HMIS. The term "comparable" has yet to be defined in the HMIS Data Standards Manual or HMIS Data Dictionary, but was defined under the HEARTH Act and ESG Interim Rule as: "a comparable database that collects client-level data over time (i.e. longitudinal data) and generates unduplicated aggregate reports based on the data" (page 32) (https://www.hudexchange.info/resources/documents/HEARTH_ESGInterimRule&ConPlanConformingAmendments.pdf) The recipient or subrecipient of Continuum of Care funds may use a portion of those funds to establish and operate a comparable database that complies with HUD's HMIS requirements. (§578.57 of the CoC Interim Rule)

Continuum of Care (CoC) – A regional or local planning body that coordinates housing and services funding for homeless families and individuals. A CoC is designed to promote communitywide commitment to the goal of ending homelessness; provide funding for efforts by nonprofit providers, and State and local governments to quickly rehouse homeless individuals and families while minimizing the trauma and dislocation caused to homeless individuals, families, and communities by homelessness; promote access to and effect utilization of mainstream programs by homeless individuals and families; and optimize self-sufficiency among individuals and families experiencing homelessness.

CoC Collaborative Applicant – Agency that is designated to carry out the activities of the CoC or grant including fiscal and compliance activities. Regular administrative tasks may include, but are not limited to: management of the annual HUD application, coordination of other funding opportunities, project and system monitoring, meeting management, etc. WV Coalition to End Homelessness is the CoC Lead Agency for the BoS CoC.

Coordinated Entry – "A centralized or coordinated process designed to coordinate program participant intake, assessment, and provision of referrals across a geographic area. The Coordinated Entry 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." [as described in 24 CFR Section 578.3 and further detailed in CPD-17-01.] It is the responsibility of each CoC to implement Coordinated Entry in their geographic area. OrgCode Coordinated Access Video: https://vimeo.com/64190826

CES – Coordinated Entry System.

Crisis Response System – All of the services and housing available to persons who are at imminent risk of experiencing literal homelessness and those who are homeless.

Department of Housing and Urban Development (HUD) – The Federal Agency that oversees the CoC and ESG Programs.

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, or other homeless assistance, 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 wait lists.

Emergency Services – Services typically accessed by a person experiencing a housing crisis, they include, but are not limited to, homelessness prevention assistance, domestic violence and emergency services hotlines, drop-in service programs, domestic violence shelters, emergency shelters and motel voucher programs, and other short- term crisis residential programs.

Emergency Shelter (ES) – A place for people to live temporarily when they cannot live in their previous residence. This includes programs that provide motel vouchers to persons experiencing homelessness. Emergency shelters assist persons experiencing homelessness in regaining permanent housing.

Emergency Solutions Grant (ESG) – A Federal grant program that funds street outreach, homelessness prevention, emergency shelter, and rapid re-housing activities.

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.

Homeless – means (Category 1) 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; (Category 2) An

individual or family who will imminently lose their primary nighttime residence, provided that: (i) 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; or (Category 4) Any individual or family who: (i) 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. 24 CFR 578.3.

Homeless Management Information System (HMIS) – A local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness. The information system designated by the Continuum of Care must comply with the HMIS requirements prescribed by HUD. The HMIS used in West Virginia Statewide HMIS Implementation, which includes all four CoCs, is ServicePoint.

Household – Covers any configuration of persons in crisis, whatever their age or number (adults, youth, or children; singles, couples or multiple adults; with or without children).

Housing Interventions – Housing programs and subsidies; these include transitional housing, rapid re-housing, and permanent supportive housing programs, as well as permanent housing subsidy programs (e.g. Housing Choice Vouchers).

Housing First – An approach to quickly and successfully connect individuals and families experiencing homelessness to permanent housing *without preconditions* and barriers to entry, such as sobriety, income, treatment or service participation requirements. Supportive services are offered to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to permanent housing entry. OrgCode Housing First 101 Video: https://vimeo.com/64412408

Housing Opportunities for Persons with Aids (HOPWA) – Federal grant program fund by the Department of Housing and Urban Development (HUD) as part of the Community Development Block Grant. HOPWA was established to help those with low-income, living with HIV/AIDS, and their families establish and/or maintain stable housing, reduce risk of homelessness, and improve access to health care and other needed support services.

Housing Prioritization Guide – A guide, or multiple guides by population group, of persons who are experiencing homelessness in the CoC and imminently "house-able". This housing guide lives virtually within HMIS. The Coordinated Entry staff oversees the housing guide along with a larger list of those who are engaged in services, but may still need additional information prior to connecting with appropriate housing intervention. Emergency Shelter and Street Outreach staff should be working closely Coordinated Entry to assist with those who are not yet engaged and maintain engagement with those who are on the list.

Non-HMIS Housing Prioritization Guide – A Housing Guide that uses anonymous, unique identifiers in order to accommodate domestic violence survivors and other households that do not consent to sharing their information in HMIS.

Permanent Supportive Housing (PSH) – Means community-based housing without a designated length of stay, and includes both permanent supportive housing and rapid re-housing. To be permanent housing, the program participant must be the tenant on a lease for a term of at least one year, which is renewable for terms that are a minimum of one month long, and is terminable only for cause. Permanent supportive housing means permanent housing in which supportive services are provided to assist homeless persons with a disability to live independently. 24 CFR 578.3.

Program Standards – A set of expectations and policies developed by program funders/grant recipients across the state for each project type, based on HUD guidance and best practices, that the CoC-funded agencies, and other agencies funded through federal partners, are required to follow.

Project – Housing and/or supportive services intended to help people exit homelessness and sustain housing.

Provider – Organizations that serve program participants in projects funded by the CoC Program, ESG Program grants, and other federal partners (e.g. SAMSHA). This includes grant recipients and sub-recipients.

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 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. The SPDAT (or “Full SPDAT”) has an individual and family tool. Staff must be trained by OrgCode Consulting or Balance of State CoC staff on the SPDAT. The SPDAT can be completed on paper or in HMIS and attached to a client record.

SSI/SSDI Outreach, Access, and Recovery (SOAR) – Initiative to train case managers on how to prepare a Social Security disability benefits application and properly document behavioral health issues to increase access to benefits for those with behavioral health issues experiencing or at risk of homelessness.

Street Outreach – A project type that meets people experiencing homelessness where they live and provides supportive services, advocacy, and access to emergency services and housing options.

Supportive Services for Veteran Families (SSVF) – A federal program by the U.S. Department of Veterans Affairs that awards grants to private non-profit organizations and consumer cooperatives who can provide supportive services to very low-income Veteran families at-risk or experiencing homelessness.

Transitional Housing (TH) – housing, where all program participants have signed a lease or occupancy agreement, the purpose of which is 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 Prescreen utilized by all projects in the WV Balance of State CoC to determine initial acuity (the presence of an issue) and utilized for housing triage prioritization and housing placement.

## COORDINATED ENTRY ROLES

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| Continuum of Care | The Continuum Care is the responsible entity for building a system of care throughout its geography in order to end homelessness while also acting as the monitor for CoC funds, and realization of HUD Performance Outcome Measures. The CoC itself and the agencies within it, hold the responsibility for creating and maintaining a functional Coordinated Entry System. |
| Continuum of Care Board | Currently, the Board of Directors of WVCEH serves as the Governance structure for the BoS CoC, with much of the Governance changing to the CoC Steering Committee in the future. |
| Coordinated Entry Staff | WVCEH employs two staff, one in North Central WV and one in Southern WV, to act as 'navigators and investigators' to ensure people move quickly and effectively from street or shelter to housing. The Coordinated Entry staff oversees the housing guide and make referrals utilizing the HMIS to the appropriate housing intervention in each region. |
| Emergency Shelters | Shelters are very often the 'first door' for people experiencing homelessness, and thus vital as an access "entry" point for coordinated entry. |
| Outreach Providers | Those providing Street Outreach are vital to the function of the Coordinated Entry System, providing an important access "entry" point for persons who are not seeking assistance or unable to seek assistance via projects that offer crisis housing or emergency shelter. |
| HMIS Lead Agency | WVCEH is the Lead Agency for HMIS and therefore works in tandem with other Coordinated Entry efforts to ensure that a proper prioritization and process in in place, via HMIS, for the entirety of the CoC. |
| Participating Provider | An agency or organization who has agreed to provide homelessness assistance on behalf of the CoC and ESG State Grantee. A participating project must execute a CE participation agreement with the CoC. The Participation Agreement (forthcoming in the WV BoS CoC) will outline the standards and expectations for the project's participation in |

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| | and adherence to the policies and procedures governing CE operations. |
| Referral Agency | A type of participating project that receives referrals for its projects from the CE system. The referral process will be tracked in HMIS. |
| Non-traditional Provider | An agency or organization who does not traditionally provide homeless services and has agreed to provide Diversion Services and/or Supportive Services in their community/region. |

## COORDINATED ENTRY PROCESS OVERVIEW

**PROCESS**: Each participating agency, with its respective projects, will be an active member of the CoC Coordinated Entry system. The four access "entry" points for the WV BoS CoC Coordinated Entry system are Emergency Shelter (including hotel/motel paid for by a charitable organization), Street Outreach, Coordinated Entry System Intake Line and Supportive Services for Veteran Families (SSVF) providers. Some areas throughout the BoS also have Transitional Housing resources funded through other federal partners and resources, and it is recommended that these providers communicate directly with Coordinated Entry staff to ensure these households are connected with appropriate housing resources. The BoS is divided into eight regions where persons experiencing homelessness are prioritized by region for the appropriate intervention. All Coordinated Entry, Emergency Shelter, Street Outreach, and SSVF programs will utilize Diversion as a service to connect people with other mainstream resources and divert them away from the system who can solve their own homelessness. The VI-SPDAT Prescreen will be utilized as the primary triage assessment for Coordinated Entry when the household is unable to be diverted away from the system. Whenever possible, the VI-SPDAT should be completed in HMIS. When not possible, the VI-SPDAT should be completed in its paper form and then entered into HMIS for each client. 1. For providers not using HMIS, or not permitted by law to utilize HMIS (Domestic Violence Providers), the VI-SPDAT can be completed outside of HMIS. Assessment data related to housing placement is collected without Personally Identifiable Information and can be inputted securely by the staff person at that agency, where it is then managed in an outside housing prioritization guide by the WV BoS CoC Point of Contact via a secure GoogleDoc. The WV BoS CoC Point of Contact will review the guide regularly and contact the DV provider to assist each household with obtaining documents for housing and when the next household on the guide is to be housed.

**STEPS**:

1. **Coordinated Entry and Emergency Shelter Personnel, Outreach Personnel and SSVF Personnel**, will be practicing Diversion as a service with all persons/families at-risk of homelessness or entering into the system for the first and/or second time within a two year period. If a person/family is a frequent user of the homeless services system (three or more times in a two year period) Diversion may still an effective tool for them, but the access "entry" point personnel may choose to skip directly to Step 2. *(We MUST use some good ol' common sense here folks, and that cannot be written into a policy.)*
2. **Only Coordinated Entry, Emergency Shelters, Street Outreach, and SSVF Personnel** will use one of the VI-SPDAT Prescreen Tools as the initial assessment for people experiencing homelessness entering the system, when previous Diversion attempts to connect with other community/housing resources are unsuccessful.
3. There is a specific VI-SPDAT for **Individuals**, one for **Families**, one for **Youth** housed in ServicePoint HMIS.
4. The Prescreen, provides **Coordinated Entry, Emergency Shelters, Street Outreach, and SSVF Personnel** with the ability to determine, across dimensions, the acuity of an individual, family, and youth.
5. Scores on the VI-SPDAT populate to the CoC-wide housing prioritization guide broken down further by CoC region in HMIS allowing the **CoC Coordinated Entry staff** to assign appropriate, eligible persons to community agencies, case managers, and others with housing resources. Housing individuals, families, and youth by acuity, while taking into account other eligibility and vulnerability criteria, such as living situation, length of time homeless, and tri-morbidity.
6. The Housing Prioritization Guide will be broken down into three parts:
    a. The "big" list of everyone entered into a literally homeless project in HMIS (Coordinated Entry System, Street Outreach, Emergency Shelter, SSVF-CES access provider ONLY, Transitional Housing programs)
    b. The "engaged" guide is the list of all households who are entered into a project in HMIS and engaged with a case manager, intake staff, or outreach worker regarding the development of a housing plan.
    *c.* The "actionable" guide is the list of all households who are entered into a project in HMIS, engaged with a case manager, intake staff, or outreach worker regarding the development of a housing plan, and who have all their documents in order to sign a lease and move into a unit. *This does not mean that the inability to obtain a document should cause someone to remain outside, or ever be a reason not to move quickly when a person is highly vulnerable on the street. This part of the guide is to ensure that access "entry" points are assisting clients with moving the documentation*

*gathering process along at the front-set, so case managers may begin to focus on stabilization at initial move-in.*

7. IMPORTANT NOTE: ONLY **Coordinated Entry staff** in the WV Balance of State Continuum of Care will assign beds to Rapid Re-Housing and Permanent Supportive Housing beginning November 1, 2017. Street Outreach providers must be linked to Coordinated Entry, regardless of funding source, in order to prioritize the most vulnerable persons experiencing homelessness in the CoC to appropriate housing interventions. The WV BoS CoC Coordinated Entry System Intake Line number is 1-833-722-2014 and email is ces@wvceh.org. Bi-weekly regional provider calls began in February 2018 and will be continued to assist with the prioritization process and improve communication between access "entry" points and housing providers.

## NON-DISCRIMINATION AND EQUAL ACCESS

The Coordinated Entry system must adhere to all jurisdictionally relevant civil rights and fair housing laws and regulations. All recipients of Federal and state funds are required to comply with applicable civil rights and fair housing laws and requirements. Recipients and sub-recipients of CoC Program and ESG Program funding must comply with the nondiscrimination and equal opportunity provisions of Federal civil rights laws as specified at 24 CFR 5.15(a), including, but not limited to, the following:

Fair Housing Act prohibits discriminatory housing practices based on race, color, religion, sex, national origin, disability, or familial status;

Section 504 of the Rehabilitation Act prohibits discrimination on the basis of disability under any program or activity receiving Federal financial assistance;

Title VI of the Civil Rights Act prohibits discrimination on the basis of race, color, or national origin under any program or activity receiving Federal financial assistance;

Title II of the Americans with Disabilities Act prohibits public entities, which includes state and local governments, and special purpose districts, from discriminating against individuals with disabilities in all their services, programs, and activities, which include housing, and housing-related services such as housing search and referral assistance. Title III of the Americans with Disabilities Act prohibits private entities that own, lease, and operate places of public accommodation, which include shelters, social service establishments, and other public accommodations providing housing, from discriminating on the basis of disability; and

HUD's Equal Access Rule at 24 CFR 5.105(a)(2) prohibits discriminatory eligibility determinations in HUD-assisted or HUD-insured housing programs based on actual or perceived sexual orientation, gender identity, or marital status, including any projects

funded by the CoC Program, ESG Program, and HOPWA Program. The CoC Program interim rule also contains a fair housing provision at 24 CFR 578.93. For ESG, see 24 CFR 576.407(a) and (b), and for HOPWA,
see 24 CFR 574.603.

*Personal Responsibility and Work Opportunity Act of 1996 (PRWORA) and HUD's Homeless Assistance Programs.* Congress restricted immigrant access to certain federal public benefits but also recognized exceptions to protect life or safety, based on a 3-part test. The link below covers the types of assistance funded through the Emergency Solutions Grants (ESG) and the Continuum of Care (CoC) Programs that are covered by the life or safety exceptions to the Act.
https://www.hudexchange.info/resources/documents/PRWORA-Fact-Sheet.pdf

Participants must be informed of the ability to file a nondiscrimination complaint and each participating provider must provide details of who the point of contact is for addressing such complaints. This process should be reviewed at all Coordinated Entry System designated access "entry" points with each participant.

## ACCOUNTABILITY

**STANDARD:** All participating providers should be contributing to and accepting referrals from the WV BoS CoC Coordinated Entry System and working to streamline and regionalize this process. HUD programs (CoC and ESG-funded) are required to participate in the process. For CoC Projects, participation will be directly tied to performance measurement and funding in the WV Balance of State CoC.

**CRITERIA:**

1. The WV BoS CoC is continually working to identify and coordinate homeless services and mainstream resources, as well as, target providers in each CoC region to become leaders in ending homelessness in their own communities, arming these identified groups with the knowledge to end homelessness on a local, grassroots level.
2. In March 2018, the CoC was divided into seven regions and bi-monthly planning meetings were being hosted throughout each region. In January 2019, the CoC regions were revised, and an eighth region was added. Planning meetings are now being hosted quarterly, while access "entry" points and housing providers participate in bi-weekly calls per region to discuss review who in the community needs to be engaged, who needs assistance with collecting documentation, and who is next household to be connected with housing utilizing the housing prioritization guide.
3. The WV BoS CoC Steering Committee members were selected from the eight regions, as a result of the CoC's onsite work with Coordinated Entry in the various

communities. This group must include persons with lived experience and represent a multitude of other disciplines and subpopulations throughout the CoC who will work alongside the CoC staff to drive the overall direction of the WV BoS CoC. Activities and goals for the Steering Committee, and its designated subcommittees, will be as follows:

a. The CoC Guidance, including this document and all other guidance for other CoC funded programs, are considered to be all living documents that change as the CoC changes. So, as the CoC continually moves forward in this planning, implementation, and refining process of the Coordinated Entry System, it is the goal to eliminate the larger regional planning meetings, and run all policy changes and updates through the CoC Steering Committee, and its designated subcommittees.
b. Define areas of CoC Performance Improvement and Build System Capacity through:
    i. Collaboration with Public Housing Authorities to prioritize homelessness and other vulnerable populations, and establish set-aside for homeless people.
    ii. Refining CoC Performance Criteria to rank and rate funded projects including reducing the length of time homeless, degree to which people exited programs for permanent housing, and increases in participant income.
    iii. Expanding system outreach coverage to speed up the documentation, prioritization and referral to permanent housing process.
    iv. Improving system access for the following subpopulations: 1)unaccompanied youth, 2)veterans, 3)victims fleeing domestic violence.
    v. Targeted training and outreach to improve statewide outcomes for SOAR (SSI/SSDI Outreach, Access and Recovery) and increase access to income for persons at-risk and experiencing homelessness who are eligible for SSI/SSDI benefits.

## COC AND ESG COORDINATION

The WV BoS CoC is committed to aligning and coordinating CoC governance, eligibility determinations and prioritization for administering CoC and ESG Program funds. The WV BoS CoC works closely with the State ESG Grantee, the WV Community Advancement

and Development Office, to review performance of shelters, outreach projects, and permanent housing projects receiving ESG and CoC funding, and has created and plans to maintain an annual co-monitoring schedule across the CoC for all CoC and ESG-funded programs. The WV BoS CoC also works closely with the WV Community Advancement and Development Office to evaluate, develop and promote a mutually agreed-upon outline and expectation for all HUD funded programs as it related to the established WV BoS CoC Coordinated Entry Process, as enumerated by regional and community input, and communicated in this document. It is a primary goal among parties to also align monitoring and project performance requirements for both ESG and CoC, when applicable, and within the parameters of the federal regulations for both funding streams, to enhance service delivery across the BoS CoC, regarding overall system performance standards, consistency, and compliance across programs.

## PREVENTION & DIVERSION SERVICES

The WV BoS Coordinated Entry System must ensure access for all program participants who are potentially eligible for homelessness prevention assistance and should also have knowledge of community mainstream resources in each CoC region. All Coordinated Entry access or "entry" points are trained on a specific Diversion assessment and should offer Diversion services prior to entering a household into the homeless services system. Staff at all access "entry" points (Intake Line, Emergency Shelter, Outreach, SSVF) should have knowledge of mainstream resources throughout their designated coverage area, such as Section 8, Public Housing, UDSA properties, Low Income Housing Tax Credit properties, and emergency assistance (DHHR, local churches, etc.) to assist persons in connecting with resources prior to entering into the homeless services system.

1. A household who is at risk of homelessness are assessed, and provided referrals to mainstream low income housing resources and/or emergency assistance resources in their area. Communication with family and/or friends they are staying with may be necessary to assist in this process.
2. A household who is at imminent risk of losing housing (14 days or less), will be provided referrals to mainstream low income housing resources and/or emergency assistance resources in their area. The household will also be assessed and connected with prevention resources in their area, when available. The household may also be connected with legal services regarding evictions, when appropriate.
3. All households contacting the intake line will first be assessed utilizing the Diversion Assessment and connected to mainstream low income housing resources and/or emergency assistance resources in their area, when appropriate. When a household cannot be successfully diverted or the safety of the household is in question, the assessor should work to connect the household quickly to temporary housing. If the household is not able to self-resolve within 14 days, they should then be assessed, utilizing the VI-SPDAT, to determine the appropriate permanent housing intervention. If this is the second diversion attempt, the timeframe to allow for the household to self-resolve should reduce 7 days. (*Again, we cannot write in common sense here, folks, so when you encounter someone*

*who is a frequent user of the homeless services system, Diversion can still be successfully practiced but may be need to be skipped all together depending on that individual household's specific circumstances.)*

4. A household presenting at an Emergency Shelter should be assessed utilizing the Diversion Assessment and connected to mainstream low income housing resources and/or emergency assistance resources in their area, when appropriate. A household should be diverted back to where they were previously staying if it is safe. Communication with family and/or friends they are staying with will be necessary to assist in this process. There should be an agreement with where they are temporarily staying for how long they can remain, with permanent housing being the ultimate goal. When a household cannot be successfully diverted or safety of the household is in question, the Emergency Shelter should offer immediate shelter or a hotel/motel voucher when full, and assist the household over the next 14 days with self-resolving. If the household is not able to self-resolve within 14 days, they should then be assessed, utilizing the VI-SPDAT, to determine the appropriate permanent housing intervention. If this is the second diversion attempt, the timeframe to allow for the household to self-resolve should reduce 7 days. If said Emergency Shelter, does not have funding for hotel/motel vouchers in circumstances when a household is not able to be accommodated, it is important to communicate this need within local community meetings/regional planning meetings to see if there are a few other organizations that may be willing to partner to assist in the effort of developing an effective after-hours plan.
5. Diversion can also be successfully utilized by Street Outreach staff for persons currently living in a place not meant for human habitation.
6. As noted above, it should be a common practice for all access "entry" points to practice diversion. However, it is important to also note that when a person self-identifies as a veteran, it is vital that they are connected with the local VA and/or SSVF provider in their service area, so eligibility for all veteran programs can be verified.

## EMERGENCY SERVICES

Initial screening through the Coordinated Entry System Intake Line is available normal business hours on Monday- Friday from 8:00am- 4:00pm, excluding holidays and weekends. Program participants have an opportunity to leave a message, and the Coordinated Entry Intake Line staff will first triage calls, and are required to return all calls within 3 business days. High priority calls (e.g. program participants contacting the intake line who are unsheltered) must be returned within 1 business day. When participants present during non-business hours, participants should be able to access their local Emergency Shelter, or assisted by either the designated participating provider or non-traditional provider in that area for temporary shelter in a motel/hotel until connection with the Coordinated Entry System Intake Line and/or Outreach in that region can be made on the following business day. If the program participant has been temporarily provided

motel/hotel assistance, it is that participating provider's responsibility to connect them the following business day with the Coordinated Entry System. If your community does not currently have an emergency shelter or any system set up with local organizations to assist with housing crises after regular business hours, this system gap should be discussed at local community meetings and at regional planning meetings in the effort of developing an effective after-hours, which is a notable barrier in isolated, rural communities.

It is important to note that all Emergency Shelters required to participate in HMIS should be tracking bed utilization **daily** to ensure accuracy of vacancies. This information is a fundamental to the referral process for the WV BoS CoC Coordinated Entry System when assisting clients with accessing emergency shelter across a 44 county coverage area.

## COVERAGE AND OUTREACH INTEGRATION

Coordinated Entry in the WV Balance of State CoC covers all of the 44 counties in the Balance of State, through various means. The CoC provides a Coordinated Entry System Intake Line (1-833-722-2014) is operated by two dedicated Coordinated Entry System Specialist. The Coordinated Entry staff can also be contacted by email at ces@wvceh.org which is a useful system of access for participating providers working with households across the CoC. The bi-weekly regional providers calls are utilized to assess community resources and service gaps, as well as, speed up the process with connecting people to housing by identifying needs of particular households through direct communication from Street Outreach providers and other access "entry" points. Since areas assigned to Street Outreach providers are often quite large in a rural BoS CoC, this direct communication allows identification of where any available resources should be allocated.

Shelters, Outreach, SSVF and the Intake Line will utilize HMIS to ensure coverage of Coordinated Entry System across the entirety of the CoC, and will serve as the access "entry" points for persons experiencing homelessness. Through these four points, persons experiencing homelessness will be assessed and prioritized for housing options. Of particular importance is the integration of Street Outreach endeavors with Coordinated Entry, as Street Outreach provides contact with individuals, families, and youth who are on the street, in the woods, and in places not meant for human habitation who otherwise may not access housing and services via an 'office setting' such as an agency or as shelter, or may not be comfortable calling the Coordinated Entry System Intake Line. The position of Outreach as a core access "entry" point centralizes access for persons who otherwise would have no, or little, access and solidifies the commitment by Street Outreach providers to perform active, quality outreach to persons who might otherwise not actively engage with the System.

The BoS CoC and HMIS staff are responsible for working with system access "entry" points (Intake Line, Street Outreach, Emergency Shelters, SSVF), providing TA and

education on best practices to these designated providers on their respective roles while concurrently identifying system coverage gaps. Likewise, the WV BoS CoC is working directly with the WV Office of Community Advancement and Development and the WV Bureau for Behavioral Health and Health Facilities to ensure that all providers receiving Federal dollars for street outreach in the WV BoS CoC:

1. Understand the concepts, best practices, and strategies that encompass quality street outreach or receive the training to do so.
2. Fully integrate street outreach with the coordinated entry process for the CoC; understanding the roles, responsibilities, and geographies for which street outreach is to be provided.
3. Agencies commit via Memorandum of Understanding with the respective state agencies and WV BoS CoC to ensure that their street outreach endeavors are part of the coordinated entry process, receive training to do so, and remain housing-focused in their endeavors through the ongoing measurement of outcomes.

## ACCESSIBILITY OF SYSTEM ACCESS "ENTRY" POINTS

The WV BoS CoC Coordinated Entry process will cover the CoC's entire 44 county geographic area which has been divided into eight distinct region and be accessible by all persons. As mentioned previous, the WV BoS CoC utilizes a Coordinated Entry Model with four primary access "entry" points for housing placement throughout the CoC: Emergency Shelter (including hotel/motel paid for by a charitable organization), Street Outreach, SSVF providers and the Coordinated Entry System Intake Line. Some areas throughout the BoS also have Transitional Housing resources funded through other federal partners and resources, and at this time, it is recommended that these providers communicate with Coordinated Entry staff to ensure these households are connected with appropriate housing resources. There is a comprehensive advertisement strategy for Coordinated Entry including social media, a dedicated page on the WVCEH website, and toll-free number which is provided to traditional & non-traditional providers throughout the CoC. The WV BoS CoC maintains a relationship with the disability providers on the statewide and local levels which provides updated information on how to access braille, audio, large-type, assistive listening devices, and sign language interpretation resources. The WV BoS CoC partners with Centers for Independent Living across West Virginia to ensure that all CoC guidance or materials released are accessible to all persons, in addition to, the coordination of annual training regarding equal access, requesting accommodations in shelter and housing for persons with disabilities, and fair housing law. In remote areas of WV, the WV BoS CoC has spent time building rapport with persons experiencing homelessness and formerly homeless, community members and local providers to raise awareness of available resources. The WV BoS CoC also works closely with and makes regular referrals to Legal Aid of West Virginia, regarding client rights, such as tenancy issues due to improper eviction processes, client capacity and safety

issues, and other serious issues, such as negligence or maltreatment by a service provider. The WV BoS CoC worked with local and statewide partners to develop and release advertising material across the CoC with information on how to access the Coordinated Entry System and is currently evaluating and working to improve procedures to ensure equal access and awareness for all population groups. The WV BoS CoC is utilizing HMIS to assess racial disparities throughout the BoS, as well as, the need for interpreters in various regions across the CoC. These procedures will be assessed on an annual basis.

For All Populations

All persons participating in any aspect of Coordinated Entry such as access, assessment, prioritization, or referral shall be afforded equal access to Coordinated Entry services and resources without regard to a person's actual or perceived membership in a federally protected class such as, race color, national origin, religion, sex, age, familial status, or disability. Additionally, all persons in populations and subpopulations in the WV BoS CoC's geographic area, shall have fair and equal access to the Coordinated Entry system. Each participating provider in the Coordinated Entry system is required to post or otherwise make publicly available a notice (provide by the WV BoS CoC) that describes the Coordinated Entry system. There should be identified staff at each agency who can explain the Coordinated Entry process to clients.

Persons Fleeing Domestic or Partner Violence

1. Individuals fleeing domestic and partner violence are defined as literally homeless under HUD guidance. Due to VAWA privacy protections, however, providers who offer services for those fleeing domestic or partner violence, are not permitted to enter data into HMIS nor are providers permitted to reveal personally identifiable information on persons fleeing domestic violence.
2. It is incumbent upon providers participating in the Coordinated Entry System, regardless of project type, to offer safety and accommodation to persons fleeing domestic violence while safeguarding privacy and confidentiality.
3. The Coordinated Entry process is currently being delineated with DV providers in order to provide a safe and effective way to prioritize and house people fleeing from Domestic or Partner Violence. All access "entry" points shall conduct initial screening of risk or potential harm perpetuated on participants, and when present risk is identified, the participant should be referred immediately to available DV services.
4. For providers not using HMIS, or not permitted by law to utilize HMIS (Domestic Violence Providers), the VI-SPDAT can be completed outside of HMIS. Assessment data related to housing placement is collected without Personally

Identifiable Information and can be inputted securely by the staff person at that agency, where it is then managed in an outside housing prioritization guide by the WV BoS CoC Point of Contact via a secure GoogleDoc. The WV BoS CoC Point of Contact will review the guide regularly and contact the DV provider to assist each household with obtaining documents for housing and when the next household on the guide is to be housed.

5. **It is vital to note that every effort must be made to safely house those who are victim of domestic violence, dating violence, sexual assault, or stalking and that these individuals and families absolutely cannot be denied access to the housing and services prioritization process.**

Veterans

1. The process for prioritization of veterans through the Coordinated Entry system is being developed by VA providers to ensure that Veterans are connected with the appropriate resources. VA providers are currently participating in the CoC regional planning meetings, and VAMC's are hosting either their own bi-name list calls or participating in the CoC regional provider calls. There will be one point person charged as the lead Coordinated Entry contact for all four of the VAMC's in West Virginia. The Veteran Subcommittee, comprised of representative from the WV VAMC Coordinated Entry Committee, the WV BoS COC and SSVF Grantees continue to develop guidance regarding the coordination and prioritization of SSVF, GPD, HCHV, and HUD-VASH resources within the WV BoS Coordinated Entry System. The goal is thorough integration and effective prioritization of Veteran resources into the WV BoS CoC Coordinated Entry System.2
2. In regards to SSVF programs exclusively, **SSVF providers will act as fourth access point** offering Diversion Services to all persons experiencing homelessness. It is important to understand that in rural communities that the veteran may seek out the SSVF agency directly. At that time, the following steps should be completed by the SSVF provider:
    a. **Practice Diversion as a service with all persons/families at-risk of homelessness or entering into the system** for the first and/or second time within a two year period. If a person/family is a frequent user of the homeless services system (three or more times in a two year period) Diversion may still an effective tool for them, but the access "entry" point personnel may choose to skip directly to Step b.
    b. Complete one of the VI-SPDAT Prescreen Tools as the initial assessment for people experiencing homelessness entering the system, when previous Diversion attempts to connect with other community/housing resources are unsuccessful.

c. There is a specific VI-SPDAT for **Individuals**, one for **Families**, one for **Youth** housed in ServicePoint HMIS.
d. The Prescreen, provides the ability to determine, across dimensions, the acuity of an individual, family, and youth.
e. Scores on the VI-SPDAT populate to the CoC-wide housing prioritization guide broken down further by CoC region and veteran subpopulation in HMIS allowing the **CoC Coordinated Entry staff** to assign next veteran household to the next available, Housing individuals, families, and youth by acuity, while taking into account other eligibility and vulnerability criteria, such as living situation, length of time homeless, and tri-morbidity.
f. Eligibility for the SSVF program is always determined by the SSVF provider. However, the Coordinated Entry provider maintains the integrity of the housing guide and oversees the referral process. Coordinated Entry staff in the WV BoS CoC will be responsible for prioritizing and referring the next eligible veteran to the SSVF program in that region, as the SSVF provider(s) in that area are simultaneously gathering documentation for eligible households and locating units. It is the SSVF provider's responsibility to keep open communication with Coordinated Entry staff regarding program capacity and unit availability. For regions with multiple SSVF programs, all parties will be responsible for maintaining open communication with Coordinated Entry staff regarding pending, current, and outstanding referrals during the bi-weekly calls to maintain transparency.
g. Upon assessment, if the veteran is found to be not eligible for SSVF resources, they should be referred to Coordinated Entry by the SSVF provider to be connected with the housing intervention.
h. At times when a veteran contacts the Coordinated Entry Intake Line first, Coordinated Entry will complete the initial assessment and connect the veteran directly to the SSVF provider in that area to assist with gathering documentation for eligibility.

Youth

1. Prioritizing Youth should be considered a 'separate' endeavor for a myriad of reasons. Youth experiencing homelessness should be stabilized in housing, using the TAY VI-SPDAT or Youth Full SPDAT, as quickly as possible. Youth should not be 'passed over' and left in shelter as a result of the regular prioritization process.
2. The reasons for a separate prioritization of youth include the inherent problems that can arise with youth remaining in shelter or on the street, aging into chronicity, and lacking the depth of service to navigate them from instability to permanent housing. A life of shelter to job or shelter to work without additional supports is

guaranteed failure for youth. Therefore, care must be taken to rely upon good housing providers and case management to ensure that permanent housing and intensive case management is provided to youth clients, particularly those coming from the street or shelter.

3. WV BoS staff is currently working to target youth providers across the CoC, the Bureau for Children and Families, the Bureau for Juvenile Services, Children's Home Society of West Virginia, and the Department of Education to collect additional data to identify need, expand youth street outreach programs and build system capacity to serve unaccompanied youth under 18 and transition age youth 18-24.

Persons with Disabilities

The WV BoS CoC will ensure that all participating providers deliver services which are physically accessible to persons with mobility barriers and provide equal access to persons seeking services 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 2000 (42 U.S.C. 15002), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability. Evidence of any disabling condition listed above may qualify as eligibility criteria for specific types of housing assistance, such as Permanent Supportive Housing; however, should never be a barrier to entry for any other housing assistance across the WV BoS CoC.

Evidence of diagnosis 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 2000 (42 U.S.C. 15002), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability, must include one of the following forms of documentation for Permanent Supportive Housing projects:

a. Written verification of the condition from a professional licensed by the state to diagnose and treat the condition;
b. Written verification from the Social Security Administration;
c. Copies of a disability check (e.g., Social Security Disability Insurance check or Veteran Disability Compensation);
d. Intake staff (or referral staff) observation that is confirmed by written verification of the condition from a professional licensed by the state to diagnose and treat the condition that is confirmed no later than 45 days of the application for assistance and accompanied with one of the types of evidence above; or
e. Other documentation approved by HUD.

It is also important to note here that the housing prioritization guide is to be utilized just as it is titled, as a "guide". When a household is eligible for a particular Permanent Supportive Housing program in their area and the resource is not available or will not be available in a reasonable amount of time, the Coordinated Entry staff should work with the available housing resources in that area (e.g. Rapid Re-Housing) to ensure the household is connected quickly to housing. In respect to households who meet the eligibility criteria of CoC-funded Permanent Supportive Housing, but of which there is no Permanent Supportive Housing resource available in the community or region of the client's choice, Rapid Re-Housing resources may be utilized as "bridge housing" until a Permanent Supportive Housing unit is available or the client may remain in Rapid Re-Housing if that intervention demonstrates it is meeting their housing stability needs. Since Coordinated Entry is the primary referral entity throughout the BoS, staff should be trained on standardized assessment techniques and always be aware steering a protected class under the Fair Housing Act to a particular housing program. Although a household meets eligibility requirements for a specific program, it is important to ask assessment questions in such a way that a household is not being steered toward a particular program. When assessing for eligibility of the HOPWA program, the assessor should gather information obtained from the VI-SPDAT question — "If there was space available in a program that specifically assists people that live with HIV or AIDS, would that be of interest to you?," along with all other necessary information, in order to make an informed decision on the most appropriate housing intervention for each household. The way the VI-SPDAT question is worded in the previous example helps to eliminates steering the household toward a particular program due to their disability status and allows the household to have options which is in compliance with Fair Housing law.

Minority, Ethnic, and Groups with Limited English Proficiency

All Coordinated Entry communications and documentation will be accessible to persons with limited ability to read and understand English. As previously mentioned, the WV BoS CoC is currently evaluating and working to improve procedures to ensure equal access for all population groups & advertising methods across the CoC. The WV BoS CoC is utilizing HMIS to assess racial disparities throughout the BoS, as well as, the need for interpreters in various regions across the CoC, which will be reviewed on an annual basis.

## CLIENT INTAKE PROCESS THROUGH COORDINATED ENTRY

**STANDARD**: The program will be an active member of the CoC Coordinated Entry System and one of the four types of identified system access "entry" points: Emergency Shelter (including hotel/motel paid for by a charitable organization), Street Outreach,

SSVF, and the Coordinated Entry System Intake Line. The program will have minimal entry requirements to ensure the most vulnerable of the population are being served. The program will ensure active client participation and informed consent. All programs identified as a system access "entry" point will utilize the VI-SPDAT as the initial Prescreen for the Coordinated Entry System, when households are unable to be successfully diverted to other mainstream and/or community resources.

**CRITERIA**:

1. All adult program participants must meet the eligibility requirements by appropriate program.
2. **Programs may require participants to meet only additional program eligibility requirements as they relate specifically to federally, state-guided, and Continuum of Care, eligibility in writing (not local or agency-mandated additional assessments, criteria, or stipulations).**
3. The only reasons programs may have the option to disqualify an individual or family from program entry are:
    a. All program beds full.
    b. Household does not meet eligibility requirements for the program as outlined in specific program regulations. The issue of ineligible clients being referred to programs should be reduced significantly, since all referrals will go through Coordinated Entry.
    c. Household make-up, provided it does not violate HUD's Fair Housing and Equal Opportunity requirements (Singles-Only programs can disqualify households with children, Families-Only programs can disqualify single households, etc.)
    d. Rental subsidy money has been exhausted. If a program has exhausted funding for the year, Coordinated Entry staff should be notified immediately, and the household should be referred back to Coordinated Entry to be connected with another housing option.
    e. If the 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 same housing facility. (CFR 578.93).
    f. Specific programs may assess income limits.
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 household member to participate in program services, but does make service usage a requirement or the denial of services a reason for disqualification or eviction.
7. The program will maintain Release of Information, Case notes, and all pertinent demographic and identifying data in HMIS. Paper files can also be kept as long as they are stored in a secure location.

## ASSESSMENT AND SCREENING

### Common Assessment Tool

The Suite of VI-SPDAT products (Individual, Family, TAY-Youth, and Diversion/Prevention) are used as the common assessment tools for entry into the Coordinated Entry System. The use of the VI-SPDAT tools populates the CoC Housing Prioritization Guide (by CoC region), supplying the most critical component of assessment and prioritization. All assessments are available within HMIS, save for the Diversion/Prevention VI-SPDAT which, as of this writing, is not available in HMIS. For Diversion and Prevention, however, a Diversion Assessment does exist in HMIS for Providers (particularly Shelters and Prevention Providers) although it is not auto-calculating like the remaining VI-SPDAT tool.

The program will utilize the Individual and Family VI-SPDATs in ServicePoint HMIS for all clients, thereby populating a housing prioritization guide per CoC region, by acuity, showing clients who most likely need:

1. Housing First/Permanent Supportive Housing;
2. Rapid Re-housing
3. Diversion (no or very little housing supports, and connection to other mainstream housing resources).

For Youth, the Transition-Aged Youth VI-SPDAT (TAY) enables the CoC to prioritize by:

1. Long-Term Housing with High Service Intensity.
2. Time-Limited, Moderate Intensity Housing.
3. Diversion (no or very little housing supports).

The VI-SPDAT is an evidence-informed common assessment tool and 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.

Based upon the Prescreen Acuity Score of the VI-SPDATs, the CoC can arrive at best possible housing intervention that applies, as follows:

**VI-SPDAT V.2 Individuals**

| Intervention Recommendation | VI-SPDAT Prescreen Score for **Individuals** |
|---|---|
| Permanent Supportive Housing/Housing First | 9+ |
| Rapid Re-Housing | 4-7 |
| Diversion | 0-3 |

**VI-SPDAT V.2 Families**

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

**VI-SPDAT V.1 Transition Age Youth**

| Intervention Recommendation | VI-SPDAT Prescreen Score for **Youth** |
|---|---|
| Long-Term Housing w/High Service Intensity | 8+ |
| Time-Limited, Moderate Intensity | 4-7 |
| Diversion | 0-3 |

When a VI-SPDAT Prescreen is performed for a client who was not successful diverted and entering the system for assistance, ServicePoint Users from delegated access “entry” points can tag the VI-SPDAT to be included in the CoC-wide housing prioritization guide. Likewise, the WV BoS CoC Coordinated Entry will provide an intake line, connecting regularly with Emergency Shelter and Outreach providers, to provide assessment and follow up for all clients entering the system. All access “entry” points must provide participant autonomy to freely refuse assessment questions and housing options without

retribution or limiting their access to assistance. For example, in cases where a person is too severely mentally ill to complete the VI-SPDAT assessment, the full SPDAT may be completed to develop a more accurate picture of a person's particular needs. The VI-SPDAT was created to be a triage tool to assist with prioritizing housing resources, and the inability to complete the assessment should never be barrier to housing.

**Full SPDAT**

The Full SPDAT (Individual, Family, and TAY) are more intensive assessments that use many of the same dimensions as the VI-SPDAT to determine the acuity of clients. The Full SPDATs require formalized training from OrgCode or the WVCEH/BoS CoC Staff. The Full SPDATs can be used to better determine the acuity of clients whose acuity is more difficult to determine via the VI-SPDAT (borderline cases, "ties" on the Housing Prioritization Guide, persons not responsive to the VI-SPDAT, etc.) but is primarily a value as an intensive ongoing case management tool. Plainly put, the VI-SPDATs are used as triage and prioritization tools, and the Full SPDATs are used after program intake to measure acuity over time in order to focus case management, and as a benefit to the community for service planning.

Use of the Full SPDATs primarily comes into play once a client in securely established in housing, after the Housing Prioritization Guide and Housing Placement Phase, and right as Case Management begins in earnest.

The Acuity measure of the Full SPDATs, is calculated differently than the VI-SPDATs due to the nature of the more comprehensive assessment and the depth of questions. Acuity via the Full SPDATs is:

**Full SPDAT Acuity Scale for Individuals V. 4.0**

| Intervention Recommendation | SPDAT Score for **Individuals** |
|---|---|
| Permanent Supportive Housing/Housing First | 35-60 |

| | |
|---|---|
| Rapid Re-Housing | 20-34 |
| Diversion | 0-19 |

**Full SPDAT Acuity Scale for Families V. 2.0**

| Intervention Recommendation | SPDAT Score for **Families** |
|---|---|
| Permanent Supportive Housing/Housing First | 54-80 |
| Rapid Re-Housing | 27-53 |
| Diversion | 0-26 |

**Full SPDAT Acuity Scale for Youth V. 1.0**

| Intervention Recommendation | SPDAT Score for **Youth** |
|---|---|
| Permanent Supportive Housing/Housing First | 35-60 |
| Rapid Re-Housing | 20-34 |
| Diversion | 0-19 |

**ASSESSMENT STEPS:**

1. **Coordinated Entry, Emergency Shelters, Outreach Personnel, and SSVF Providers** will utilize the VI-SPDAT, Family VI-SPDAT, or TAY VI-SPDAT for entrance into the housing and homelessness assistance system when a household is not successful diverted.
2. Once a client is engaged in services by one of the identified system access "entry" points, every effort will be made to provide suitable triage for persons living in a place not meant for human habitation through identified access "entry" points. Triage would include emergency shelter or hotel/motel vouchers. Triage is any

temporary housing situation that can be utilized until more permanent housing placement can be made (RRH, PSH, TH).

3. Street Outreach, Emergency Shelter, SSVF and Coordinated Entry System Intake Line staff should be working intensely to assist engaged clients with obtaining required documentation for housing (ID, birth certificate, documentation for length of time, etc.). However, it is important to note here that documentation should never become a barrier to housing a high acuity, vulnerable client. A client should never feel pressured or forced to provide information that they do not wish to disclose, including specific disability or medical diagnosis information. *An important note for SSVF providers in regards to document readiness:* SSVF providers are required to assist all engaged veterans with obtaining required documentation for housing. SSVF providers are also required to assess non-veterans and ineligible veterans who are unable to be diverted and provide a timely referral to the Coordinated Entry staff to assist the non-veteran or ineligible veteran with documentation gathering. There may also be rare circumstances in a rural setting throughout the BoS where the SSVF provider is the only provider in town and will be asked to assist the non-veteran or ineligible veteran with scanning in and/or faxing documentation and information to the Coordinated Entry staff.
4. Coordinated Entry staff will follow the order of priority by program type, prioritizing by acuity score, while assessing a multitude of factors such as, program eligibility criteria, barriers to access housing, length of time homeless, disabling conditions, street homelessness, client location and unit availability by region to identify and refer each household to the appropriate housing intervention.
5. The Coordinated Entry staff oversees the housing prioritization guide and make referrals utilizing the Homeless Management Information System (HMIS) to the appropriate housing intervention in each region. Details on the referral process are outlined below in the *Referrals and Assigning Units with Client Choice section.*

## PRIORITIZATION AND CORE COMPONENTS OF HOUSING ASSISTANCE

Program eligibility does not drive placement in the WV BoS CoC. Rather, placement is driven by acuity and need via prioritization. The WV BoS CoC Coordinated Entry System and Subsystems creates equal access for all populations and sub-populations by relying on an actionable, rapid prioritization that considers clientele across various aspects of the Continuum simultaneously.

All population groups experiencing homelessness are prioritized on a common list (housing prioritization guide) by CoC region utilizing the latest versions of the VI-SPDAT for Singles, the VI-SPDAT for Families, and the VI-SPDAT for Transition Age Youth,

respectively. Households are matched to units based on acuity, need, client choice, and availability of units. As a first step, Diversion should be performed for all persons initially accessing resources, exhausting all other mainstream housing and income options before placement into the narrow band of HUD homeless assistance resources, if at all possible.

## Transitional Housing Assistance

Prioritization and housing placement for Transitional Housing in the BoS CoC comes in three basic "flavors":

1. "Bridge Housing" for high acuity people being "spring-boarded" into other types of permanent housing. It is also important to note that if a client enters in to Transitional Housing chronically homeless, that they are still eligible for homeless housing assistance post exit, but they are no longer eligible for Dedicated Permanent Supportive Housing beds.
2. Interdictions for Youth who otherwise cannot or will not thrive in regular modes of permanent housing (PSH, RRH, or Public and Market Rate Housing).
3. Persons in shelter or from the street with no immediate access to permanent housing.

Placements into Transitional Housing should be of moderate to high acuity (generally, 8-12 on the VI-SPDATs) and be awaiting document-readiness for placement from the housing prioritization guide. Transitional Housing should NOT be considered a destination or a measure that exhausts its length of stay requirements (generally, 18-24 months).

## Rapid Rehousing Assistance

**Order of Priority for Rapid Re-Housing:**

Utilizing a standardized assessment tool, eligibility criteria for all Rapid Re-housing programs throughout the CoC by region, and taking into account client choice, the CoC has set guidelines for Coordinated Entry to prioritize the following households for Rapid Rehousing assistance.

1) A household who is chronically homeless and living in a place not meant for human habitation.
2) A household whose length of time homeless is longer than a year, but not chronically homeless, and living in a place not meant for human habitation.
3) A household who is chronically homeless and living in emergency shelter.
4) A household whose length of time homeless is longer than a year, but not chronically homeless, and living in emergency shelter.
5) A household whose length of time homeless is less than a year and living in a place not meant for human habitation.

6) A household whose length of time homeless is less than a year and living in emergency shelter.

*Other criteria to assess when prioritizing for Rapid Re-housing assistance:*

- Household member with multiple disabling conditions (tri-morbidity/co-morbidity) and currently living in a place not meant for human habitation.
- Household member over the age of 60 and currently living in a place not meant for human habitation.
- Household with a single parent and 3 or more dependent children.
- Household consisting of unaccompanied youth.
- Household currently fleeing domestic violence.

The application of Rapid Rehousing resources will vary greatly by geography, availability, and community need. Rapid Re-Housing is housing created for the purpose of providing an immediate permanent housing situation for moderately vulnerable individuals. Common types of Rapid Re-Housing include HUD CoC Rapid Re-Housing, Emergency Solutions Grant funded Rapid Re-Housing (ESG), and Supportive Services for Veteran Families funded Rapid Re-Housing (SSVF). Contemporary research has shown Rapid Re-Housing to be one of the most effective types of housing in the fight to end homelessness from both a cost and housing stability perspective.

Rapid Re-Housing programs should adopt a housing first philosophy, and all programs in the WV BoS CoC are encouraged to do so. This practice is guided by the belief that people need basic necessities like food and a place to live before attending to anything less critical, such as getting a job, budgeting properly, or attending to substance use issues. Rapid Re-Housing projects have tremendous latitude in determining the type of population the project will serve, and a great degree of flexibility in how subsidies are applied, in duration and amount, to house and stabilize individuals and families. Many Rapid Re-Housing projects are utilized to end homelessness among youth and family populations, while a host of others design their services to specifically target the needs of families, survivors of domestic violence, and persons experiencing chronic or episodic homelessness.

*Joint TH and PH-RRH*

The Joint TH and PH-RRH component project combines two existing program components–transitional housing and permanent housing-rapid rehousing– in a single project to serve individuals and families experiencing homelessness. Both components of the program are required to adopt a Housing First approach and program participants may only receive up to 24-months of total assistance. The type of housing proposed,

including the number and configuration of units, must fit the needs of the program participants (e.g., two or more bedrooms for families). The project will provide enough Rapid Re-Housing assistance to ensure that at any given time a program participant may move from Transitional Housing to permanent housing. This may be demonstrated by identifying a budget that has twice as many resources for the Rapid Re-Housing portion of the project than the Transitional Housing portion, by having twice as many PH-RRH units at a point in time as TH units, or by demonstrating that the budget and units are appropriate for the population being served by the project. The ultimate goal of the program is to connect clients with permanent and stable housing, while ensuring client choice throughout this process. Joint TH and PH-RRH programs are required to be an active participant in the Coordinated Entry System referral process. Please reference the previous sections—*Transitional Housing Assistance* and *Rapid Re-Housing Assistance* which outline the prioritization process for each component.

## Permanent Supportive Housing Assistance

**Order of Priority of Permanent Supportive Housing:**

### CoC-FUNDED DEDICATED CHRONICALLY HOMELESS BEDS

A critical role of any Coordinated Entry System is to provide the quickest access to housing and supports for persons who are most likely to die on the streets. In the West Virginia Balance of State CoC, people would be considered those individuals and families who meet the criteria for chronic homelessness, have the longest length of time homeless, severe service needs, and highest acuity scores on the VI-SPDAT. Given the questions asked on the VI-SPDAT as to length of time homeless, residence prior, the presence of mental health and acute health conditions, and risk factors, the VI-SPDAT tool is an excellent tool for the WV BoS CoC to use for the prioritization of people for housing. The following is the priority by which all Chronically Homeless individuals and families will be prioritized for permanent supportive housing for projects with dedicated beds for those experiencing chronic homelessness. Dedicated Permanent Supportive Housing beds are those which required through their grant agreement to only serve persons experiencing chronic homelessness unless there are no persons within the CoC's geographic area that meet that criteria. If there are no persons experiencing chronic homelessness at the time of a bed vacancy, Coordinated Entry staff will follow the Order of Priority listed below to make a referral to the next available Dedicated bed. Once a new Dedicated bed becomes vacant again, the Coordinated Entry staff will assess to determine if there is a chronically homeless individual or family throughout the CoC (by region) at the time.

### CoC-FUNDED NON-DEDICATED CHRONICALLY HOMELESS BEDS

Non-Dedicated beds are always encouraged to change their Permanent Supportive Housing programs to Dedicated beds, and at a minimum, are encouraged to prioritize the chronically homeless beds as they become vacant until there are no persons throughout the entire CoC's geographic area (per CoC region) who meet this criteria. Non-Dedicated beds being prioritized for chronically homeless individuals and families may be increased at any time during the operating year and may occur without an amendment to the grant agreement.

**CoC-FUNDED DEDICATEDPLUS CHRONICALLY HOMELESS BEDS**

During the FY2017 NOFA, the concept of DedicatedPLUS Permanent Supportive Housing beds was introduced, allowing for households who are highly vulnerable, but not currently experiencing chronic homelessness, to be served in a timely manner. This concept was not released in order for programs to "get around" serving those who are highly vulnerable and often thought to be, difficult to serve. The concept of DedicatedPLUS was strictly created to eliminate the barriers to services for the following areas:

- The challenge of working with an individual who likely meets the definition of chronically homeless and is highly vulnerable, yet adequate third-party verification is not readily available.

- Household who had met the eligibility criteria for Permanent Supportive Housing, but then resided in Transitional Housing because there were no other options available at the time.

- Household experiencing chronic homelessness that the initial permanent housing situations did not work, and they ended back on the street. However, they were in the unit long enough to count as a break and affect their status.

- Persons who had been residing on the street for several years, and recently had a stay longer than 90 days in an institutionalized setting. However, they were discharged back to the street or shelter.

- Household whose length of time homeless equals 12 months or longer in the past three years, but the number of episodes is less than four.

A DedicatedPLUS project is a CoC-funded permanent supportive housing project where the entire project will serve individuals and families that meet one of the following criteria at project entry:

1) Experiencing chronic homelessness as defined in 24 CFR 578.3;

2) Residing in a transitional housing project that will be eliminated and meets the definition of chronically homeless in effect at the time in which the individual or family entered the transitional housing project;
3) Residing in a place not meant for human habitation, emergency shelter, or safe haven; but the individuals or families experiencing chronic homelessness as defined at 24 CFR 578.3 had been admitted and enrolled in a permanent housing project within the last year and were unable to maintain a housing placement;
4) Residing in transitional housing funded by a Joint transitional housing (TH) and rapid re-housing (PH-RRH) component project and who were experiencing chronic homelessness as defined at 24 CFR 578.3 prior to entering the project;
5) Residing and has resided in a place not meant for human habitation, a safe haven, or emergency shelter for at least 12 months in the last three years, but has not done so on four separate occasions; or
6) Receiving assistance through a Department of Veterans Affairs (VA)-funded homeless assistance program and met one of the above criteria at initial intake to the VA's homeless assistance system.

**STANDARD:** Programs receiving CoC-funded Permanent Supportive Housing which have beds that are dedicated to serve individuals and families who are identified as chronically homeless are required to follow the order of priority in accordance with the Order of Priority section of Notice CPD-16-11, and per the agreed-upon Order of Priority as established by the WV Balance of State CoC when selecting participants for housing. The WV BoS CoC utilizes a Coordinated Entry Model with four primary access “entry” points for placement of Permanent Supportive Housing clients throughout the CoC. The four access “entry” points for Coordinated Entry— Emergency Shelter (including hotel/motel paid for by a charitable organization), Street Outreach, SSVF and the Coordinated Entry System Intake Line (operated by the WV Coalition to End Homelessness) must exercise due diligence when conducting outreach and assessment to ensure that persons are served by the established Order of Priority, as adopted by the Balance of State CoC. Chronic Homeless status and other established prioritization criteria are clearly indicated on the CoC-wide housing prioritization guide, making adherence to the following priority simple and straightforward. The prioritization process by CoC region considers access for all population groups, barriers to service, and allows Coordinated Entry staff to work with local access “entry” points to assess and evaluate each household’s needs when referring to a Permanent Supportive Housing bed.

**CRITERIA:** The following is the Order of Priority by which all Chronically Homeless individuals and families will be prioritized for Permanent Supportive Housing resources for projects with Dedicated, Non-Dedicated, and DedicatedPLUS beds throughout the

WV BoS CoC. HOPWA programs are also advised to utilize this Order of Priority, with the understanding that clients who may be eligible for HOPWA services, and who meet the highest priority, will also be prioritized concurrently for CoC-funded Permanent Supportive Housing resources in their area.

**First Priority –** Chronically Homeless Individuals and Families as defined in 24 CFR 578.3 for which all of the following are true:

- Longest History of Homelessness (3 or more years)
- Most Severe Service Needs (tri-morbidity)
- Residing in a Place Not Meant for Human Habitation
- VI-SPDAT acuity score is 13 or above

**Second Priority –** Chronically Homeless Individuals and Families as defined in 24 CFR 578.3 which all of the following are true:

- Longest History of Homelessness (3 or more years)
- Most Severe Service Needs (tri-morbidity)
- Residing in a Place Not Meant for Human Habitation
- VI-SPDAT acuity score is 8-12

**Third Priority –** Chronically Homeless Individuals and Families as defined in 24 CFR 578.3 which all of the following are true:

- Longest History of Homelessness (3 or more years)
- Most Severe Service Needs (tri-morbidity)
- Residing in an Emergency Shelter (or Safe Haven if applicable to your area)
- VI-SPDAT acuity score is 13 or above

**Fourth Priority –** Chronically Homeless Individuals and Families as defined in 24 CFR 578.3 which all of the following are true:

- Longest History of Homelessness (3 or more years)
- Most Severe Service Needs (tri-morbidity)
- Residing in an Emergency Shelter (or Safe Haven if applicable to your area)
- VI-SPDAT acuity score is 8-12

**Fifth Priority –** Chronically Homeless Individuals and Families as defined in 24 CFR 578.3 which all of the following are true:

- Longest History of Homelessness (3 or more years)
- Less Severe Service Needs
- Residing in a Place Not Meant for Human Habitation

- VI-SPDAT acuity score is 8+

**Sixth Priority –** Chronically Homeless Individuals and Families as defined in 24 CFR 578.3 which all of the following are true:

- Longest History of Homelessness (3 or more years)
- Less Severe Service Needs
- Residing in an Emergency Shelter (or Safe Haven if applicable to your area)
- VI-SPDAT acuity score is 8+

**Seventh Priority –** Chronically Homeless Individuals and Families as defined in 24 CFR 578.3 which all of the following are true:

- Longest History of Homelessness (1-3 years)
- VI-SPDAT acuity score is 8+

**Eighth Priority –** Literally Homeless Individuals and Families as defined in 24 CFR 578.3 which all of the following are true :

- VI-SPDAT acuity score is 8+

The following outlines the criteria that Coordinated Entry staff is to follow once they are down to the **8th priority** for any CoC region that does not currently have any chronically homeless households on their guide, or in a CoC region with highly vulnerable households that has DedicatedPLUS beds available:

1. Longest History of Homelessness:
    a. Household whose length of time homeless equals 12 months or longer in the past three years, but the number of episodes is less than four.
    b. Length of time homeless just shy of one year and is about to age into chronicity.
2. Most Severe Service Needs (tri-morbidity)
3. Residing in a Place Not Meant for Human Habitation
4. Household member over the age of 60
5. Person is currently residing in a literally homeless situation; but the individuals or families experiencing chronic homelessness had been admitted and enrolled in a permanent housing project within the last year and were unable to maintain a housing placement.
6. Persons who have been residing on the street for several years, and now currently residing in an institutionalized setting with no current facility discharge plan. The person still must meet the definition of literally homeless, so this current stay in the institutionalized setting must have been less than 90 days, and they must have entered the institution from a homeless situation.

7. Persons who had been residing on the street for several years, and recently had a stay longer than 90 days in an institutionalized setting long enough to count as a break and affect their status. However, they were discharged back to the street or shelter.
8. Household who had met the eligibility criteria for Permanent Supportive Housing, but then resided in Transitional Housing because there were **no other options available at the time**. There must be documentation in the client file for why PSH is the best housing intervention now for this client. *Household cannot be transferred from Transitional Housing to a Dedicated PSH bed.*

*IMPORTANT NOTE: When observing the Eighth Priority, it is important to note that the eligibility requirements for ALL CoC-funded Permanent Supportive Housing programs, require that the head of household must have a documented disabling condition, as defined in 24 CFR 583.5.*

*For <u>DEDICATED</u> CHRONICALLY HOMELESS BEDS only, CoC-funded projects may only serve the Eighth Priority in regions where there are no other chronically individuals or families have been identified by Coordinated Entry.*

Permanent Supportive Housing is housing created for the purpose of keeping highly vulnerable individuals and families with complex issues from dying on the streets by providing them with a safe, stable place to live coupled with intensive case management. It is, by definition, a potentially permanent type of housing that seeks to provide a stable place for persons who otherwise would not succeed in remaining stable with a Housing Choice Voucher, Public Housing, market rate housing, or homeownership. Permanent supportive housing is a housing type designed for persons with prolific mental health, physical health, and/or substance use issues, including persons who are chronically homeless. Types of permanent supportive housing include HUD CoC Permanent Supportive Housing and HOPWA Tenant Based Rental Assistance, in addition to, other types of housing created specifically at a state or local level to house this population.

Successful permanent supportive housing utilizes a housing first philosophy— the philosophy that all persons can be housed immediately without preconditions of sobriety, income, or behavior. This practice is guided by the belief that people need basic necessities like food and a place to live before attending to anything less critical, such as getting a job, budgeting properly, or attending to substance use issues. Evidence has shown that people experiencing homelessness, even chronic homelessness, can be placed in an apartment with case management services, abide by their lease, and successfully remain in housing over a long period of time. Unsuccessful permanent

supportive housing relies on rules, preconditions, and barriers to obtaining housing, and is not the environment where high need or chronically homeless persons typically thrive.

## REFERRALS AND ASSIGNING UNITS WITH CLIENT CHOICE

**STANDARD:** The program will provide safe, affordable housing that meets participants' needs in accordance with the Coordinated Entry and Prioritization process, based on acuity and eligibility. The program will also provide the most barrier-free, rapid, and successful entry into housing for each eligible client, by acuity, with as few barriers to housing as possible. The program will not concentrate on only the clients eligible for their specific program, but the ability of all clients in a community to access the appropriate housing. Specific diagnosis or disability information may only be obtained for purposes of determining program eligibility to make appropriate referrals. When the housing prioritization guide is pulled from HMIS by Coordinated Entry and reviewed by CoC region, clients always have the option to access housing resources, as available, in the area of their choice and are not confined to resources to a particular region.

### *Notification of Vacancy*

Participating programs are required to notify the WV BoS Coordinated Entry System when they have permanent housing units coming available or vacant. The Coordinated Entry staff can be contacted via phone at 1-833-722-2014 or contacted by email at ces@wvceh.org. Coordinated Entry will provide all referrals throughout the WV BoS CoC to participating programs by region. At this time, vacancies in CoC-funded programs can be tracked in HMIS, and providers should be doing so to ensure utilization of resources CoC-wide. Other participating programs, such as ESG-funded and SSVF-funded programs, should also maintain ongoing communication with the WV BoS CoC Coordinated Entry system regarding notification of upcoming vacancies in their programs in an effort to reduce vacancy rates. As previously discussed, Coordinated Entry staff will host regional bi-weekly provider calls with access "entry" points and housing providers to ensure that the process for notification of unit vacancies, sending referrals, accepting referral, unit location and move-in is reviewed on a regular basis, as households enter and exit the system. The goal of these calls is to speed up the process of connecting people with housing through identifying needs of particular households, increasing knowledge of when units are available, and also working together to ensure HMIS information and documentation is up-to-date and as accurate as possible. Client choice is at the center of any referral and placement, including the household in the next steps of their journey from street into housing, and promoting awareness of the processes to get them there.

All referral procedures from the WV BoS CoC Coordinated Entry System will be performed through ServicePoint (WV Statewide HMIS Implementaiton) for those providers utilizing HMIS. For providers not using HMIS, a traditional mode of phone/email referral will be performed per the protocol outlined by the individual participating partner.

**CRITERIA:**

Referrals to Transitional Housing

All funding streams of Transitional Housing programs will be an active member of the Coordinated Entry system throughout the WV BoS CoC. Transitional Housing may act as an access "entry" point in specific communities, but will also accept referrals directly from Coordinated Entry. This referral process will be tracked in HMIS. As mentioned previously, placements into Transitional Housing should be of moderate to high acuity (generally, 8-12 on the VI-SPDATs) and be awaiting document-readiness for placement from the housing prioritization guide. It is also important to note that if a client enters in to Transitional Housing chronically homeless, that they are still eligible for homeless housing assistance post exit, but they are no longer eligible for Dedicated Permanent Supportive Housing beds. Transitional Housing should NOT be considered a destination or a measure that exhausts its length of stay requirements (generally, 18-24 months).

Referrals to Rapid Re-Housing

All funding streams of Rapid Re-Housing programs will be an active member of the Coordinated Entry system throughout the WV BoS CoC. Rapid Re-Housing programs will act as a referral point for Coordinated Entry who will utilize the Order of Priority (listed below), knowledge of all program eligibility criteria, client need and location, and unit availability to identify and refer the household to the appropriate Rapid Re-Housing program. This referral process will be tracked in HMIS. There is an expectation for all Rapid Re-Housing programs that once a household is referred from Coordinated Entry to a particular program, that the assigned staff at the agency will be directed by the program supervisor to follow up with the appropriate access "entry" point— Coordinated Entry, Street Outreach, Emergency Shelter, or SSVF— where the household is residing in order to make contact to begin the housing process with the goal of project start date/enrollment to move-in being within 20 days or less. It is important to note here for sheltered households, the case manager will make initial contact with the client, allotting 10 days from referral to enrollment. For unsheltered households, Coordinated Entry will refer directly to outreach, when appropriate, allotting 10 days to locate and refer to the permanent housing project. The process from referral to housing in its entirety should be less than 30 days for Rapid Re-Housing projects. In an CoC-wide effort to ensure the most vulnerable of the population are being served, referrals to Rapid Rehousing providers will be tracked in HMIS and during annual review process, be allotted a 10%

denial rate. Any projects falling below this criteria, will not obtain maximum points regarding participation with the Coordinated Entry System during annual CoC ranking and rating. Denial rates will also be tracked in HMIS for all participating providers and information will be provided to funders upon request. All programs will ensure active client participation and informed consent.

Referrals to Permanent Supportive Housing

All types of Permanent Supportive Housing programs will be active members of the Coordinated Entry system throughout the WV BoS CoC. Permanent Supportive Housing programs will act as a referral point for Coordinated Entry who will utilize the Order of Priority (listed above), knowledge of all program eligibility criteria, client need and location, and unit availability to identify and refer the household to the appropriate Permanent Supportive Housing program. This referral process will be tracked in HMIS. There is an expectation for all Permanent Supportive Housing programs that once a household is referred from Coordinated Entry to a particular program, that the assigned staff at the agency will be directed by the program supervisor to follow up with the appropriate access "entry" point— Coordinated Entry, Street Outreach, Emergency Shelter, or SSVF— where the household is residing in order to make contact to begin the housing process with the goal of project start date/enrollment to move-in being within 50 days or less. It is important to note here for sheltered households, the case manager will make initial contact with the client, allotting 10 days from referral to enrollment. For unsheltered households, Coordinated Entry will refer directly to outreach, when appropriate, allotting 10 days to locate and refer to the permanent housing project. The process from referral to housing in its entirety should be less than 60 days for Permanent Supportive Housing projects. In an CoC-wide effort to ensure the most vulnerable of the population are being served, referrals to Permanent Supportive Housing providers will be tracked in HMIS and during annual review process, be allotted a 10% denial rate. Any projects falling below this criteria, will not obtain maximum points regarding participation with the Coordinated Entry System during annual CoC ranking and rating. Denial rates will also be tracked in HMIS for all participating providers and information will be provided to funders upon request. All programs will ensure active client participation and informed consent.

***Program to Program Transfer Policy***

A sound and successful Coordinated Entry System considers the need for transfers between program types to better meet the preferences and needs of a household. A key component to any transfer process is an on-going assessment of a household to determine whether the levels of service are appropriate or need to be increased or reduced. A household may need to transfer to another program within the CES for a myriad of reasons including, though not limited to, changes to family composition, the

defunding of an agency or program, or criminal record for state-mandated restrictions. Providers are often confronted with scenarios in which a household may need most intensive services and require a move from rapid re-housing to permanent supportive housing. The WV BoS CoC CES program transfer policies are focused on providing a flexible strategy to structure assistance to meet a household's needs and employing ongoing assessment to determine those needs.

Transfers between Programs within the Same Program Model

When a current household must transfer to another program within the same program model (RRH to RRH or PSH to PSH), the provider should contact the Coordinated Entry staff to assist in connecting with the receiving provider in the CoC region that the household is being transferred. The receiving provider will review the request and decide on whether the transfer is available and feasible within one week and communicate this decision with the referring provider. If the transfer is approved, the referring provider will be responsible for arranging moving assistance with the new provider. If the request is not accepted, the referring provider may contact Coordinated Entry again to assist with locating other options.

Transfers from One Program Model to Another

RRH is a model for helping individuals and families who are experiencing homelessness to obtain and maintain permanent housing, and it can be appropriate to use as a bridge to other permanent housing programs. Program transfers may be made from RRH to PSH, so long as the household meets the eligibility criteria under the specific program and the requirements for the PSH project in the Notice of Funding Availability (NOFA) for the year the project was awarded. Requests for transfers from RRH to PSH should be offered (when the resource is available) to households who were experiencing chronic homelessness prior to entry into RRH and are requiring additional supports that RRH is unable to provide.

*Households CANNOT be transferred between the following Program Models:*

- PSH to RRH
- TH to PSH (Dedicated beds)
- RRH to TH
- RRH (when the household was not chronically homeless prior to entry) to PSH

## ANNUAL TRAINING FOR AGENCY STAFF

**STANDARD:** The WV BoS CoC is committed to ensuring that all staff who assist with the daily operations of the Coordinated Entry System receive sufficient training to implement

their daily tasks in a manner consistent with the mission and framework of the WV BoS CoC Coordinated Entry System, as outlined in this document.

**CRITERIA:**

1. Annual review of the WV BoS CoC's written Coordinated Entry guidance, including any adopted variations for specific subpopulations.
2. Requirements for use of assessment information to determine prioritization.
3. Protocol for uniform decision-making and referrals.
4. Intensive training for new staff on the use of the assessment tools, along with annual reviews for current staff who work at all identified system access "entry" points.
5. Technical Assistance on an as needed in regards to any updates regarding changes to HMIS as it pertains to the Coordinated Entry System.

## DATA SYSTEMS- PRIVACY AND PROTECTIONS

The WV BoS CoC and all participating providers contributing data to the Coordinated Entry System must ensure participants' data are secured regardless of the systems or locations where participant data are collected, stored, or share, whether on paper or electronically. Additionally, participants must be informed how their data are being collected, stored, managed, and potentially shared, with whom, and for what purpose.

1. All CoC, ESG, and PATH funded programs are required to report client level data in HMIS. The following VA funded programs are also required to report client level data in HMIS— SSVF, GPD, and HCHV. HOPWA and RHY funded programs are also required to report in HMIS, but the client level data is locked down to those providers only for confidentiality of the program participant receiving the services. All non-funded Emergency Shelters are encouraged to participate in HMIS to create a more accurate picture of the need in each community, and in order to connect those households more quickly to housing. The Coordinated Entry staff cannot assess and prioritize a household for housing if they do not know they exist.
2. For providers not using HMIS, or not permitted by law to utilize HMIS (Domestic Violence Providers), the VI-SPDAT can be completed outside of HMIS. Assessment data related to housing placement is collected without Personally Identifiable Information and can be inputted securely by the staff person at that agency, where it is then managed in an outside housing prioritization guide by the WV BoS CoC Point of Contact via a secure GoogleDoc. The WV BoS CoC Point of Contact will review the guide regularly and contact the DV provider to assist each household with obtaining documents for housing and when the next household on the guide is to be housed.
3. Any data collection methods at it relates to Coordinated Entry must adhere to the Violence Against Women's Act. For additional guidance regarding the 2013

reauthorization of VAWA reference, https://www.hudexchange.info/resource/4718/federal-register-notice-proposed-rule-violence-against-women-act-2013-vawa-2013/.

4. Data may not be collected without consent from the participant. All intake line staff are required to obtain verbal release from the client, and record the Release of Information in HMIS. All Street Outreach staff are allotted time to build rapport with the client and may obtain verbal consent for Release of Information in HMIS, until a written release is able to be obtained. All other providers participating in HMIS, should be obtaining a written Release of Information from the program participant which identifies what data will be collected, what data will be shared, which agencies data will be shared with and what the purpose of the data sharing is. Participants should always have the option to decline signing the consent without making them ineligible for services.
5. HMIS should be also be utilized by the Coordinated Entry System to track bed and unit vacancies. This should be done with all participating Emergency Shelters and CoC-funded programs. For ESG-funded and SSVF programs, units may also be tracked in HMIS. However, since ESG and SSVF do not apply for a set number of beds, agency staff should be in communication with Coordinated Entry staff regarding capacity and upcoming vacancies.
6. Participant Assessment Information should be updated at least once a year, if the participant is served by any provider within the Coordinated Entry System for more than 12 months. Staff should be updating any new information in the client record as it becomes known.

## EVALUATION

**STANDARD:** Regular and ongoing evaluation of the Coordinated Entry System will be conducted to ensure that improvement opportunities are identified, that results are shared and understood, and that the Coordinated Entry System is held accountable.

**CRITERIA:**

1. The Coordinated Entry System will be evaluated on the bi-annual using HMIS data. The following results will be published on the WVCEH website and reviewed by the WV BoS CoC Steering Committee including, but not limited to, reduction in the length of time homeless, reduction in the number of persons experiencing first time homelessness, increase in the number of placements into permanent housing, and reduction in the length of time it takes to move from street to housing.
2. The WV BoS CoC will work garner feedback from participating providers and community stakeholders. Participating provider feedback will be collected via the participant feedback survey which is published on the WVCEH website site.

Participating providers and community stakeholders will be directed to the survey during regional meetings and other public events throughout the planning process.

3. The WV BoS CoC will work with frontline staff to collect feedback from program participants on a quarterly basis regarding overall system function. WV BoS CoC staff have contracted with the company, Pulse for Good, to develop a program participant survey. Currently, a pilot study is being conducted with WVCEH direct service staff to collect feedback from clients regarding their full experience from beginning to end with the Coordinated Entry System. Pulse for Good creates simple surveys that are easily accessible on iPADs, where customized kiosks can also be set up at different agencies across CoC, and the survey results are automatically tabulated. The purpose of the program participant survey is to collect meaningful feedback, while utilizing data to assess system successes and failures, allocate resources, and identify service gaps to make program/system-wide improvements.

## APPEAL PROCESS

**STANDARD:** If a program participant or participating provider is dissatisfied with a service, decision, action or situation involving WV BoS CoC Coordinated Entry System, or wish to file a complaint against a perceived incidence of unfair treatment, the following procedures may be followed:

**CRITERIA:**

1. The program participant or participating provider may make a verbal complaint to WVCEH Coordinated Entry System Supervisor (WVCEH Chief Programs Officer, Rachael Coen) at the WVCEH Main Office by phone at 304-842-9522.
2. If the contact with the WVCEH Chief Programs Officer does not resolve the problem or if the program participant or participating provider does not feel comfortable making the complaint to the WVCEH Chief Programs Officer, they may contact the WVCEH Chief Executive Officer, Zachary Brown, at the WVCEH Main Office at 304-852-9522. An attempt to resolve complaint will be made within 5 business days.
3. If the program participant or participating provider is unhappy with the resolution and would like to file a formal written complaint, they may submit a written grievance via mail or email to the WVCEH Board.
4. Within 30 days of receipt, the Board will review the formal complaint and determine best course of action. Complaints regarding the program acceptance or denial process will be reviewed closely on a case by case basis. The Board may require

the individual or agency issuing the complaint to meet with the Board to discuss the need of reconsideration for a particular individual or to obtain additional information from the agency filing the appeal.

5. Within 7 business days after review of the written complaint, the Board will inform the program participant or participating provider of the resolution of the complaint. The decision will be a written letter documenting the original complaint, all measures taken to resolve complaint and the final decision. This letter will be issued to the person or agency making complaint via the Coordinated Entry System email ces@wvceh.org and signed by the Board President. All decisions made by the Board will be final.

The above steps are provided in sequence; however, some steps may be eliminated if the program participant or participating provider wishes. The program participant or participating provider may also at any time complete a formal complaint or an anonymous complaint and returning it to a staff member or via mail. After each step in the process, the program participant or participating provider will receive notice of the actions taken as a result of their complaint. All complaints reported will be documented and kept on file at the WVCEH main office and written copies will be available upon request.

Wayne Bailey 7/2/19

Wayne Bailey
President, WVCEH Board of Directors/WV Balance of State Continuum of Care

7/2/19

Zachary Brown
CEO, WV Coalition to End Homelessness/WV Balance of State Continuum of Care