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Continuum of Care NY-505 Coordinated Entry Policy & Procedures and Project Written Standards

Syracuse/Auburn, Onondaga, Oswego and Cayuga Counties

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Part One: Introduction & Overview

The Continuum of Care (CoC) is responsible for coordinating and implementing a system to meet the needs of the population and subpopulations experiencing homelessness within the geographic area of Onondaga, Oswego and Cayuga Counties. Both the Emergency Solution Grant Rules and Regulations (ESG) and the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Continuum of Care Program Interim Rules state that the Continuum of Care (CoC), in consultation with recipients of Emergency Solutions Grants program funds within the geographic area, (1) establish and consistently follow written standards for providing Continuum of Care assistance, (2) establish performance targets appropriate for population and program type, and (3) monitor recipient and sub-recipient performance.

All programs that receive ESG or CoC funding are required to abide by these written standards. Agency program procedures should reflect the policy and procedures described in this document. The CoC strongly encourages programs that do not receive either of these sources of funds to accept and utilize these written standards.

The written standards have been established to ensure that persons experiencing homelessness who enter programs throughout the CoC will be given similar information and support to access and maintain permanent housing.

The written standards have been created in conjunction with HUD Notice CPD-16-11 issued on July 25, 2016 titled Notice on Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing that can be found online here: <https://www.hudexchange.info/resources/documents/notice-cpd-16-11-prioritizing-persons-experiencing-chronic-homelessness-and-other-vulnerable-homeless-persons-in-psh.pdf>

The Continuum of Care Written Standards will:

- Assist with the coordination of service delivery across the geographic area and will be the foundation of the coordinated entry system;
- Assist in assessing individuals and families consistently to determine program eligibility;
- Assist in administering programs fairly and methodically;
- Establish common performance measurements for all CoC components; and
- Provide the basis for the monitoring of all CoC and ESG funded projects.

The CoC Written Standards have been approved by the CoC, the County and City ESG recipients and providers. The Written Standards will be reviewed and revised as needed at a minimum of once per year by the Governance/Policies Committee and the Coordinated Entry Workgroup.

Coordinated Entry Participation Expectations

All programs that receive ESG or CoC funding are required to abide by these written standards. Agency program procedures should reflect the policy and procedures described in this document. The

CoC strongly encourages programs that do not receive either of these sources of funds to accept and utilize these written standards.

CoC & ESG Coordination

These written standards have been developed in conjunction with ESG recipients (City of Syracuse, Onondaga County) and with service providers to allow for input on the procedure of Coordinated Entry/Assessment System, standards, performance measures and the process for full implementation of the standards throughout the CoC from the perspective of those organizations that are directly providing homeless housing and services, Street Outreach (SO), Emergency Shelter (ES), Transitional Housing (TH), Permanent Supportive Housing (PSH) and Rapid Rehousing (RRH).

Guiding Principles

All CoC and ESG projects are committed to the following community values.

Housing First

Housing providers are required to adhere to a Housing First philosophy and implement this philosophy into their intake process as well as their program process. A Housing First philosophy and intervention must be adopted by all CoC and ESG programs, which lowers barriers to housing by ensuring applicants are not screened out.

Client Centered Approach

Emergency Shelters and Outreach Providers should assess the strengths, goals, risk, and protective factors of all individuals and families prior to referring them to the coordinated entry prioritization list. This will allow the programs to not only identify areas of risk/concern, but also identify areas of strength that will assist the client with maintaining housing stability and increasing overall well-being. Emergency Shelters and Outreach Providers should fully explain the difference in housing options available through the Coordinated Entry system. Clients are able to be referred to both Rapid Re-Housing and Permanent Supportive Housing options.

Serving Victims of Violence

Participants may not be denied access to the coordinated entry process on the basis that the participant is or has been a victim of domestic violence (DV), dating violence, sexual assault or stalking.

Terms and Definitions

Chronically Homeless	HUD’s definition <i>Chronically homeless</i> means: (1) A “homeless individual with a disability,” as defined in Section 401(9) of the McKinney-Vento Homeless Assistance Act,
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	who: i. Lives in a place not meant for human habitation, a Safe Haven, or an emergency shelter; AND ii. Has been homeless continuously for at least 12 months or on at least four separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in (i) above.
Case conferencing	Local process for CE staff to coordinate and discuss ongoing work with persons experiencing homelessness in the community, including the prioritization or active list. The goal of case conferencing is to provide holistic, coordinated, and integrated services across providers, and to reduce duplication.
Continuum of Care	Group responsible for the implementation of the requirements of HUD’s CoC Program Interim Rule. The CoC is composed of representatives of organizations, including nonprofit homeless providers, victim service providers, faith-based organizations, governments, businesses, advocates, public housing agencies, school districts, social service providers, mental health agencies, hospitals, universities, affordable housing developers, law enforcement, organizations that serve homeless and formerly homeless veterans, and homeless and formerly homeless persons.
Continuum of Care (CoC) Program	HUD funding source to (1) promote communitywide commitment to the goal of ending homelessness; (2) 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; (3) promote access to and effect utilization of mainstream programs by homeless individuals and families; and (4) optimize self-sufficiency among individuals and families experiencing homelessness.
Emergency Shelter	Short-term emergency housing available to persons experiencing homelessness.
Emergency Solutions Grant (ESG) Program	HUD funding source to (1) engage homeless individuals and families living on the street; (2) improve the quantity and quality of emergency shelters for homeless individuals and families; (3) help operate these shelters; (4) provide essential services to shelter residents; (5) rapidly rehouse homeless individuals and families; and (6) prevent families and individuals from becoming homeless.
Homeless Management Information System (HMIS)	Local information technology system used by a CoC to collect participant-level data and data on the provision of housing and services to homeless individuals and families and to persons at risk of homelessness. Each CoC is responsible for selecting an HMIS software solution that complies with HUD’s data collection, management, and reporting standards.
Permanent Supportive Housing (PSH)	Permanent housing with indefinite leasing or rental assistance paired with supportive services to assist homeless persons with a disability or families with an adult or child member with a disability achieve housing stability.
Rapid Re-Housing (RRH)	Program emphasizing housing search and relocation services and short- and medium-term rental assistance to move homeless persons and families (with or without a disability) as rapidly as possible into permanent housing.
Release of Information	Written documentation signed by a participant to release his/her personal information to authorized partners.
Transitional Housing (TH)	Program providing homeless individuals and families with the interim stability and support to successfully move to and maintain permanent housing. Transitional housing funds may be used to cover the costs of up to 24 months of housing with accompanying supportive services. Program participants must have

	a lease (or sublease) or occupancy agreement in place when residing in transitional housing.
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Roles of Coordinated Entry Stakeholders

Coordinated Entry Workgroup

The Coordinated Entry Workgroup covers the entire CoC geographic region (Onondaga, Oswego and Cayuga Counties) and is primarily comprised of shelter discharge planners, permanent housing intake workers, street outreach providers and LDSS/211 staff. The workgroup ensures that the HHC is prioritizing those experiencing chronic homelessness and other vulnerable individuals and families for housing. The workgroup reviews and revises the Coordinated Entry Policies and Procedure manual annually.

Emergency Shelter & Street Outreach

Emergency Shelter and Street Outreach providers are responsible for assessment of those experiencing homelessness and referral to the Coordinated Entry system.

Housing Providers

All CoC and ESG funded housing providers are required to use the Coordinated Entry system to fill vacancies in order of community priority. Non-CoC and ESG funded housing providers are encouraged to use the Coordinated Entry system to fill vacancies.

Housing & Homeless Coalition Staff

HHC staff oversees and manages the Coordinated Entry system, including housing the Coordinated Entry list in HMIS. HHC staff addresses any concerns regarding the operation of the Coordinated Entry system, including receiving client grievances. Grievances and concerns with the Coordinated Entry system should be sent to the designated staff, Fred Hintz at fhintz@unitedway-cny.org.

HHC Client Advisory Board

The HHC Client Advisory Board is responsible for providing input on changes in the Coordinated Entry Policies and Procedures from the lens of those with lived experience.

HHC Advisory Board

The HHC Advisory Board reviews and revises the Coordinated Entry policies. The board has final approval for updated policies.

Versions of Document

This is the second version of the Coordinated Entry Policy and Procedure Manual. The Coordinated Entry Workgroup is responsible for creating the draft of the policies with input from the Client Advisory Board. The HHC Advisory Board is responsible for review & approval of the document. The revision process will be completed at least once annually. Anyone interested in submitting suggestions for revisions to the document should submit them to hhc@unitedway-cny.org

Version	Date Released	Key Changes
1.0	January 23, 2018	N/A
2.0	January	Updated Prioritization Clarified Roles

Full Geographic Coverage

The Coordinated Entry Policies & Procedures cover CoC NY-505’s entire geographic area, including Cayuga, Onondaga, and Oswego Counties.

Affirmative Marketing and Outreach

The Coordinated Entry system is publically advertised through community websites (2-1-1, HHC, Local DSSs, local Agencies), community outreach, local press via interviews, and social media (Facebook and Twitter). The broad advertisement of the system ensures that all people within the CoC in need of homeless services will have fair and equal access to the system regardless of where or how the household presents at any entry point.

All housing and supportive services including, but not limited to, entry points into the homeless services system will be affirmatively marketed throughout the CoC to eligible persons regardless of race, color, national origin, religion, sex, age, familial status, or disability who are least likely to apply in the absence of special outreach, and maintain records of those marketing activities. (24 CFR 5.105 (a)(2).

Safety Planning and Risk Assessment

Should an individual or family seeking shelter or services that is currently fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking, and are unable to access a licensed victim service provider, a non-victim service provider should take the following steps to ensure the safety and confidentiality of the individual or family:

- Thoroughly informing the individual or Head of Household (HoH) regarding the CNY HMIS Release of Information (ROI), and what information will be shared across the CoC, specifically addressing who has access to that knowledge.

- (discussion with group) HMIS ROI for non-DV Providers.
- All records containing their Personal Identifying Information (PII) are kept secure and confidential and the address of any family violence project not be made public.

Nondiscrimination

All participating agencies must adhere to their agency's requirements, along with the CoC's requirements for incorporating cultural and linguistic competencies surrounding all special populations; including immigrants, refugees, and other generation populations; youth; individuals with disabilities; and lesbian, gay, bisexual, transgender, queer, or questioning (LGBTQ) persons.

All participating agencies must connect all individuals and families who require access to interpretation services to an interpreter.

Part Two: Access

Access

The coordinated entry system serves the entire geographic area of Onondaga, Oswego and Cayuga Counties through a “No Wrong Door” policy. Participants are able to access Coordinated Entry by appearing at any homeless assistance agency within the community. Access to emergency shelter is through a single point of access through the local Departments of Social Services. The CoC is in a Right to Shelter state and no prioritization is needed to access shelter services.

Accessibility of Access Sites

All access sites are physically accessible for people with mobility barriers. Written materials are available in English and Spanish. Participating agencies make translation services available when needed.

Emergency Shelter Access

County	Entry Point	Hours of Operation
Onondaga County	Onondaga County Department of Social Services	M-F 8am to 4pm
	Contact 2-1-1	24/ 7 Access; Shelter placement after hours and referrals.
	Vera House Crisis line	24/ 7 Access
	Outreach	5 to 6 days a week and via Contact 2-1-1
Oswego County	Oswego County Department of Social Services	M-F 8am to 4pm
	Contact 2-1-1	24/ 7 Access; Shelter placement after hours (M-F after 4:30pm and weekends)
	OCO Crisis line	24/ 7 Access
	Outreach	Ad hoc
Cayuga County	Cayuga County Department of Social Services	24/7 and has an afterhours line for shelter referrals
	Finger Lakes 2-1-1	24/ 7 Access to provide referrals and DSS After hours line for shelter
	DV Crisis line	24/ 7 Access
	Outreach	Ad hoc

Prevention Services

Department of Social Services, Contact 211, and Emergency Shelters assess for diversion and homeless prevention. Any persons qualifying for homeless prevention programs will be referred to appropriate services.

Street Outreach

The CoC ensures that people who are sleeping on the streets are equally prioritized for assistance as anyone else presenting with service needs.

Access for Specialized Populations

Survivors of DV

Survivors of domestic violence residing in DV shelters are able to access Coordinated Entry through referral to the HHC staff. The referrals are de-identified by DV shelter staff and contain only the minimum information required for proper prioritization. The form used for Domestic Violence Shelter Clients can be found in Attachment 3.

Veterans

Veterans are able to access the Coordinated Entry system through shelters and also through outreach from Supportive Service for Veteran Families (SSVF) and Veteran Affairs (VA). The local VA inputs data into HMIS and is able to both refer to and accept referrals from the Coordinated Entry system.

Part Three: Assessment

Standardized Assessment Approach

All coordinated entry locations offer the same assessment approach and referrals using transparent and uniform decision-making processes. The Vulnerability Index Service Prioritization Decision Assistance Tool (VI-SPDAT) developed by OrgCode Consulting has been approved by the CoC and will be the coordinated entry tool for single individuals, including the chronically homeless and will be used by all projects that are dedicated or prioritized for the chronically homeless. The Family SPDAT (F-SPDAT) developed by OrgCode Consulting has been approved by the CoC and will be the coordinated entry tool for families who are experiencing homelessness. The Transition Aged Youth SPDAT (TAY-SPDAT) developed by OrgCode Consulting has been approved by the CoC and will be the coordinated entry tool for unaccompanied youth (24 and under) who are experiencing homelessness. For purposes of this document, the written standards will use the term “assess” or “assessment” which will refer to these tools and will specify the types of tools as needed. All shelter and street outreach providers are responsible for conducting these assessments and entering them in to HMIS.

All coordinated entry locations also assess based on length of time homeless, using client report and HMIS data to determine the number of months an individual or family has experienced homelessness in the three years prior to their current episode of homelessness.

Phases of Assessment

All projects participating in Coordinated Entry will follow the assessment and triage protocols of the CE System.

The CoC has adopted the following phased approach to engage and appropriately serve persons seeking assistance through the Coordinated Entry system;

Initial Triage- This phase will focus on identifying the immediate housing crisis, and clarifying that the CoC crisis response system is the appropriate system to address needs. L-DSS’s in each county is responsible for this phase.

Diversion- This phase of assessment will determine if CoC resources and options could be used to avoid the participant entering the homeless system. L-DSS’s in each county is responsible for this phase.

Emergency Service Intake- For those who are identified as needing emergency shelter, appropriate shelter placement is made. L-DSS’s in each county are responsible for this phase.

Shelter Assessment- Emergency Service providers should attempt to determine whether or not a person needs housing intervention through Coordinated Entry. Development of a housing plan is made in conjunction with the person experiencing homelessness.

Comprehensive Assessment- Emergency service providers should assess using the VI-SPDAT and the Coordinated Entry Specific Data Elements in Attachment II and working with the individual or family to determine the number of months homeless. Case managers should use HMIS records, third party documentation, and up to 3 months of self reported homeless time to document a client's time homeless. This should be completed, at most, two weeks after shelter entry, if it is the first time the individual or family has experienced homelessness. Assessments and referrals can happen immediately for anyone that is unsheltered or has been in emergency shelter within the last year. Emergency service providers should also be determining chronic homeless status and obtaining necessary paperwork.

Assessment Screening

The CE process may collect and document participants' membership in Civil Rights protected classes but will not consider membership in a protected class as justification for restricting, limiting, or steering participants to particular referral options.

Assessor Training

The Housing and Homeless Coalition of Central New York (HHC) will provide training on the Coordinated Entry Process and Procedures at least annually and if there are any updates/changes to the policy or procedure. This is typically done via the HMIS Agency Administrator Training, along with the Coordinated Entry and Data Administrators Committees.

The HHC also provides, quarterly Coordinated Entry user training for shelter, street outreach, and housing providers on the process of Coordinated Entry.

All Coordinated Entry Assessors will be required to attend a training once a year. The HHC will maintain a list of assessors that have completed assessor training in the past year.

Participant Autonomy

Participants must be free to decide what information they provide during any assessment process. This includes, but is not limited to the entry assessments by shelter or housing providers that are done upon entry, and the assessment to determine program eligibility. Providers are prohibited from denying assessment or services to a participant if the participant refuses to provide certain pieces of information, unless the information is necessary to establish or document program eligibility. Providers are also

prohibited from denying services to participants if the participant refuses their data to be shared via HMIS.

Emergency Shelter and Street Outreach staff should have an understanding of possible restrictions, trauma related issues, and obstacles in regards to particular housing providers or housing types. They should educate themselves in this via the assessment process. Programs working with an individual/family that has experienced significant trauma and is triggered during the administering of the VI-SPDAT tool, that staff person can stop the assessment to allow that client a break. When the client feels comfortable and able to continue the staff can come back to finish the assessment on a later date.

Nondiscrimination Complaint and Appeal Processes

The HHC will respond to grievances regarding Coordinated Entry in the following manner, depending on the nature of the concern or grievance.

Housing Program Grievance- Grievances about rejections from homeless housing programs will be redirected back to the program to follow grievance policies and procedures of that organization. Agencies should maintain internal documentation of all complaints received. If a client is not satisfied with the housing program's response to the grievance, they can contact the HHC staff to request that the HHC review the grievance, and if needed, enter into discussion with the housing provider. Requests may be made by telephone or in writing.

Fair Housing Grievance- Grievance about a participating program's screening or program participation practices which appear to have a discriminatory impact: Contact CNY Fair Housing. More information at: <http://cnyfairhousing.org/>

Program Grievance- Grievances about HHC Coordinated Entry policies and procedures should be sent to the HHC staff. A grievance is an expression of dissatisfaction about any aspect of the Coordinated Entry service delivery. It is an informal process that can be initiated by telephone or in writing. Upon receipt of the complaint, if possible, HHC staff will address the grievance. If the grievance cannot be resolved by HHC staff, the grievance will be brought to the attention of the Governance Committee.

Privacy Protections

CE participating agencies are required to obtain releases of information for the collection, use, and disclosure of participant's personally identifying information. All agencies must follow the privacy guidelines outlined in the HMIS user manual.

Disclosure of Disability or Diagnostic Information

The assessment and prioritization process cannot require disclosure of specific disabilities or diagnoses. Specific diagnosis or disability information may only be obtained for purposes of determining program eligibility to make appropriate referrals.

Updating the Assessment

Staff may update assessments as information changes. VI-SPDATs should be re-administered every two years or if there have been changes to major risk factors recorded by the VI-SPDAT.

Part Four: Prioritization

The CoC uses the following prioritization criteria to fill vacancies in permanent housing projects. The following prioritization criteria were developed to create a dynamic prioritization system to ensure that those experiencing homelessness are matched with appropriate housing services.

Prioritization Criteria: Permanent Supportive Housing Leasing

The CoC will use the following order of prioritization for filling vacancies in **PSH leasing projects**:

1. Chronically homeless individuals and families a VI-SPDAT score of 8 or above.
2. All other chronically homeless individuals and families with a VI-SPDAT score of 8 or below.
3. Non-chronic homeless individuals and families with a disability with the most severe service needs, evidenced by their assessment score on their respective VI-SPDAT, having a score of 8 or above.
4. All other non-chronic homeless individuals and families with a disability

Tie Breakers:

1. Longest history of homelessness in the past three years. History of homelessness is measured by total cumulative months homeless counted in the last three years.
2. An individual or family who is living in an unsheltered location during Code Blue
3. Enrolled in an RRH project and imminently losing their housing
4. VI-SPDAT score
5. Veteran status

Prioritization example:

An individual or family with cumulatively 20 months of homelessness with a VI-SPDAT score of 10 will be prioritized over a family with cumulatively 12 months of homelessness with a VI-SPDAT score of 14.

Prioritization Criteria: Permanent Supportive Housing- Rental Assistance

The CoC will use the following order of prioritization for filling vacancies in **PSH Rental Assistance projects**:

1. Homeless individuals and families with a VI-SPDAT between 8 to 10
2. All other homeless individuals and families

Tie-Breakers:

1. Longest history of homelessness in the past three years. History of homelessness is measured by total cumulative months homeless counted in the last three years.
2. Families

3. An individual who is living in an unsheltered location during Code Blue
4. Enrolled in an RRH project and imminently losing their housing

Prioritization Criteria: Rapid Re-Housing

The CoC will use the following order of prioritization for filling **RRH** vacancies:

1. Individuals and families with VI-SPDAT scores of 10 & below

Tie Breakers:

1. Longest length of current episode of homelessness (measured by Approximate Date homelessness started)
2. An individual or family who is living in an unsheltered location during Code Blue

The CoC does not place additional stipulations on CoC Rapid Re-Housing assistance. Rental assistance may be offered for the entirety of the eligible 24-month period and there are no income limits. CoC projects should follow any requirements in their approved applications to HUD.

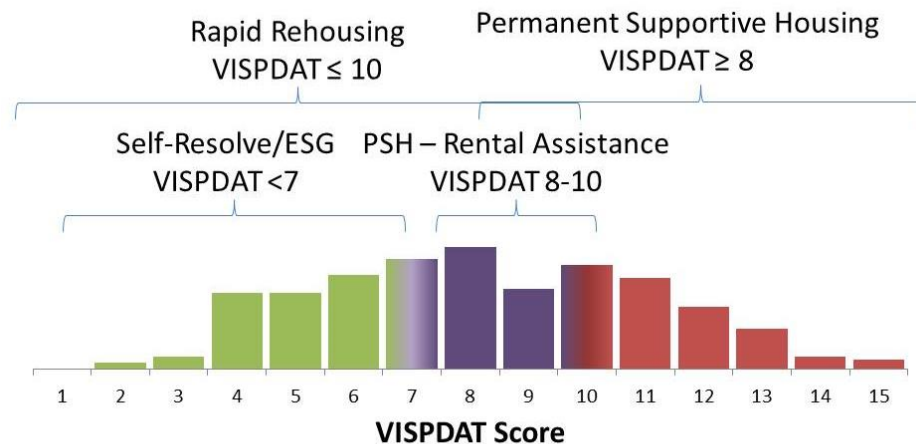
Prioritization Criteria: Emergency Solutions Grant and Transitional Housing Projects

The CoC will follow the following order of prioritization for filling vacancies in **ESG RRH projects and Transitional Housing projects**:

1. Literally homeless individuals and families with a VI-SPDAT or F-SPDAT score of 7 or less

Tie Breakers:

1. Longest length of current episode of homelessness (measured by Approximate Date homelessness started)
2. Households with a housing option identified
3. An individual or family who is living in an unsheltered location during Code Blue
3. Individuals or families fleeing domestic violence
5. Veteran Status



Part Five: Referral Process & Project Acceptance/Rejection

Coordinated Entry List

The CoC has developed one streamlined waitlist that can be found in the CoC's HMIS:

<https://sp5.servicept.com/cnyhmis/com.bowmansystems.sp5.core.ServicePoint/index.html>

HHC staff emails the de-identified by name list, in order of priority, out weekly to the Coordinated Entry Workgroup.

Client/Provider Matching

Housing providers must communicate with Coordinated Entry staff the number of openings available in their program on a weekly basis, either through e-mail or by updating vacancies in HMIS. Clients will be matched to open beds/slots on the basis of prioritization and open beds by Housing and Homeless Coalition staff. In the absence of client preference or restrictions, matches will be made by alternating providers according to need.

Clients who are absent from shelter for 7 days or do not engage with street outreach for 30 days are removed from the active referral list, and will not be matched with a housing service provider. As soon as clients re-engage with street outreach or shelter, they will be returned to the active referral list and considered for a match to a housing provider.

Matches will be listed in HMIS and will be distributed to all housing service providers, shelter, and street outreach staff. Two matches will be made per provider opening.

Emergency Shelter and Street Outreach staff are required to thoroughly explain the program types that they clients are allow to select so that they can make an informed decision/choice to accept that housing provider's referral. This includes, but is not limited to which program they are being referred, what the program expects of them and what they can expect of the program.

Projects will be matched first with clients within their county. If there are fewer assessed clients in a given county than a project has openings, projects will be matched with assessed clients that have expressed a willingness to move to a different **area**.

Case Conferencing

At the monthly case conferencing meeting (Chronic task force) or in an ad-hoc meeting requested by either the client, housing provider, or shelter/street outreach, changes to housing matches due to client characteristics can be made. Client characteristics that warrant a change in housing provider are conditions that limit access to the unit like a mobility impairment or a legal restriction by probation or parole. Clients assigned to providers at the case conferencing meeting will be changed in HMIS and on the weekly CE list.

Acceptance/Rejection Policy- Housing Provider

Attempts to contact clients must be documented in HMIS using the designated HMIS data collection procedures. Housing Providers can only reject a referral that matches their program eligibility requirements for the following reasons: the client is a danger to themselves or others, or client has previously been unsuccessful in the agency's housing project. These decisions will be documented in HMIS and securely communicated to the HHC staff via email with the reasons as to why the housing provider is not accepting the client. If a client is rejected due to safety concerns, the client will be added to the case conferencing discussion during the Coordinated Entry Workgroup meeting.

Acceptance/Rejection Policy- Client

Should a housing provider select an individual or family off of the prioritization list, the family can then choose to accept or reject that housing option. Should the individual or family decide to reject the housing provider, the original provider will then select the next individual or family from the list by following the prioritization process listed in this policy. If an individual or family rejects multiple housing provider placements the Case Conferencing meeting will review the case and discuss reasons for rejections in order to come up with alternative housing solutions. If an individual or family consistently rejects housing placements, they will be re-engaged by street outreach and/or shelter caseworkers on a bi-weekly basis to offer housing. These attempts will be documented in HMIS.

Clients who do not accept housing program matches will be matched with another provider offering similar services. Only 2 program matches will be made per client during a given engagement with the coordinated entry system. Clients' entry in the assessment provider will be closed after denying services from 2 programs. Clients can decide to re-engage with coordinated assessment at any time, however clients will be matched according to their prioritization metrics at the time they change their status.

Should an individual/household be housed via a non-ESG/CoC funded project or subsidized housing provider they should be taken off of the list by the Emergency Shelter/ Street Outreach provider who made the referral. An individual/household should be taken off of the list if there is no contact or shelter stay for a period of more than 90 days. Street outreach and shelter providers should continue to make attempts to engage those persons that have been resistant to accepting an offer of housing (PSH, RRH & TH) and these individuals and families must continue to be prioritized until they are housed. If a client disappears that is next on the list and is no longer in shelter, the housing provider will hold that bed while the shelter or street outreach staff attempt to make contact with that client. Beds can only be held for a maximum of two weeks. If there has been no contact made within two weeks, the housing provider can then move on to the next eligible person on the list. If the person re-appears then they will be eligible for the next housing placement that opens up.

Transfer Policy

A transfer describes a process where a client enrolled in one housing program is moved or transferred to another housing program. Transfers take place when 1) there is a presentation of strong evidence

indicating that a particular type of housing or housing project is not meeting a client's needs, 2) the unmet needs results in threats to the client's safety and overall well-being or threats to another program participants safety or well-being, and 3) another type of housing provided by a different agency is appropriate.

Requesting a transfer is not a mandatory step prior to exiting a client from a permanent housing program. Transfers are also not to be used for clients who need a higher level of care than CoC-funded housing programs are able to provide.

Housing providers must submit a CoC Housing Program Transfer Request Form (Attachment IV), with supporting documentation, to the permanent supportive housing case conferencing committee, as well as complete a coordinated entry referral in the HMIS system with the form scanned and uploaded to the client's HMIS profile. This form must be completed and sent to the HHC staff member assigned to coordinated entry at least one week before the case conferencing meeting. The HHC staff member will determine whether or not the transfer request is appropriate and respond to the project within three business days. This determination can be appealed to the HHC Director within two weeks of the decision. Secondary appeals can be made to the executive committee of the HHC board.

Using the Housing Program Transfer Request Form, the provider requesting a transfer must show that they have exhausted their resources to overcome the obstacles that are the cause of a client's risk of homelessness, including offering to relocate their housing unit and making continued efforts to link them with appropriate services and supports. Housing providers must also show how transferring the client can provide a potential resolution to the client's particular issue.

Final decisions on transfers will be made in the monthly case conferencing committee meeting.

Client transfer from programs with different program requirements should be carefully reviewed to ensure the client(s)' eligibility and documentation are appropriate for the new program.

Data Systems

Programs receiving ESG and CoC funding must participate in HMIS (Homeless Management Information System), unless otherwise stated by federal regulations. Homeless programs that are not federally funded are strongly encouraged to participate in HMIS. The CoC has established an HMIS Policies and Procedures Manual. [This manual can be found here.](#)

Programs must meet minimum HMIS data quality standards (maintaining under a 5% error rate on the Data Quality Framework Report in HMIS).

Programs providing Domestic Violence services may opt out of HMIS participation but must utilize a comparable database to collect HUD required data elements.

Participants are free to decide what information they provide during any assessment process. This includes, but is not limited to the Entry assessments by shelter or housing providers that are done upon entry, and the assessment to determine program eligibility. Providers are prohibited from denying assessment or services to a participant if the participant refuses to provide certain pieces of information, unless the information is necessary to establish or document program eligibility. Providers are also prohibited from denying services to participants if the participant refuses their data to be shared via HMIS.

Evaluation

The Coordinated Entry policies above will be monitored by HHC staff and will communicate any issues or concerns to the agency in question.

In the quarterly Coordinated Entry meetings, key metrics of the Coordinated Entry system will be evaluated. These measures include but are not limited to, time from referral to Coordinated Entry to service, appropriateness of referrals, and recidivism from project types.

These matters will be reviewed and reported annually to the Advisory Board and to the Coordinated Entry Workgroup.

Attachments:

- I. VI-SPDAT Assessments
- II. Coordinated Entry Specific Data Elements
- III. Coordinated Entry Form for DV Providers
- IV. Housing Program Transfer Request Form

Attachment II. Coordinated Entry Specific Data Elements

Is client interested in Permanent Supportive Housing, and has the program been discussed with client, including wait list times and eligibility requirements? ___Yes ___ No

Is client interested in CoC Rapid Re-Housing, and has the program been discussed with the client, including waitlist times and eligibility requirements? ___Yes ___No

Is Client interested in ESG Rapid Re-housing, and has program been discussed with client, including wait times and eligibility requirements? ___Yes ___No

Months Homeless in the last 3 years _____ months

Would this client live in/move to Onondaga County? __Yes ___No

Would Client Live in/move to Oswego County? __Yes ___No

Would client live in/move to Cayuga County? ___Yes ___No

Sexual Orientation ___Heterosexual (Straight) _____Homosexual (Gay, Lesbian) _____Bisexual
___Something Else ___Don't Know

Is Client Pregnant? ___ Yes ___No

Has Length of Time Paperwork?

_____ No Length of Time Documentation

_____ Incomplete Length of Time Homeless (Breaks) Documentation

_____ Completed Length of Time Homeless (Breaks) Documentation

Has Disability Paperwork?

_____ No Disability Documentation

_____ Disability Documentation Requested/In Progress

_____ Complete Disability Documentation

Family Composition _____

Attachment III. Coordinated Entry Referral Form for DV Shelters/Clients

Coordinated Entry Referral Form

This form should be completed, scanned, and e-mailed to the manager of the Coordinated Entry list after completing the VI-SPDAT/VI-FSPDAT and the client signs the ROI for the HMIS and HHC.

1. **Client ID (not HMIS ID) #** _____
2. **Program desired:**
____ Permanent Supportive Housing ____ Rapid Rehousing _____ ESG Rapid rehousing
3. **VI-SPDAT Score (For Individuals)** _____
4. **VI-FSPDAT Score (For Families)** _____
5. **TAY-VI-SPDAT Score (For Individuals 24 yrs or younger)** _____
6. **Is the head of household 24 years of age or younger?** _____
7. **Client Gender** _____
8. **Client Veteran Status:** ____ Veteran ____ Non-Veteran
9. **How many months has this individual/family been homeless in the past 3 years?** _____
10. **How many separate episodes of literal homelessness (HUD Definition) has this individual/family experienced in the past 3 years?** _____
11. **What was the approximate date this client's episode of literal homelessness (HUD Definition) began?** ____/____/____

Length of time homeless (Breaks in homelessness) paperwork for Chronic PSH referrals:
Choose one:

- ____ Referring Case manager does not have length of time paperwork for client
____ Referring Case manager has requested/is working on length of time (breaks) paperwork for client
____ Referring Case manager has completed length of time (breaks) paperwork for client

12. **Does the head of household have a documented disability?** ____ Yes ____ No
 - a. (If has a disability) What type? ____ Substance Abuse ____ Mental Health
____ Physical ____ Developmental ____ Other (must be documented)

Status of disability paperwork for PSH referrals (choose one) :

- ____ Referring Case Manager does not have disability paperwork for client
____ Referring Case Manager is working on disability paperwork for client
____ Referring Case Manager has appropriate disability paperwork for client

13. Number of bedrooms required in housing unit: _____ (2 people per bedroom)

14. (If Family) Does the family have medical insurance? ____ Yes ____ No

a. If Yes, what type? _____

15. (If Family) Does the HoH receive regular income? If so, amt. and source?

16. To which county is the client interested in moving? Choose all that apply

____ Onondaga ____ Cayuga ____ Oswego

17. Staff Name

Completing _____

18. Staff Contact info Email: _____ Phone

19. Date Completed _____

20. Date E-mailed to CE staff _____

Current CE staff: Fred Hintz, Housing and Homeless Coalition, 315-428-2219;

fhintz@unitedway-cny.org

Attachment IV. Housing Program Transfer Request Form

CoC Housing Program Transfer Request Form

Date of Request ____/____/____ Client HMIS ID _____
Provider Name _____ Provider Contact _____
Contact Phone _____ Contact E-mail _____

Please provide the reason for requesting a transfer (Use additional space if necessary)

RRH to PSH Transfer (Higher level of need)

PSH to PSH Transfer (Housing Unit is inappropriate)

PSH to PSH Transfer (Service needs cannot be met)

Transfer due to Domestic Violence (Please do not provide any identifying information on this form)

Please describe a benefit that another program could provide to this client that the current program is unable to provide? (Use additional space if necessary)

Has the client been consulted about moving programs, and have they agreed to switch programs?

Yes No

Has the client moved apartment locations in the current program? If so, how many times have they been relocated?

Are there any apartment buildings where the client cannot reside?

Is the request being made out of an immediate concern for the client's risk of inflicting harm to themselves or to others? Yes No

What services/interventions have been provided and offered to improve the client's stability in the project?

Please attach case notes describing such services, if not included in HMIS.

For HHC Staff use: Outcome of transfer: Denied _____ Accepted _____ Initial _____ Date moved _____