BROWARD COUNTY FLORIDA

Community Partnerships Division

Homeless Initiative Partnership

HCoC WRITTEN STANDARDS OF CARE

Broward County Homeless Continuum of Care FL-601

October 2020

Version of Document

Version	Date Released	Noted Changes
1.0	September 8, 2016	Created
2.0	August 5, 2020	Updated for HUD guidance on CEA requirements. Added complete CEA section and timeframes.
3.0	TBA	Rewrite and add ESG Appendix 3

Table of Contents

Resources:

The U.S. Department of Housing and Urban Development (HUD) requires all Continuums of Care (HCoCs) to adopt "written policies and procedures" to guide the general operations and day-to-day activities of their coordinated entry (CEA) systems. HUD detailed these requirements in its 2017 Notice Establishing Additional Requirements for a Homeless Continuum of Care Centralized or Coordinated Assessment System:

Each HCoC must incorporate additional requirements into their written policies and procedures to ensure that its coordinated entry implementation includes each of the requirements described in [Section II.B].

In the Written Standards the HUD document is referred to as HUD's "Coordinated Entry (CEA) Notice."

HUD intends this Outline to be used by HCoC's as a foundation in drafting a CEA "policies and procedures" (P&P) document that documents additional requirements and operational practices that each HCoC adopts for its CEA process.

Disclaimer: The Broward Coordinated Access system uses a two-step process to first triage for the best housing intervention (Permanent Supportive [PSH] or Rapid Re-housing [RRH]), and then determines prioritization based on multiple needs which includes vulnerability. Housing programs are extremely limited, and there is no guarantee that the individual/family will meet the final eligibility requirements for – or receive a referral to- a particular housing option. A housing referral is submitted to coordinated entry is also not a guarantee for housing placement, placement is dependent upon funding and vacancy availability.

The Written Standards have been developed for the Broward FL 601 Continuum of Care, which geographically includes all of Broward County Florida and are not all evidence based. The Standards are reviewed annually and updated according to changing community needs and the HUD regulations.

Terms and Definitions

Chronically Homeless	HUD's definition: *Chronically homeless* means: (1) A "homeless individual with a disability," as defined in Section 401(9) of the McKinney-Vento Homeless Assistance Act, who: Lives in a place not meant for human habitation, or an emergency shelter. AND Has been homeless continuously for at least twelve (12) months or on at least four separate occasions in the last three (3) years, as long as the combined occasions equal at least twelve (12) months and each break in homelessness separating the occasions included at least Seven (7) consecutive nights of not living as described in (i) above.
Case Conferencing	Local process for CEA 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.
Homeless Continuum of Care (HCoC)	Group responsible for the implementation of the requirements of HUD's HCoC Program interim rule. The HCoC 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.
Homeless Continuum of Care (HCoC) 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 Initiative Partnership (HIP)	HIP is collaborative applicant for the Broward FL 601 HCoC. as designed in ordinance by the Broward County Board of County Commissioners and is the HCoC Board Coordinator. HIP coordinates an array of funding to implement innovative, effective, performance-based approaches to alleviate homelessness and its causes in Broward County through the Homeless Continuum of Care in concert with the HEARTH Act.
Homeless Management Information System (HMIS)	Local information technology system used by a HCoC 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 HCoC is responsible for selecting an HMIS software solution that complies with HUD's data collection, management, and reporting standards.
Projects for Assistance in Transition from Homelessness (PATH)	Substance Abuse and Mental Health Services Administration (SAMHSA)–funded program to provide outreach and services to people with serious mental illness (SMI) who are homeless, in shelter or on the street, or at imminent risk of homelessness.
Public Housing Authority (PHA)	Local entity that administers public housing and Housing Choice Vouchers (HCV) (aka Section 8 vouchers).
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 (ROI)	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.

System Overview

Homeless Continuum of Care Purpose

The purpose of the Homeless Continuum of Care (HCoC) is to create a collaborative, inclusive, community- based process and approach to effectively and efficiently planning and managing homeless assistance resources and programs with the ultimate goal of ending homelessness in Broward County. Broward County's HCoC is specified by the Department of Housing and Urban Development as FL-601-HCoC, in accordance with 24, CFR Part 578, Homeless Emergency Assistance and Rapid Transition to Housing Act (HEARTH Act).

The Broward County HCoC aligns its three (3) (year plan, "A Way Home Plan" updated December 2018), to End Homelessness and the goals with the HEARTH Act, the Federal Strategic Plan to End Homelessness, and the United States Interagency Council on Homelessness *Opening Doors* Plan to End Homelessness. Broward HCoC has set a path to end homelessness in Broward County by focusing its resource needs on the provision of quality best practice housing focused programs, supportive services and employment services located in strong sustainable communities.

Broward County HCoC Homeless Initiative Partnership Points of Contact:

The Broward HCoC oversees a network of housing and service agencies that work together as part of the Coordinated Entry and Assessment (CEA) system to facilitate access to services through designated coordinated entry points. Below are the identified points of contact for Coordinated Entry FL-601-HCoC.

Role	Name	Phone	Email
Human Services Administrator	Rebecca McGuire, Ph.D.	954-357-5686	RMCGUIRE@BROWARD.ORG
Human Service Manager	Kavaja Sarduy, M.S.	954-357-5392	KSARDUY@BROWARD.ORG
Senior Contract Grant Administrator	Tracie Bostick	954-357-7845	TBOSTICK@BROWARD.ORG
Program Project Coordinator	Brittany Odom	954-357-7096	BODOM@BROWARD.ORG
Senior Program Project Coordinator	Andrea Webster	954-357-9704	AWEBSTER@BROWARD.ORG
HMIS Program Manager	Ricardo Moore	954-357-5882	RPMOORE@BROARD.ORG
Program Project Coordinator	Kenisha Bryant, Ed.D.	954-357-8078	KBRYANT@BROWARD.ORG
Administrative Officer	Charlesy Nance	954-357-9589	CSNANCE@BROWARD.ORG

Target Population / Defining Homelessness

Broward County HCoC's target population includes individuals and families (family as defined by HUD) experiencing literal homelessness (categories 1 and 4 as defined by HUD). Potential clients should be homeless in Broward County at least 90 days and will be served based on availability of resources and at the discretion of the service provider. Additionally, potential clients' current living situations must meet the definition of homelessness according to the HEARTH Act. Youth under the age of 21 who are literally homeless will meet the homeless definition for programs funded to serve this population, currently provided by Covenant House. Special consideration may be given to victims of domestic violence.

HUD's homeless definitions and recordkeeping requirements can be accessed online at:

https://www.hudexchange.info/resources/documents/HomelessDefinition_RecordkeepingRequirementsandCriteria.pdf

The chart below is a tool that provides a quick and simple category determination. Additional information is included in Appendix F.

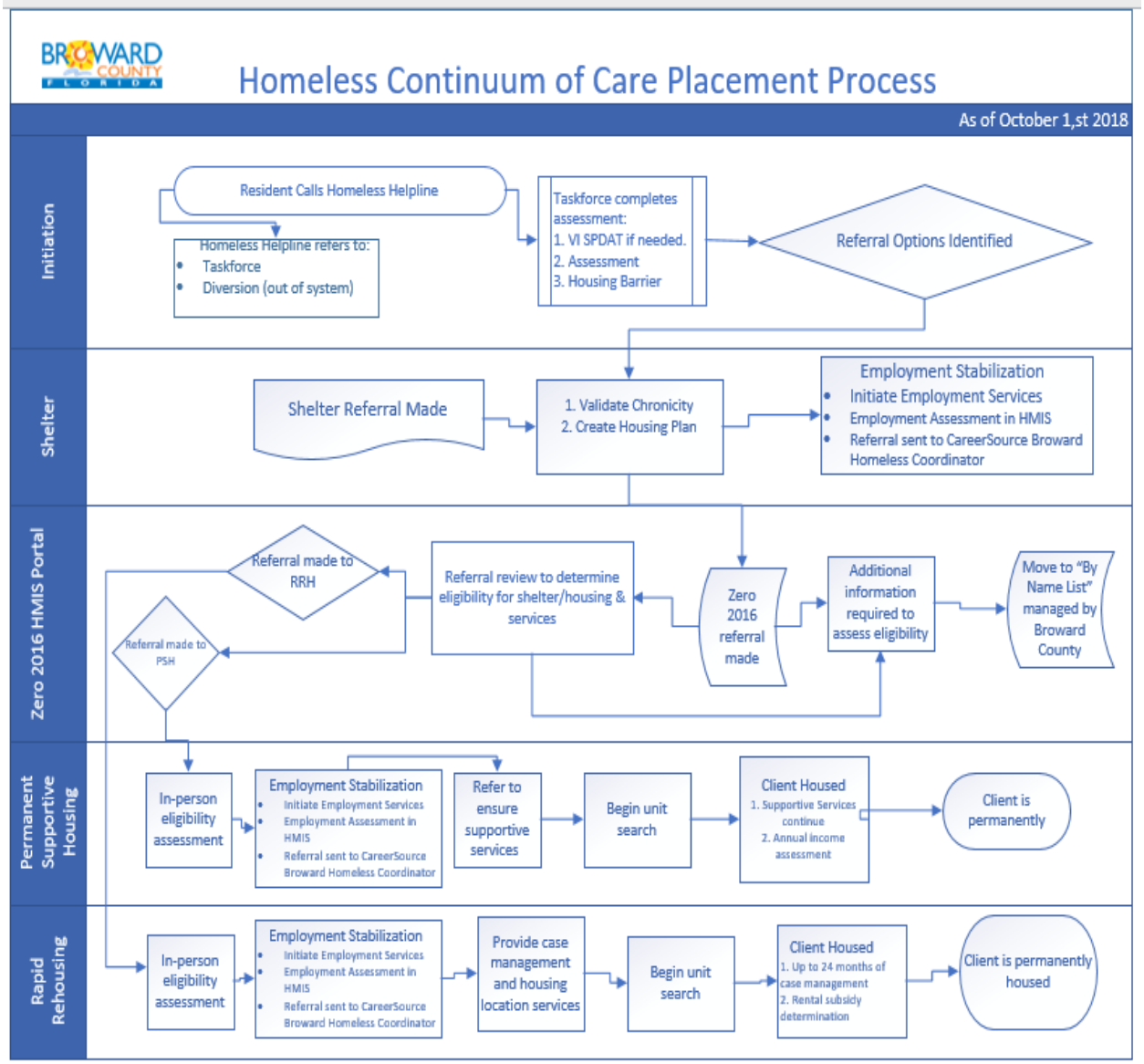
CRITERIA FOR DEFINING HOMELESS			
Category 1 **(LITERALLY HOMELESS)**	Category 2 **(IMMINENT RISK OF HOMELESSNESS)**	Category 3 **(HOMELESS UNDER OTHER FEDERAL STATUTES)**	Category 4 **(FLEEING OR ATTEMPT TO FLEE DOMESTIC VIOLENCE)**
Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: 1. Has a primary nighttime residence that is a public or private place not meant for human habitation; 2. Is living in a publicly or privately-operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or 3. Is exiting an institution where (s)he has resided for ninety (90) days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution	Individual or family who will imminently lose their primary nighttime residence, if: 1. Residence will be lost within 14 days of the date of application for homeless assistance; 2. No subsequent residence has been identified; and 3. The individual or family lacks the resources or support networks needed to obtain other permanent housing	Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who: 1. Are defined as homeless under the other listed federal statutes; 2. Have not had a lease, ownership interest, or occupancy agreement in permanent housing during the 60 days prior to the homeless assistance application; 3. Have experienced persistent instability as measured by two or more moves during in the preceding sixty (60) days; and 4. Can be expected to continue in such status for an extended period due to special needs or barriers	Households fleeing domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions (including human trafficking) 1. Fleeing, or is attempting to flee, domestic violence 2. Has no other residence 3. Lacks the resources or support networks to obtain other permanent housing

There may be occasions that certain programs serve categories 2 and 3 as defined by HUD. Those instances will be outlined in the individual contracts and will follow the same Coordinated Entry and Assessment process.

Homeless Homeless Continuum of Care Placement Process

Broward County HCoC provides a coordinated entry process and offers multiple access points that are well marketed. All access points are accessible by individuals experiencing homelessness through designated providers. The coordinated entry process may, but is not required, to include separate access points for HUD determined sub populations to the extent necessary to meet the needs of specific subpopulations. The infographic below demonstrates the process flow through the system.

Broward's CEA has multiple designated access points to help direct both individuals and families experiencing homelessness to the access point best able to meet their needs and to assist with the appropriate level of housing, a standardized decision-making process, and does not deny services to victims of domestic violence, date violence, sexual assault or stalking services. The CEA system is modeled after a Housing First approach. Housing First is an evidence- base model **that prioritizes providing permanent housing to people experiencing homelessness**, **thus ending their homelessness; and the ability to focus on personal goals and improve their quality of life**. This approach 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. and has migrated from a housing readiness system of care. Additionally, the system is person centered and strengths based.


Homeless Continuum of Care Placement Process
As of October 1,st 2018
Initiation
Resident Calls Homeless Helpline
Homeless Helpline refers to:
Taskforce
Diversion (out of system)
Taskforce completes assessment:
1. VI SPDAT if needed.
2. Assessment
3. Housing Barrier
Referral Options Identified
Shelter
Shelter Referral Made
1. Validate Chronicity
2. Create Housing Plan
Employment Stabilization
Initiate Employment Services
Employment Assessment in HMIS
Referral sent to CareerSource Broward Homeless Coordinator
Zero 2016 HMIS Portal
Referral made to RRH
Referral made to PSH
Referral review to determine eligibility for shelter/housing & services
Zero 2016 referral made
Additional information required to assess eligibility
Move to "By Name List" managed by Broward County
Permanent Supportive Housing
In-person eligibility assessment
Employment Stabilization
Initiate Employment Services
Employment Assessment in HMIS
Referral sent to CareerSource Broward Homeless Coordinator
Refer to ensure supportive services
Begin unit search
Client Housed
1. Supportive Services continue
2. Annual income assessment
Client is permanently
Rapid Rehousing
In-person eligibility assessment
Employment Stabilization
Initiate Employment Services
Employment Assessment in HMIS
Referral sent to CareerSource Broward Homeless Coordinator
Provide case management and housing location services
Begin unit search
Client Housed
1. Up to 24 months of case management
2. Rental subsidy determination
Client is permanently housed

Diversion

Client's Housing Situation	Intervention Used	Services Provided (In All Interventions)
AT IMMINENT RISK OF LOSING HOUSING (precariously housed and not yet homeless)	**PREVENTION**	Housing Search Rental Subsidy Other Financial Assistance Utility Assistance Case Management Mediation Connection to Mainstream Resources Legal Services
REQUESTING SHELTER (at the "front door" or another program/system entry point seeking a place to stay)	**DIVERSION**	
IN SHELTER (homeless/in the homeless assistance system)	**RAPID RE-HOUSING**	

According to *Closing the Front Door: Creating a Successful Diversion Program for Homeless Families*, published by the NAEH and the Center for Capacity Building, interventions include:

Diversion is a strategy that prevents homelessness for people seeking shelter by helping them identify immediate alternate housing arrangements and, if necessary, connecting them with services and financial assistance to help them return to permanent housing. According to the National Alliance to End Homelessness (NAEH), diversion targets people as they are applying for entry into shelter, while prevention targets people at imminent risk of homelessness and rapid-rehousing targets people who are already in shelter. *Broward County Diversion Services are provided by community resource agencies within FL-601-HCoC.*

Coordinated Entry into Shelter for Individuals

In October of 2018, Broward County HCoC streamlined access points for entry into emergency shelters. The Street Outreach provider coordinates entry into all HCoC funded shelter beds. Although there are multicentral access points that "feed" into Street Outreach, the single point of access into the emergency shelter system is through Street Outreach. Referrals to shelter are entered into HMIS exclusively by TaskForce Fore Ending Homelessness, Inc. to the four HCoC funded shelters, including The Salvation Army and the South, Central and North Homeless Assistance Centers. The CEA system of care monitors the status of referrals, the reason for declining a referral, and other system barriers that may need to be addressed. Other sources that feed into Street Outreach include, but are not limited to: the Homeless Helpline (helpline); a domestic violence help line (Women in Distress of Broward County); the Broward Behavioral Health Coalition; municipal police departments; three (3) Homeless Assistance Centers (HACs); a Safe Haven; and an interfaith community-based shelter network (Salvation Army and HOPE South Florida).

Referral Process: Referrals for individuals to the four HCoC shelter providers are made by the Street Outreach provider TaskForce Fore Ending Homelessness, Inc. TaskForce Outreach only submits Shelter Referrals for Individuals, for entry into emergency shelters. As of October 2, 2018, the Homeless Help Line no longer assigns beds for individuals in need of emergency shelter.

- Individuals experiencing homelessness can contact the Homeless Helpline (954.563.4357), to receive direction to TaskForce Fore Ending Homelessness (TaskForce) Street Outreach locations or meet at their designated daily locations within the community. Meeting with TaskForce ensure the Client Profile is updated, assessments that may be necessary to access shelter or to make permanent housing referrals.
- The three Homeless Assistance Centers (HACs) are strategically placed in North, Central, and South Broward County to provide services to families, single men & women who are experiencing homelessness.
- The Salvation Army provides low barrier shelter beds for individuals and families experiencing homelessness.
- Hope South Florida provides shelter to families only.

Admission into shelters is not guaranteed, as there is a waitlist and admissions are based on a prioritization matrix. Included in this matrix are the length of time homeless, physical, and mental disabilities, age, and vulnerability measured by the VI-SPDAT.

Coordinated Entry into Emergency Shelter for Families

The Administrative Officer from HIP monitors the need and process for families to create a more effective Coordinated Entry into Emergency Shelters and immediate referrals to Housing. Additionally, the Administrative Officer will ensure families have an updated profile in HMIS service point and VI-SPDAT in HMIS completed.

Referral Process: Referrals for families to the three shelter providers are made by our Homeless Helpline (954.563.4357) to the designated HIP Administrative Officer through HMIS.

1. All referrals for a family's intake into a COC Emergency Shelter must be referred to Coordinated Entry at the Homeless Initiative Partnership (HIP). All referrals should be sent via **Family *Prioritization***.
2. The Coordinated Entry, HIP Administrative Officer will review and accept the referral(s) and contact the family.
3. If the Family reports they are no longer in need of Emergency shelter, their referral for Emergency Shelter Prioritization will be closed.
4. The HIP Coordinated Entry, Administrative Officer will (if necessary) complete:
   i. The Client Profile (HMIS)
   ii. The VI- SPDAT (screening tool in HMIS)
5. Families will be prioritized based on their VI-SPDAT score, length of time homeless, other assessed vulnerability needs.
6. Upon the next shelter vacancy (based off prioritization), the family will be referred to a CoC Emergency Shelter. The Administrative will manage the wait list, and once notified by the providers regarding shelter vacancies, the Administrative Officer will send the referral by

entering the client number on service point; *under the client's profile*, *add the ROI, select the service transaction tab and add the referral for emergency shelter to the appropriate shelter (code).*

7. Once the referral has been sent in HMIS system, the CoC Emergency Shelter staff will review and accept the referral in HMIS within (2 calendar days). The Emergency Shelter provider will attempt to contact the family at least once per day for three days after the referral has been accepted to schedule an intake with the family at their facility. The CoC Emergency Shelter provider must document every attempt to contact the family in the Notes section of the client's profile in HMIS. When a family is not able to be contacted within the three-day period, the CoC Emergency Shelter provider will decline the referral in HMIS (dropdown: client unable to be located) and will notify the CEA Administrative Officer by email.
8. Once contacted by the CoC Emergency shelter, the family will have 24 hours to arrive at the CoC Emergency Shelter to complete the intake.
9. The CoC Emergency Shelter provider will make contact (via e-mal) to alert Coordinated Entry (Administrative Officer) of a family's arrival/non- arrival within (2 calendar days) of the referral to the shelter. If the client is a NO SHOW, the shelter must notify the Administrative Officer via at CoordinatedEntry@broward.org . The Administrative Officer will review and adjust the family's wait on the shelter list.
10. If the Family does not arrive at the CoC Emergency Shelter, as instructed within the agreed upon time frame, their referral will go back onto the CoC Emergency Shelter Prioritization Wait List for Families.

Coordinated Entry into Overflow Emergency Shelter for Families

1. The Administrative Officer will refer to Overflow Shelter in the event there is no emergency shelter vacancy available.
2. Families referred to the Overflow Shelter will be prioritized based on their VI-SPDAT score, length of time homeless, other assessed vulnerability needs (from the family prioritization list).
3. Once the referral has been sent in HMIS system, the (Overflow Shelter) provider will review and accept the referral in HMIS within (2 calendar days). The Overflow shelter provider will attempt to contact the family at least once per day for three days after the referral has been accepted to schedule an intake with the family at their facility. The Overflow Shelter provider must document every attempt to contact the family in the Notes section of the client's profile in HMIS. When a family is not able to be contacted within the three-day period, the overflow shelter provider will decline the referral in HMIS (dropdown: client unable to be located) and will notify the CEA Administrative Officer by email.
4. If the family does arrive at the overflow shelter, the referral will be accepted and the household will reside in the overflow shelter for a maximum of 2 weeks or whenever an appropriate shelter vacancy becomes available for that household.
5. The Overflow shelter provider will send a referral back to family prioritization within 7 days of the household's stay and the Administrative Officer CEA will accept the referral on the family prioritization waitlist.
6. Households on the family prioritization waitlist from the overflow shelter will be prioritized to enter shelter first as they are already a part of the shelter system.

7. Once there is a vacancy appropriate to the household, a referral will be sent to the emergency shelter *(Begin at Step 7 of Coordinated Entry into Emergency Shelter for Families)*.

The Coordinated Entry and Assessment assigned Administrative Officer will set up a system that operationalizes both families into emergency shelter and also permanent housing. Families can have referrals to both types of services simultaneously.

Special Population and/or other housing options

- Covenant House: (954) 561-5559 or walk-in (Serves youth experiencing homelessness)
- Safe Haven (Henderson): Referrals are made through the HMIS (Zero 2016 virtual portal). Serves individuals who are diagnosed with severe mental illness and who are also experiencing homelessness
- Women in Distress: 24-hour crisis line (954) 761-1133 – (Serves individuals and children fleeing domestic violence)

Coordinated Entry into Housing Programs

The Coordinated Entry Assessment for Housing (CEA) system is intended to increase and streamline access to housing and services for individuals and families experiencing homelessness. The Coordinated Entry Assessment for Broward County is designed utilizing the four main tenets as recommended by the Housing and Urban Development (HUD): Access, Assessment, Prioritization, and Referral.

Coordinated Entry and Assessment utilizes a standardized assessment tools, Housing Barrier Assessment, the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT, VI-F-SPDAT, Y -SPDAT). These tools assist the provider in consistently evaluating the level of need of individuals and families accessing services. The assessments should only be updated every 6 months if the client is not housed, or situation changes.

These separate assessment tools are used to prioritize homeless households for entry into Permanent Supportive Housing or Rapid Re-Housing programs. The assessment tools target youth, families, and single adults. All tools focus on length of literal homelessness and residential instability, number of children, trauma history, substance abuse history, and employment history.

After the assessments are administered to a literally homeless client, the following happens**:**

1. The staff person who completes the assessments refers the client to the Coordinated Entry and Assessment for the appropriate housing intervention (RRH, TH, PSH) and when a shelter placement is available and appropriate the client is referred through HMIS Service Point.
2. As housing program openings become available, Coordinated Entry prioritizes households through the CEA process, for referral to various programs based on the Housing Placement Prioritization process.
3. Coordinated Entry and Assessment team sends the referral via HMIS to the identified housing agency. The agency is chosen based on availability and the provider who can best meet the needs of the individual.

4. The housing agency staff begins to work with the client to find housing and appropriate support services.
5. After appropriate housing is identified, the housing agency staff administer ongoing assessments, housing placement services and case management as appropriate.

- Housing providers must record move-in dates for the assigned program into HMIS within two calendar days of acceptance into housing program. Below are the definitions of the various dates that are tracked by the CEA team monthly in HMIS system to ensure referral timeframes to move in timeframes improve. The physical location in the assigned unit can take 60-90 days based on housing inventory. **ALL DATES MUST BE ENTERED INTO HMIS WITH THREE (3) CALENDAR DATES OF THE ACTION HAPPENING.**

Referral Date:

- Date the housing agency received the referral.

Acceptance of Referral Date:

- This is the date the housing agency accepted the referral.

Intake Date:

- This is the date the housing agency completed the initial assessment and intake.

Housing Navigation Date:

This is the date housing Search began.

Move-In Date:

- This is the date the tenant has keys and moved into the unit.

Exit Date:

- Exit date from the program is the date the individual either exited from the unit or became self-sufficient and is no longer in need of services or subsidy or has been discharged from the program. All City and zip codes must be entered into HMIS upon the Client moving into the units.

Housing Interventions

Permanent Supportive Housing

Permanent housing that is an intervention coupled with supportive services that are appropriate to the needs and preferences of residents. Individuals have leases, must abide by rights and responsibilities, and may remain with no program-imposed time limits. Housing may include various combinations of subsidy resources and services.

Program Description	Essential Program Elements	Time Frame	Population	Desired/Expected Outcome
Rental assistance with supportive services for persons who are coming from the street or shelter/interim housing. Majority of programs serve households with a household member who has a disabled, but disability requirement with be based on subsidy source requirements.	**Case Management** • Assistance with lease process • Provision of or linkage to: Assessment, Intervention, link to mainstream resources, community building peer to peer and all other services that assist a person in remaining stably housed • Services are voluntary to the clients and are not a condition of the lease • Employment assessment and assistance • Employment training **Rental Subsidy** • Provides a rental subsidy to make the unit affordable • Provide assistance in accessing housing relocation resources/supports (security deposits, utilities, furnishings, etc.) • Ensure coordination between property manager or landlord **Health Care Access** • Wellness services • Physical and mental health services	No time frames	• Any high needs individuals with multiple barriers to housing that is literally homeless (lease-based program) • Specialized eligibility requirements for subsidies including veterans, disable, long term homeless, or domestic violence **Prioritizing:** • Disabling condition and long-term, multiple episodes of homelessness. • Highest Vulnerability Index Score • Unique Populations: ○ Families with Children ○ Elderly ○ Veterans	**Outcome: Clients will remain in permanent housing.** 80% of Clients will remain in permanent housing. **Client will increase earned income.** **Indicators:** Threshold (increasing):56% of all participants have non-employment income. Threshold (increasing): 56% of participants obtain mainstream benefits. Threshold 35% of participants will increase earned income.

Rapid Re-Housing

This program is to provide stabilization and assessment and subsidy assistance and case management, with an express focus securing stable housing as quickly as possible, regardless of disability or background. Although this is targeted to be a short term intervention, housing agencies may provide rental subsidy and case management for up to 24 months.

Program Description	Essential Program Elements	Time Frame	Population	Desired/Expected Outcome
Rental assistance and supportive services programs that rapidly re-houses and stabilizes persons who are homeless into appropriate permanent housing.	**Case Management/Housing Navigation** Housing Location Housing stabilization planning using common tools Employment assistance Employment training Linkage to mainstream resources Linkage to mental health services as appropriate Linkage to medical services as needed Linkage to substance use treatment services as appropriate Transportation assistance Financial management Domestic designate Specific Consideration Access to crisis intervention services Safety planning Legal advocacy **Temporary Financial Assistance** • Rental assistance based on lease and housing stabilization plan • Need based rental assistance • Utility assistance • Childcare • Employment assessment and Referral and Job Training **Housing Relocation** • Provision of or formalized partnership to housing referrals and placement services • Linkage to community supports and/or wraparound system of services in relation to housing placement	Up to 24 months of rent subsidy and supportive services, during which households are stabilized Supportive and Employment Services although voluntary may be provided indefinitely.	Literally homeless households or those residing in shelters. Households that show the ability to become self-sufficient in a short period of time as evidence by having income potential, and do not need intense services to remain housed; recently became homeless; no serious known disabilities May be used as a bridge to PSH Priority populations: Households with children residing on streets or in emergency shelters who are not eligible for VA-funded RRH.	**Outcome: Households will secure and maintain appropriate, affordable permanent housing** **Households will increase earned income.** **Indicators:** Threshold: 80% of households will exit to permanent housing. Threshold: 70% of households remain housed 6 months after exit. Threshold: 70% of households increase income during program enrollment. Threshold: 70% of eligible participants obtain mainstream benefits Threshold: 45% of eligible participants will increase earned income

	• Temporary financial assistance (security deposits, utility deposits, furniture, household supplies) **Harm Reduction and Housing First** • All supportive housing embraces and practices Harm Reduction and Housing First • Incorporate proven best practices and evidence-based practices • Programs do not require sobriety or medication/treatment compliance as a condition of housing attainment or retention			

Transitional Housing (TH)

Transitional housing provides interim stability and support to successfully move to maintain permanent housing. Transitional housing covers up to 24 months of housing with accompanying supportive services. Upon completion of any transitional housing program, consumers must only be referred to Rapid Re-Housing and non-chronic PSH.

Program Description	Essential Program Elements	Time Frame	Population	Desired/Expected Outcome
Short-term housing and supportive, wrap around services (up to 1 yr.) to prepare individuals that are homeless to secure and maintain permanent housing at exit. Intended to rapidly house and stabilize without barriers to enrollment (i.e., eligibility requirements such as income, sobriety, childcare, rental history)	**Case Management** • Housing Focused • Linkage mainstream resources and other supports as needed • Not mandatory for continued housing • Tailored to participant needs not to program and does not prescribe a standard "program" for every household. • Employment screening and assessment • Employment Training Domestic Violence Specific Considerations: • Access to crisis intervention services • Safety Planning • Legal Advocacy **Housing** • Provision of or formalized partnership to housing referrals and placement services • Primary responsibility of program is to locate permanent housing • Must be licensed or have licensed overnight if substance use, mental or physical health oriented. **Harm Reduction and Housing First** • Incorporate proven best practices and evidence-based practices • Program agreement does not include "zero tolerance" policies (except for physical violence or threats) for attainment or retention of housing. • Comply with Fair Housing Laws (no-single-gender programs or arbitrary caps on ages, numbers or genders of children) • Comply with HUD Equal Access Rule	Up to 24 months of housing subsidy and case management Up to 6 months of follow-up services provided after exit	Youth who cannot sign a lease (under 18 years), those fleeing domestic violence, those interested in substance use treatment and/or recovery support, and recently released from institutions, those seeking licensed medical or mental health housing May be used as a bridge to RRH for enrolled clients awaiting housing location or approval	**Outcome: Exiting households will secure and maintain permanent housing.** **Households will increase earned income.** **Indicators:** Threshold: 80% of households will exit to permanent housing. Threshold: 40% of participants will have (earned)employment income. Threshold: 10% of all participants have non-employment income Threshold: 35% of participants will increase earned income.

Employment Initiative

During admission in to shelter, employment and income is assessed and discussed as an immediate goal in order to ensure that the client's housing placement is sustainable. Shelter providers must complete an employment assessment with in the first two engagements with the client. The employment assessment will help gain an understanding of the client's employment history, skills, competencies, and needs. Clients who are deemed unemployable should be screened for disability status and referred to a SOAR Specialist for SSI/SSDI Outreach Assessment & Recovery application assistance upon that determination being made.

The goal is from initial engagement to ensure individuals are being assessed to determine the best course of action to assist with employment stabilization. Shelter providers complete the employment assessment in HMIS and create a short-term plan and long-term service plan to address the employment needs. When completed the assessment should be forwarded to the designated CareerSource Broward Homeless Coordinator after information releases have been signed by the individual.

Coordinated Entry and Assessment (CEA) Policies and Procedures

The HCoC establishes the following guiding principles for its CEA:

- The CEA team will operate with a person-centered approach, and with person-centered outcomes.
- The CEA team will ensure that participants quickly receive access to the most appropriate services and housing resources available.
- The CEA team will reduce the stress of the experience of being homeless by limiting assessments and interviews to only the most pertinent information necessary to resolve the participant's immediate housing crisis.
- The CEA team will incorporate cultural and linguistic competencies in all engagement, assessment, and referral coordination activities.
- The CEA team will implement standard assessment tools and practices and will capture only the limited information necessary to determine the severity of the participant's needs and the best referral strategy for him or her.
- The CEA team will integrate mainstream service providers into the system, including local Public Housing Authorities and VA medical centers.
- The CEA team will utilize HMIS for the purposes of managing participant information and facilitating quick access to available HCoC resources.
- The CEA team will monitor the wait list monthly, to ensure referrals on the wait list are being referred to housing providers upon availability.

Policy 1: Coordinated Entry Expectations

All HCoC Program-and ESG Program funded projects are required to participate in the Broward CEA. The HCoC still aims to have all homeless assistance projects participating in its CEA process and will work with all local projects and funders in its geographic area to facilitate their participation in the CEA process. Source: HCoC Program interim rule: 24 CFR 578.7(a) (9); ESG interim rule: 24 CFR 576.400 (d) and (e).

As part of the annual HCoC and ESG application processes, each project must submit a report that identifies the number of participants its project referred, accepted, rejected, and /or served from the CEA process.

Policy 2: HCoC and ESG Coordination

The HCoC is committed to aligning and coordinating CEA policies and procedures governing assessment, eligibility determinations, and prioritization with its written standards for administering HCoC and ESG Programs funds. The Coordinated Entry process covers the geographical area of Broward County and is mandatory for all funded providers by the County.

At least annually the HCoC Coordinated Entry will convene to identify any changes to their written standards and present to the Homeless Continuum of Care Board for approval.

Policy 3: Geographic Coverage

The HCoC's CEA process covers the HCoC's geographic area which is the entire Broward County Florida. *HUD Coordinated Entry Notice, Section II. B. 1*

Policy 4: Non-Discrimination

The CEA system must adhere to all jurisdictionally relevant civil rights and fair housing laws and regulations. *HUD Coordinated Entry Notice: Section I.D*

Housing funded by Broward's HCoC will be available to individuals and families without regard to actual or perceived sexual orientation, gender identity, or marital status in accordance with "Equal Access to Housing in HUD Programs Regardless of Sexual Orientation or Gender Identity" 24 CFR 5.105 (a)(2). All recipients and sub-recipients that participate in the Broward HCoC regardless of their funding source and the type of service/housing that they provide must comply with the nondiscrimination provisions of Federal civil right laws, including, but not limited to, the Fair Housing Act, Section 504 of the Rehabilitation Act, Title VI of the Civil Rights Act, and Title II of the Americans with Disabilities Act, as applicable.

The HCoC is committed to ensuring that no information is used to discriminate or prioritize households for housing and services on a protected basis such as race, color, religion, national origin, sex, age, familial status, disability, actual or perceived sexual orientation, gender identify, or marital status. *HUD Coordinated Entry Notice: Section Ii.B.2.g.*

The HCoC has designated the Broward County HIP CEA staff, as the entity responsible for monitoring agencies on compliance with all CEA requirements, including adherence to civil rights and fair housing laws and regulations.

- Failure to comply with these laws and regulations will result in a monitoring finding on the project, which may affect its position in the local HCoC rating and ranking process.
- 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 include 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.

Policy 5: Affirmative Marketing and Outreach

In accordance with the Non-Discrimination Policy all persons participating in any aspect of CEA such as access, assessment, prioritization, or referral shall be afforded equal access to CEA services and resources.

- Each project participating in CEA is required to post or otherwise make publicly available a notice (provided by the HCoC) that describes coordinated entry.

- This notice should be posted in the agency waiting areas, as well as any areas where participants may congregate or receive services (e.g., dining hall). All staff at each agency are required to know which personnel within their agency can discuss and explain CEA to a participant who seeks more information.
- This information must also be provided in the intake processes to each Client regardless of acceptance into the program.

Policy 6: Privacy Protection and Disclosure of Disability or Diagnostic Information

All CEA participating agencies are required to notify and obtain participant consent for the collection, use, and disclosure of participants' personally identifiable information (PII) and must have policies and procedures that specifically address participant confidentiality. *HUD Coordinated Entry Notice: Section II.B. 12.a.*

All participant information collected, stored, or shared in the operation of CEA functions, regardless of whether or not those data are stored in HMIS, shall be considered personal and sensitive information worthy of the full force of protection and security associated with data collected, stored, or shared in HMIS. *HUD Coordinated entry Notice: Section Ii.B.12.a.*

Throughout the assessment process, participants must not be pressured or forced to provide CEA staff with information that they do not wish to disclose, including specific disability or medical diagnosis information. *HUD Coordinated Entry Notice: Section II.B.* 12.F.

Policy 7: Safety Planning and Risk Assessment:

All persons who are fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking shall have immediate and confidential access to available crisis services within the defined CEA geographic area. *HUD Coordinated Entry Notice: Section II.B 10*

The CEA system must include a local domestic violence hotline, which is staffed 24 hours a day, seven days a week, to ensure that all persons who are fleeing or attempting to flee domestic violence or sexual assault have immediate access to crisis response services. All persons will have access to this hotline regardless of which access point they initially contact for services and assistance through Broward's CE. (Broward County DV Hotline – 954-761-1133).

The County has the Victims Against Women Act Transfer Plan that must be adhere to by all HCoC Funded projects funded by the County.

Policy 8: Approved Access Points for Broward County

The HCoC has adopted a "no-wrong door" approach to CEA. In doing so, participants are able to access CEA by appearing at any homeless assistance agency within the community. A list and map of all access points in the community is shown below. *HUD Coordinated Entry Notice: Section I.C. 3.*

The HCoC, recognizing that a growing number of families with very young children are seeking assistance through its CEA process, has designed a separate access point for families to better address the unique needs of households with dependent children. This access point through various providers listed below and monitored at the County's CEA. However, the CEA team will have a designated person to coordinate the Family Shelter process with referrals coming the multiple access points.

The Broward County HCoC has multiple access points through the continuum. Referrals are submitted and accepted through those HIP approved access points listed below:

Broward Behavioral Health Coalition
Broward County Housing Authority
Broward Housing Solutions
Broward Partnership (CHAC and NHAC)
Care Resource Community Health Center
CareerSource Broward
ChildNet
Covenant House
FLITE Center
Henderson Safe Haven
Hope South Florida
Homeless Helpline
Miami Rescue Mission/ South Homeless Assistance Center (SHAC)
North Hospital District
South Hospital District
Taskforce Fore Ending Homelessness
The Salvation Army
Volunteers of America

Policy 9: Access Coverage for Individuals and Shelters

The HCoC's entire geographic area is accessible to CEA for Shelters processes through defined location-specific access points for TaskForce Outreach or through the Homeless Helpline community information and referral hotline that is accessible throughout the entire HCoC geography. TaskForce Outreach is accessible in public geographic regions in the county, where individuals experiencing homelessness gather and congregate. TaskForce Outreach hours of operations are Monday-Sunday from 6:30am-9:30pm. For locations individuals must call the Homeless Helpline (954-563-4357) to obtain daily information regarding emergency shelter services.

The HCoC will ensure that CEA services are physically accessible to persons with mobility barriers. All CEA providers must have policies and procedures in place to ensure that communications and documentation will be accessible to persons with limited ability to read, write, and communicate in English.

The HCoC designates the CEA coordinating entity to serve as the primary point of contact for ensuring that all CEA materials are available in English, Spanish, and Creole. In addition, CEA participating agencies will, to the greatest extent practicable, provide communication accommodation through translation services to effectively and clearly communicate with persons who have disabilities, as well as

with any person with limited English proficiency. The CEA coordinating entity (Broward County) will provide visually and audibly accessible CEA materials when requested by agencies or participants in CEA.

Policy 10: Emergency Services

CEA initial screening and assessment services for emergency shelters for individuals are only available through Broward's Street Outreach provided by TaskForce Fore Ending Homelessness. TaskForce Outreach hours of operations are Monday-Sunday from 6:30am-9:30pm. For location individuals must call the Homeless Helpline (954-563-4357) to obtain daily information regarding emergency shelter services. The Homeless Helpline hours of operations are, Monday- Friday, from 8am-6pm, and Saturday-Sunday 8am-12pm.

For Families, the CEA Team will have a designated position that will coordinate the intake of families into Emergency Shelter and ensure they have an updated Client Profile and FVI-SPDAT.

Policy 11: Prevention / Diversion Services

The CEA system will ensure that all potentially eligible Homeless Prevention participants will be screened for homelessness prevention assistance, regardless of the access point at which they initially seek assistance. *HUD Coordinated Entry Notice: Section II.B. 8*.

Screening will be completed at all access point, the Homeless Helpline and on some occasions during intake with TaskForce Fore Ending Homelessness.

Policy 12: Street Outreach

Street outreach teams (TaskForce for Ending Homelessness) will function as access points to the CEA process for Shelter for Individuals. Additionally, street outreach teams will seek to engage persons who may be served through CEA but who are not seeking assistance or are unable to seek assistance via projects that offer crisis housing or emergency shelter. Referrals will be made through the virtual portal Zero 2016. *HUD Coordinated Entry Notice: Section II.B.6.*

Policy 13: Standardized Assessment Approach

The HCoC's CEA process will provide a standardized assessment process to all CEA participants, ensuring uniform decision-making and coordination of care for persons experiencing a housing crisis. The HCoC is committed to ensuring that all staff who assist with CEA operations receive sufficient training to implement the CEA system in a manner consistent with the vision and framework of CEA, as well as in accordance with the policies and procedures of its CEA system. *HUD Coordinated Entry Notice: Section II.B. 14*

The HCoC will provide an annual training for persons who will manage access point processes and conduct assessments for CEA. Training will be offered at no cost to the agency or staff and will be delivered by an experienced and professional trainer who is identified by the HCoC. Topics for training will include the following:

- Review of HCoC's written CEA policies and procedures, including variations adopted for specific subpopulations;
- Requirements for use of assessment information to determine prioritization;
- Intensive training on the use of the CEA assessment tool; and
- Criteria for uniform decision - making and referrals.

All persons served by CEA will be assessed using the coordinated assessments. All access points must use these tools to ensure that all persons served are assessed in a consistent manner, using the same process. The coordinated assessments will documents set of participant conditions, attributes, need level, and vulnerability, allowing the access point and/or assessment staff to identify a service strategy to the CEA staffer who manages the HCoC's prioritization list. Please see *Appendix H: CPD 14-012 Federal Notice on Prioritization*

Policy 14: Participant Autonomy

It is crucial that persons served by the HCoC's CEA system have the autonomy to identify whether they are uncomfortable or unable to answer any questions during the assessment process, or to refuse a referral that has been made to them. In both instances, the refusal of the participant to respond to assessment questions or to accept a referral shall not adversely affect his or her position on the CEA's prioritization list.

Note that some funders require collection and documentation of a participant's disability or other characteristics or attributes as a condition for determining eligibility. Participants who choose not to provide information in these instances could be limiting potential referral options. *HUD Coordinated Entry Notice: Section II.B. 11*

Policy 15: Updating the Assessment:

Participant assessment information should be updated at least once a year, if the participant is served by CEA for more than 12 months. Additionally, staff should update participant records with new information as new or updated information becomes known by staff. *HUD Coordinated Entry Notice: Section II.B.12.f.*

Individuals who choose not to participate in data collection upon initial assessment or project entry may later decide that their information can be collected and entered into HMIS. Participant data in HMIS can be updated after an initial CEA data collection period and throughout project enrollment to reflect emergence of new information, corrections to previously collected information, or additions of previously unanswered questions. The Broward County HCoC will continuously work to improve participant engagement strategies to achieve completion rates of required HMIS data elements that are as high as possible.

Housing Assessment Process

The CEA utilizes a **standardized assessment for housing needs.** Assessments are based on a participant's strengths, goals, risks, and protective factors. The assessments and tools used are easily understood and sensitive to the participant's lived experiences. Broward County's HCoC uses a phased assessment process to determine the appropriate housing intervention needed that includes: Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT/ Y-SPDAT/ Youth SPDAT) that helps determine client(s) acuity level, Taskforce Assessment and Rapid Re-housing Barrier Assessment and Verification. Tools utilized are tested, calibrated annually and appropriate, as well as reliable, comprehensive, and culturally and linguistically competent.

For employment needs, HMIS has a screening assessment to begin to build a profile on the individuals to determine if they need technical or vocational training, basic resume and interviewing skills, and/or a referral to CareerSource Broward (CSBD) for additional employment – related services. Agencies referring customers to CSBD must complete a referral form, completed assessment and a signed release

of information form. Agencies that elect to utilize a customized employment assessment tool must include all of the elements included in the CEA's employment assessment.

Please See Appendix A for all Standardized Assessments

There are special assessments that can be utilized for the HUD-designated subpopulations. These include:

- Adults without children;
- Adults accompanied by children;
- Unaccompanied Youth;
- Households fleeing domestic violence, dating violence, sexual assault stalking or other dangerous conditions (human trafficking);
- Persons at imminent risk of literal homelessness. **Applicant Rights***:* Applicants have the right to complete a Coordinated Entry standardized housing assessment and have the right to request a Skilled Assessor who speaks their native language or translation services.

As needed, applicants have the right to update their Coordinated Entry Assessment either with the Skilled Assessor who originally completed the assessment with the individual or household or with any other Skilled Assessor. Applicants may call the Homeless Helpline at (954)563-4357 or visit http://www.broward.org/Homeless/Pages/Default.aspx to inquire about Coordinated Entry Access Points

Applicant Responsibility: As part of this process applicants will be asked to sign a Homeless Management Information System (HMIS) Release of Information that will ask what level of sharing, if any, they approve of. This consent will be explained, and the applicant has the right to ask questions related to how their data will be used or shared so that they can make an informed decision.

While completing a variety of assessments, applicants are responsible for sharing information as accurately as possible. When providers are interacting with applicants, they should always inquire about the need to update their information such as contact information, new hospitalizations or the diagnosis of a disabling condition, change in family composition, and change in income. These updates allow for a more accurate understanding of eligibility for housing programs and when matched to housing, updated contact information allows the housing agency to reach the household.

Refusals of Housing Assessment: Individuals who do not sign the Release of Information and who do not complete the assessment may delay or negatively impact their ability to access housing. When assessors encounter individuals, who do not provide a response to any of the first questions, they should stop and acknowledge that the assessment will not provide useful information. The assessor should inform the individual that referrals are not permitted to be sent to service providers without the participant's consent.

Individuals who are not able to complete either a VI-SPDAT, FSPDAT or Y-SPDAT can request reasonable accommodations which may include the use of TTY: (954)831-3940. If additional assistance is needed, then they may contact the Homeless Helpline through TTY.

Applicants are responsible for responding to service providers' calls and should inform the provider if they are in need of any additional supports. Extra support may include scheduling a housing intake appointment, accessing documents, or resources within the community, and etc. The service provider must attempt to contact the applicants within five (5) calendar days of the referral and should attempt

to contact the applicants a minimum of five (5) times. All attempts should be documented in the Client Notes section in the client's HMIS record.

The assessments determine the client's service needs based on HUD's Criteria of Defining Homeless (Categories 1 and 4). Category 4 clients (victims of domestic violence) must be referred immediately to Women in Distress of Broward County.

Policy 16: Assessor Training

The HCoC is committed to ensuring that all staff who assist with CEA operations receive sufficient training to implement the CEA system in a manner consistent with the vision and framework of CEA. Training will be offered monthly by the County through both HIP staff and HMIS staff. Additionally, if training is needed for specific assessments, this will be offered semi-annually by the County. *HUD Coordinated Entry Notice: Section II.B.14*

The HCoC will provide at quarterly and/or monthly trainings for providers who manage access point processes and conduct assessments for CEA. Training will be offered at no cost to the agency and will be delivered by an experienced and professional trainer at Broward County who is identified by the HCoC. Topics for training will include the following:

- Review of HCoC's written CEA policies and procedures, including variations adopted for specific subpopulations;
- Requirements for use of assessment information to determine prioritization;
- Intensive training on the use of the CEA assessment tools; and
- Criteria for uniform decision-making and referrals.

Policy 17: Housing Prioritization

HCoC will use data collected through the CEA process to prioritize homeless persons within the HCoC's geography. Prioritization is be used for all housing intervention including PSH, RRH, Transition and shelters. *HUD Coordinated Entry Notice: Section II.B.3.*

Prioritization is the process of determining a household's priority for housing and support services. Broward utilizes several need factors to prioritize individuals experiencing homelessness. These include but are not limited to; the VI-SPDAT, the Housing Barrier Assessment, length of time homeless, number of episodes of homelessness and severity of service needs. Severity of service needs may not necessarily be based on a specific diagnosis or disability type, but only on the severity of needs of the individual or family, considering history of high utilization of crisis services e.g. emergency rooms, jails, and psychiatric facilities); significant health or behavioral health challenges, age and substance use disorder or functional impairment that require a significant level of support to maintain permanent housing. These may also include the presence of a child under the age of two (2) or two or more children under the age of five (5) who are currently living in a place not met for human habitation, and/or the presence of a pregnant woman in the household.

The housing assessments and referral process is built into the Broward HCoC Homeless Management Information System (HMIS) to promote accuracy and transparency across service providers. A Release of Information (ROI) is required from all service providers to ensure all providers have access to the individual's information and can provide a consistent level of care. The ROI must be entered into HMIS the SAME DAY the service is rendered. The ROI enforces coordination of services and is required before inputting client's information into the HMIS. **The ROI must be completed and dated the same day as the client's entry into the program, otherwise no other providers can view any information about the**

client. It is critical that the ROI is properly dated and documented in HMIS in order to avoid duplicate entries and to ensure that clients receive the correct services.

All assessments and VI-SPDAT must be recorded in the HMIS within three (3) calendar days.

Per Section 578,57 (a)(3) of the HCoC Program Interim Rule, the primary purposes of using HMIS for CEA is to store client data and enable case management direct service personnel to use HMIS as a referral platform for housing and services providers.

Additionally, HMIS is also used in this process to provide data on client outcomes to case management activities, housing service providers activities, and shelter staff service providers to monitor homeless prevention and housing.

Finally, HMIS serves as a communication platform for coordinated entry sites to view client placements, share information on the households they serve and reduce duplication. Critical documents are uploaded in the system to assist with the Clients housing process.

This also applies to the ESG Projects that are within the Broward HCoC. Broward HCoC has adopted the provisions and requirements set out in HUD Notice CPD-16-11 and CPD-17-01 for prioritizing housing placement for persons experiencing chronic homelessness and other vulnerable homeless persons in its PSH program.

A. Order of Prioritization

Broward County HCoC has adopted the order of priority prescribed in HUD's Notice CPD-16-011: "Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing"

https://www.hudexchange.info/resource/5108/notice-cpd-16-11-prioritizing-persons-experiencing-chronic-homelessness-and-other-vulnerable-homeless-persons-in-psh/

Recipients of HCoC program funded PSH should follow the order of priority below while also considering the goals and any identified target populations served by the project. All referrals to PSH will be through Coordinated Entry based on the following prioritization:

A. Order of Priority for HCoC-Program funded Permanent Supportive Housing Beds Dedicated or Prioritized for Occupancy by Persons Experiencing Chronic Homelessness

1. Chronically Homeless Individuals and Families with the Longest Histories Residing in Places not meant for Human Habitation, in Emergency Shelters, and in Safe Havens and with the Most Severe Service Needs.

2.Chronically Homeless Individuals and Families with the Longest Histories Residing in Places not meant for Human Habitation, in Emergency Shelters, and in Safe Havens

3.Chronically Homeless Individuals and Families with the Most Severe Service Needs.

4. All Other Chronically Homeless Individuals and Families.

B. Order of Priority in Permanent Supportive Housing Beds Not Dedicated or Prioritized for Persons Experiencing Chronic Homelessness

1.Homeless Individuals and Families with a Disability with Long Periods of Episodic Homelessness and Severe Service Needs

2.Homeless Individuals and Families with a Disability with Severe Service Needs

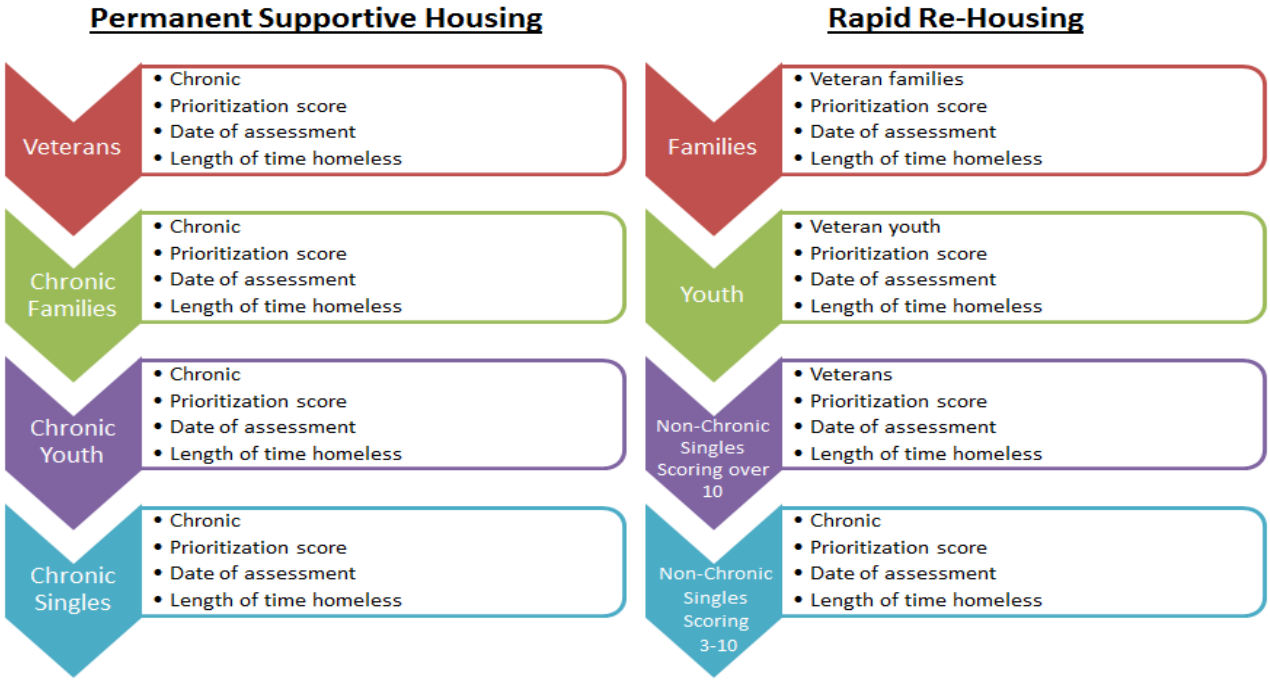
3.Homeless Individuals and Families with a Disability Coming from Places Not

Meant for Human Habitation, Safe Havens, or Emergency Shelter without Severe Service Needs

4.Homeless Individuals and Families with a Disability Coming from Transitional Housing

Persons are prioritized for PSH based on their length of time homeless and the severity of their needs following the order of priority described above. HUD and the HCoC recognize that some persons–particularly those living on the streets or in places not meant for human habitation–might require significant engagement and contacts prior to their entering housing and recipients are not required to keep units vacant indefinitely while waiting for an identified eligible individual or family to accept an offer of PSH.

- Recipients of HCoC Program-funded PSH are encouraged to follow a Housing First approach to the maximum extent practicable. Street outreach providers should continue to make attempts to engage those persons that have been resistant to accepting an offer of PSH and these individuals and families must continue to be prioritized until they are housed.
- The Priority List will be maintained via the HMIS system managed by Coordinated Entry.
- Any agency representative trained to conduct the VISPDAT may assess a client to be placed on the list.
- Under no circumstances shall the order of priority be based upon diagnosis or disability type, but instead on the length of time an individual or family has been experiencing homelessness and the severity of needs of the individual or family.



Prioritization Process for all Clients eligible for PSH and RRH:

The following criteria and timeframes will be followed by all agencies providing PSH services to all Clients eligible for any PSH program (HUD or General Funds):

- Referrals from the approved Access Point to Broward County's CEA staff must be processed by the housing provider within three (3) calendar days.
- The Housing Provider has three (3) calendar days to note in HMIS the disposition of the referral. If a referral (individual) is declined, the case must be staffed by CEA to decide the direction on next steps for the individual/family.
- Housing agencies will hold an open unit for a period of (5) five calendar days while searching for the Client. The Housing Provider will make 5(five) attempts to contact clients and document these efforts in the Client Notes section in the client's HMIS record.
- Search methods can include consulting existing waiting lists, contacting client's emergency contacts listed in HMIS, contacting Street Outreach, researching last contact in HMIS, contacting local law enforcement Homeless Outreach Teams (HOT), BBHC and coordinated entry information.
- Agencies will make efforts to help clients address program requirement barriers that might otherwise exclude them from qualifying, such as, verification of Chronicity (if applicable), obtaining an ID, and documentation of disabling conditions (if applicable).
- If the Individual experiencing homelessness cannot be found within the 5 (five) calendar day timeframe, the agency needs to contact the Homeless Initiative Partnership (HIP) agency and notify the efforts made to locate. The CEA staff will verify the efforts in HMIS and place the referral back onto the respective By -Name List for the next meeting. CEA staff will then send 2 referrals to assist with filling that slot. Referrals will be sent by the County within 3 (three) calendar days of the provider's request.
- During housing intake, the agency will ensure that an employment assessment has been completed and documented in HMIS. If the Client has not done so, the agency will include this in the intake process.
- The Broward County CEA staff will send two (2) referrals for every open slot the Housing Provider is reporting within 3 (three) calendar days of noting the opening.
- If a Housing Provider declines a referral, they must notify the County CEA staff and review efforts to locate.

CH + Longest History + Highest Level of Need

Broward HCoC will prioritize clients who are referred to the centralized PSH wait list through its coordinated intake and assessment process as follows:

1. Prioritizing PSH Beds Dedicated to Serve Chronically Homeless Clients:
    a. Priority – Chronically Homeless clients, with the longest history of homelessness, the most severe service needs and acuity as determined by the VI-SPDAT.

b. The type of Permanent and Supportive Housing that is available.

Homeless + Longest History + Disability + Highest Level of Need

If there are PSH beds targeted towards non-chronic and/or no chronically homeless clients that can be identified for placement, then the HCoC lead agency prioritization list will follow the process for assigning PSH Beds. Prioritizing PSH Beds that are not for Dedicated Chronic Homeless Clients

1. Priority – Homeless clients with a disability and most severe service needs (consider age) who are not Chronic,
    a. Streets, safe havens, shelter for any period including
    b. Clients exiting an institution where they have resided for less than ninety (90) days and were on the streets, safe have, shelter immediately before the institution.

Prioritization of Matrix for Clients with the same VI-SPDAT Score: If there are two (2) or more homeless clients that have the same VI-SPDAT score, then the following criteria will apply:

- Veteran Status
- Unsheltered Sleeping Location
- Medical Vulnerability (Those with severe medical needs who are at a greater risk of death)
- Overall Wellness (Behavior health, mental health, history of substance use, or other behavioral health conditions that mark or exacerbate medical condition)
- Length of Time of Homeless (Prioritize those experiencing homelessness the longest)
- Date of VI-SPDAT (Prioritize those experiencing homelessness the longest)
- Elderly

Housing Navigators: Clients will be referred to the HCoC Housing Navigators through BPHI, who in turn will assist individuals and families to locate and obtain permanent housing. Referrals will be made to the Housing Navigators through HMIS. The role of the Housing Navigators is:

- Provide assistance with housing search
- Maintain an ongoing and updated list of available units
- Work collaboratively with the Housing Case Manager
- Provide resources for housing units

Clients, as well as veterans who are not eligible for Supportive Services for Veteran Families (SSVF), Transition in Place (TIP), and Government Pension Offset (GPO) can be referred to RRH program if they express an interest in the program. Based on the quantity of available units, RRH placement will use the following prioritization process:

- Unsheltered Sleeping Location: Priority given to unsheltered client over sheltered client.
- Length of Time Homeless: Priority given to client that has experienced homelessness the longest.

- Date of VI-SPDAT Assessment: Priority given to the oldest date of assessment and the longest time on the By Name Lists.
- Overall Wellness: Priority given to client with medical needs when they have behavioral health conditions or histories of substance use, which may either mask or exacerbate medical conditions.
- Medical Vulnerability: Priority given to client with severe medical needs who are at greater risk of death.

HIP generates the HMIS housing placement prioritization wait lists which are reviewed by an assigned HCoC By Name workgroup to determine appropriate housing placements.

Policy 18: By Name List Process

Broward County has 5 (five) sub populations for PSH and RRH housing interventions. Each category will convenes a meeting as noted below and provide updates and prioritization for each sub population. The intention of a prioritization list is to have a single, centralized list for each sub population for the entire HCoC, that includes all relevant participant-level information to identify which persons are most vulnerable and therefore most likely to be in the most immediate need for HCoC assistance prioritized through CEA. The use of a prioritization list ensures that HCoCs do not serve persons on a "first come, first served basis," but rather according to each participant's level of need, vulnerability, and risk of greater harm should the household not receive accelerated access to HCoC assistance.

The purpose of the By Name Lists meetings is to ensure transparency in the prioritization of five (5) sub populations for PSH and RRH Housing. These five sub populations are:

- Chronically Homeless Households
- Veterans
- Families (adult plus minor child(s))
- Youth (18-24 years)
- Adult only Households with non-chronic disability

Additionally, this process is designed to expedite referrals to housing providers and decrease the amount of time referrals are in queue and not being processed. The maximum amount of time a referral should be in queue is 5 (five) calendar days.

These meetings are held quarterly and cannot be **cancelled without the written approval of the Homeless Initiative Administrator approval**. Requests for cancellation must be made in writing at least 10 calendar days prior to the meeting and the justification for the cancellation by HIP Administrator clearly documented.

The goal of the By Name Lists meetings is to expedite the housing process and decrease the time from referral to move in for individuals experiencing homelessness from 120 days to 60 days (50%) decrease.

Broward County has five (5) By Name Lists that managed monthly by Coordinated Entry and Assessment and staffed quarterly with providers and partners. These lists include:

1. **Youth:** – review monthly youth ages 18-24 who are experiencing homelessness (literally homeless - HUD categories 1 and 4). This is a quarterly face to face meeting to discuss and prioritize the youth. During the COVID 19 pandemic these meetings are held virtually. Attendees should include:

- Covenant House
- BBHC
- ChildNet
- Sun Serve
- BCHA
- BPHI – Housing
- VOA
- BHS
- Hope South Florida
- The Salvation Army
- School Board (person who targets 1 and 4 categories)
- Lippman Shelter
- Handy
- Flite Center
- South Florida Wellness
- CareerSource Broward
- FSAD
- Camelot
- Gulf Coast
- Henderson
- CareerSource Broward

2. **Families:** This list is managed monthly by Coordinated Entry and Assessment and staffed quarterly with providers and partners to review those families identified as experiencing homeless. Family is defined as an adult with minor (under age 18) children. This is a face to face meeting to discuss and prioritize. During the COVID-19 pandemic these meetings will be held virtually. Families must be literally homeless (HUD categories 1 and 4). Attendees:

    - Broward School Board
    - ChildNet
    - BPHI North and Central HAC
    - BOC – South HAC
    - BPHI Housing
    - The Salvation Army
    - Hope South Florida
    - BCHA
    - BHS
    - VOA
    - Flite Center
    - CareerSource Broward
    - FSAD
    - TaskForce
    - BBHC
    - Camelot
    - Gulf Coast
    - Henderson
    - Silver Impact

3. **Chronic:** This list is managed monthly by Coordinated Entry and Assessment and staffed quarterly with providers and partners discuss those individuals who are identified as chronically homeless. During the COVID-19 pandemic this meeting is held virtually This meeting will review their status and prioritize placement. Attendees:

    - North Hospital District
    - South Hospital District
    - TaskForce
    - BSO
    - BCHA
    - BHS
    - VOA Housing
    - BPHI Housing
    - Fort Lauderdale PD
    - Hollywood PD
    - City of Pompano
    - BBHC
    - FSAD
    - Henderson
    - The Salvation Army
    - BOC
    - VOA Supportive Services
    - ChildNet

4. **Individuals (not Chronic):** This list is managed monthly by Coordinated Entry and Assessment and staffed quarterly with providers and partners to review those individuals who are not chronic but are high multi-system users. This meeting reviews their status and prioritize them for placement. This meeting is a monthly face to face meeting, however during the COVID-19 Pandemic it is held virtually. These may at time be inclusive of encampments. Attendees:

    - South Hospital District
    - North Hospital District
    - BBHC
    - BSO
    - BPHI Housing
    - BPHI shelter (north and south)
    - BHS
    - BCHA
    - BOC
    - Hope South Florida
    - The Salvation Army
    - City of Pompano
    - City of Hollywood
    - Henderson
    - CareerSource Broward
    - FSAD
    - TaskForce

5. **Veterans**: This list is managed monthly by Coordinated Entry and Assessment and staffed quarterly with providers and partners. This is to review the status of each person on the list and ensure action is being taken to house them.

    - Veterans Administration (VA)
    - Operation Sacred Trust (OST)
    - Keystone Halls
    - Mission United/ United Way
    - Urban League of Broward County (SSVF)
    - TaskForce
    - Broward County Housing Authority (HUD-VASH)
    - HOPE South Florida (HOPE 4 Vets)
    - Miami Rescue Mission
    -

Policy 19: Referral

All CEA participating providers enroll new participants only from the HCoC's CEA referral process. To facilitate prompt referrals and to reduce vacancy rates, participating providers must notify the CEA coordinating entity of any known and anticipated upcoming vacancies.

When a Emergency Shelter, TH, RRH, or PSH vacancy occurs or is expected to occur in the immediate future, the provider agency with the vacancy must alert the CEA Coordinator via email within three (3) calendar days of the vacancy becoming aware of the vacancy. The notification could include specific details of the vacancy, including the project name, unit size, location, and any funder-defined eligibility requirements who will work to identify a prioritized household to fill the vacancy during the next regularly scheduled housing referral coordination meeting.

Referrals on Active List

Emergency Shelter: Participants who have been referred for **emergency shelter** will be listed on the active wait list through Coordinated Entry and Assessment for **"families".**

The emergency shelter (excluding Safe Haven) that has vacancies alert the Outreach Team via email Monday through Friday by 10:00 am for "**individuals".**

Permanent Housing: Participants who have been referred for permanent housing will be listed on the active wait list through Coordinated Entry and Assessment.

1. Participants shall remain on the active waitlist for (90) calendar days.
2. Homelessness Initiative households will remain active as long as they have a minimum of one update through the HCoC every 90 days.

Participants on the **active list** will be matched to emergency shelter services and housing providers. This practice allows our community to connect participants experiencing homelessness to emergency shelter services and housing providers while accounting for the inconsistency of updates regarding participants who may no longer face homelessness or live within Broward County. A minimum of one update through the HCoC every 90 days, must be outlined within the HCoC system. Contact with Coordinated Entry Access Providers, contact with Emergency Shelter's, verifiable contact information for participants (email, telephone numbers, point of contact, and or location for contact).

Referrals on Inactive List

Emergency Shelter: Participants who have been referred for **emergency shelter** and or **permanent housing** will be listed on the inactive wait list through Coordinated Entry and Assessment and Taskforce Outreach.

1. Refusal to complete intake at an available emergency shelter as scheduled.
2. Failure to connect with any homeless program providers within (90) calendar days, will be moved to the inactive.

Participants only enrolled in the Coordinated Entry System are moved to the **inactive list** due to no contact with any HCoC providers reporting agencies and no updates to their assessment in (90) calendar days. Participants must re-engage with any part of the HCoC providers to submit a new referral to be moved back onto the active list.

Participants are removed from the wait list once they have obtained permanent housing such as TH, RRH, and PSH.

Policy 20: Participant Declined Referrals

One of the guiding principles of CEA is participant choice. This principle must be evident throughout the CEA process, including the referral phase. Participants in CEA are allowed to reject service strategies and housing options offered to them, without repercussion.

Individuals and families will be given information about the programs available to them by the referring provider and provided choices whenever feasible based on assessment information, vulnerability and need scores, preliminary eligibility pre-determinations, and available resources. Of the options available, participants will be afforded their choice of which project to be referred to. If an individual or family declines a referral to a housing program, they remain on the *prioritization list* until the next housing opportunity is available.

Policy 21: Provider Declined Referrals

There may be instances when agencies decide not to accept a referral from the CEA system. When a housing agency declines to accept a referred prioritized household into its project, the agency must notify the CEA Coordinator of the denial and the reason for the denial within (3) calendar days. The CEA team member must then notify in writing the Human Service Manager or Administrator and if deemed necessary at staffing will be convened to address the declined referral. The reason for the decline must be documented in HMIS.

Refusals by projects are acceptable only in certain situations, including these:

- The person does not meet the project's eligibility criteria as set forth by the funding stream.
- The person would be a danger to self or others if allowed to stay at this particular project.
- The services available through the project are not sufficient to address the intensity and scope of participant need.

- The project is at capacity and is not available to accept referrals at this time.
- Other justifications as specified by the "referred to" project.

***** referrals can not be rejected based on income *****

The agency must communicate the rejected referral to the CEA Coordinator within (3) calendar days of rejecting the referral. The agency must notify the CEA Coordinator as to why the referral was rejected, how the referred participant was informed, what alternative resources were made available to the participant, and whether the project staff foresee additional, similar refusals occurring in the future. This information will then be shared by the CEA Coordinator with the Human Service Manager and Administrator, which will be discussed to decide on the most appropriate next steps for both the project and the participant.

Policy 22: Evaluation of the CEA System

Regular and ongoing evaluation of the CEA system will be conducted to ensure that improvement opportunities are identified that results are shared and understood, and that the CEA system is held accountable.

The CEA will evaluate the housing agency using HMIS data on a quarterly basis. Results will be published on the County's website, after they have been reviewed by the CEA Committee and the housing agency. The CEA Committee has selected the following as key outcomes for CEA:

1. Reduction in the length of time homeless (system and project level).
2. Reduction in the number of persons experiencing first-time homelessness (system and project level).
3. Increase in the number of placements into permanent housing (system and project level).
4. Reduction in the length of time from intake to move in date.

The Homeless Initiative Partnership will evaluate the effectiveness of its CEA System (through County, housing agency and Client feedback) using feedback gathered via a web-based survey. The housing agency requests the Clients feedback at the time of entry and exit from the project. Indicators measured via the survey will include:

- appropriateness of questions asked on assessment
- effectiveness of process to find and secure referrals; and
- satisfaction with placement.

Policy 23: Recordkeeping Requirements:

Agencies that are required by Federal, State, and County regulations and/or statutes participate in Broward HCoC must adhere to the following requirements:

- All records containing personally identifying information must be kept secure and confidential.
- Programs must have a written confidentiality/privacy policy and notice a copy of which should be made available to participants if requested.
- Documentation of homelessness (following HUDs guidelines as mentioned in CPD-16-11. Documentation of Homelessness must follow HUD's guidance, listed below in order of preference below and explained in Appendix D:

- Literally Homeless (Category 1): third party verification; written observation by an outreach worker; or certification by the individual or head of household seeking assistance stating he/she was living on the streets or in a shelter.
- Imminent Risk of Homelessness (Category 2): a court order resulting from an eviction action notifying the individual or family they must leave within 14 days; OR for an individual or family leaving a hotel or motel evidence they lack the financial resources to stay; OR a documented written or oral statement that the individual or family will be literally homeless within 14 days AND self-certification or other written documentation that the individual lacks the financial resources and support needed to obtain permanent housing.
- Chronically Homeless Individuals and Families with the most Service Needs (Category 3): third party verification; written observation by an outreach worker; or certification by the individual or head of household seeking assistance stating he/she was living on the streets or in a shelter.
- Fleeing or Attempting to Flee Domestic Violence (Category 4): For Victim Service Providers: An oral statement by the individual or head of household seeking assistance which states: they are fleeing; they have no subsequent residence and they lack resources. Statement must be documented by a self-certification or certification by the intake worker.

For -Victim Service Providers

For Victim Service Providers an oral statement is obtain by the individual or head of household seeking assistance that they are fleeing. This statement is documented by a self-certification or by the caseworker. Where the safety of the individual or family is not jeopardized, the oral statement must be verified; and Certification by the individual or head of household that no subsequent residence has been identified; and Self-certification or other written documentation that the individual or family lacks the financial resources and support networks to obtain other permanent housing.

- A record of services and assistance provided to each participant.
- Documentation of any applicable requirements for providing services/assistance.
- Documentation of use of Coordinated Entry Assessment system.
- Documentation of use of HMIS.
- Records must be retained for the appropriate amount of time as prescribed by HUD.

Please see Appendix D for full details on Recordkeeping Requirements based on Homeless Category.

Policy 24: Financial Recordkeeping Requirements

- Documentation for all costs charged to the grant;
- Documentation that funds were spent on allowable costs;
- Documentation of the receipt and use of program income;
- Documentation of compliance with expenditure limits and deadlines;
- Retain copies of all procurement contracts as applicable; and
- Documentation of amount, source and use of resources for each match contribution.

Appendices

Appendix A VI-SPDAT

Appendix B VI-FSPDAT

Appendix C Y-SPDAT for Youth

Appendix D Taskforce Assessment

Appendix E Rapid Rehousing Barrier Assessment

Appendix F Homeless Definition

Appendix G HMIS Release of Information

Appendix H CPD 14-012 Federal Notice on Prioritization

Appendix I Employment Assessment

THIS PAGE INTENTIONALLY LEFT BLANK.

Appendix A: VI-SPDAT

Vulnerability Index -
Service Prioritization Decision Assistance Tool
(VI-SPDAT)

Prescreen Triage Tool for Single Adults

AMERICAN VERSION 2.01

1 (800) 355-0420 info@orgcode.com www.orgcode.com

COMMUNITY SOLUTIONS

Welcome to the SPDAT Line of Products

The Service Prioritization Decision Assistance Tool (SPDAT) has been around in various incarnations for over a decade, before being released to the public in 2010. Since its initial release, the use of the SPDAT has been expanding exponentially and is now used in over one thousand communities across the United States, Canada, and Australia.

More communities using the tool means there is an unprecedented demand for versions of the SPDAT, customized for specific client groups or types of users. With the release of SPDAT V4, there have been more current versions of SPDAT products than ever before.

VI-SPDAT Series

The Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) was developed as a pre-screening tool for communities that are very busy and do not have the resources to conduct a full SPDAT assessment for every client. It was made in collaboration with Community Solutions, creators of the Vulnerability Index, as a brief survey that can be conducted to quickly determine whether a client has high, moderate, or low acuity. The use of this survey can help prioritize which clients should be given a full SPDAT assessment first. Because it is a self-reported survey, no special training is required to use the VI-SPDAT.

Current versions available:

- VI-SPDAT V 2.0 for Individuals
- VI-SPDAT V 2.0 for Families
- VI-SPDAT V 1.0 for Youth

All versions are available online at

www.orgcode.com/products/vi-spdat/

SPDAT Series

The Service Prioritization Decision Assistance Tool (SPDAT) was developed as an assessment tool for front-line workers at agencies that work with homeless clients to prioritize which of those clients should receive assistance first. The SPDAT tools are also designed to help guide case management and improve housing stability outcomes. They provide an in-depth assessment that relies on the assessor's ability to interpret responses and corroborate those with evidence. As a result, this tool may only be used by those who have received proper, up-to-date training provided by OrgCode Consulting, Inc. or an OrgCode certified trainer.

Current versions available:

- SPDAT V 4.0 for Individuals
- SPDAT V 2.0 for Families
- SPDAT V 1.0 for Youth

Information about all versions is available online at

www.orgcode.com/products/spdat/

1 (800) 355-0420 info@orgcode.com www.orgcode.com

SPDAT Training Series

To use the SPDAT, training by OrgCode or an OrgCode certified trainer is required. We provide training on a wide variety of topics over a variety of mediums.

The full-day in-person SPDAT Level 1 training provides you the opportunity to bring together as many people as you want to be trained for one low fee. The webinar training allows for a maximum of 15 different computers to be logged into the training at one time. We also offer online courses for individuals that you can do at your own speed.

The training gives you the manual, case studies, application to current practice, a review of each component of the tool, conversation guidance with prospective clients – and more!

Current SPDAT training available:

- Level 0 SPDAT Training: VI-SPDAT for Frontline Workers
- Level 1 SPDAT Training: SPDAT for Frontline Workers
- Level 2 SPDAT Training: SPDAT for Supervisors
- Level 3 SPDAT Training: SPDAT for Trainers

Other related training available:

- Excellence in Housing-Based Case Management
- Coordinated Access & Common Assessment
- Motivational Interviewing
- Objective-Based Interactions

More information about SPDAT training, including pricing, is available online at

http://www.orgcode.com/product-category/training/spdat/

1 (800) 355-0420 info@orgcode.com www.orgcode.com

Administration

Interviewer's Name	Agency	☐ Team ☐ Staff ☐ Volunteer
_____	_____	
Survey Date	**Survey Time**	**Survey Location**
DD/MM/YYYY ____/____/_____	__ __ __ __	_____

Opening Script

Every assessor in your community regardless of organization completing the VI-SPDAT should use the same introductory script. In that script you should highlight the following information:

- the name of the assessor and their affiliation (organization that employs them, volunteer as part of a Point in Time Count, etc.)
- the purpose of the VI-SPDAT being completed
- that it usually takes less than 7 minutes to complete
- that only "Yes," "No," or one-word answers are being sought
- that any question can be skipped or refused
- where the information is going to be stored
- that if the participant does not understand a question or the assessor does not understand the question that clarification can be provided
- the importance of relaying accurate information to the assessor and not feeling that there is a correct or preferred answer that they need to provide, nor information they need to conceal

Basic Information

First Name	Nickname	Last Name
_____	_____	_____

In what language do you feel best able to express yourself? _____

Date of Birth	Age	Social Security Number	Consent to participate	
DD/MM/YYYY ____/____/_____	_____	_____	☐ Yes	☐ No

IF THE PERSON IS 60 YEARS OF AGE OR OLDER, THEN SCORE 1. **SCORE:**

A. History of Housing and Homelessness

1. Where do you sleep most frequently? (check one)

☐ Shelters
☐ Transitional Housing
☐ Safe Haven
☐ **Outdoors**
☐ **Other (specify):** _____
☐ **Refused**

IF THE PERSON ANSWERS ANYTHING OTHER THAN "SHELTER", "TRANSITIONAL HOUSING", OR "SAFE HAVEN", THEN SCORE 1.	**SCORE:**

2. How long has it been since you lived in permanent stable housing? _____ ☐ Refused
3. In the last three years, how many times have you been homeless? _____ ☐ Refused

IF THE PERSON HAS EXPERIENCED 1 OR MORE CONSECUTIVE YEARS OF HOMELESSNESS, AND/OR 4+ EPISODES OF HOMELESSNESS, THEN SCORE 1.	**SCORE:**

B. Risks

4. In the past six months, how many times have you...
   a) Received health care at an emergency department/room? ____ ☐ Refused
   b) Taken an ambulance to the hospital? ____ ☐ Refused
   c) Been hospitalized as an inpatient? ____ ☐ Refused
   d) Used a crisis service, including sexual assault crisis, mental health crisis, family/intimate violence, distress centers and suicide prevention hotlines? ____ ☐ Refused
   e) Talked to police because you witnessed a crime, were the victim of a crime, or the alleged perpetrator of a crime or because the police told you that you must move along? ____ ☐ Refused
   f) Stayed one or more nights in a holding cell, jail or prison, whether that was a short-term stay like the drunk tank, a longer stay for a more serious offence, or anything in between? ____ ☐ Refused

IF THE TOTAL NUMBER OF INTERACTIONS EQUALS 4 OR MORE, THEN SCORE 1 FOR **EMERGENCY SERVICE USE.**	**SCORE:**

5. Have you been attacked or beaten up since you've become homeless? ☐ **Y** ☐ N ☐ Refused
6. Have you threatened to or tried to harm yourself or anyone else in the last year? ☐ **Y** ☐ N ☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **RISK OF HARM.**	**SCORE:**

7. Do you have any legal stuff going on right now that may result in you being locked up, having to pay fines, or that make it more difficult to rent a place to live? ☐ **Y** ☐ N ☐ Refused

IF "YES," THEN SCORE 1 FOR **LEGAL ISSUES.** SCORE:

8. Does anybody force or trick you to do things that you do not want to do? ☐ **Y** ☐ N ☐ Refused

9. Do you ever do things that may be considered to be risky like exchange sex for money, run drugs for someone, have unprotected sex with someone you don't know, share a needle, or anything like that? ☐ **Y** ☐ N ☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **RISK OF EXPLOITATION.** SCORE:

C. Socialization & Daily Functioning

10. Is there any person, past landlord, business, bookie, dealer, or government group like the IRS that thinks you owe them money? ☐ **Y** ☐ N ☐ Refused

11. Do you get any money from the government, a pension, an inheritance, working under the table, a regular job, or anything like that? ☐ Y ☐ **N** ☐ Refused

IF "YES" TO QUESTION 10 OR "NO" TO QUESTION 11, THEN SCORE 1 FOR **MONEY MANAGEMENT.** SCORE:

12. Do you have planned activities, other than just surviving, that make you feel happy and fulfilled? ☐ Y ☐ **N** ☐ Refused

IF "NO," THEN SCORE 1 FOR **MEANINGFUL DAILY ACTIVITY.** SCORE:

13. Are you currently able to take care of basic needs like bathing, changing clothes, using a restroom, getting food and clean water and other things like that? ☐ Y ☐ **N** ☐ Refused

IF "NO," THEN SCORE 1 FOR **SELF-CARE.** SCORE:

14. Is your current homelessness in any way caused by a relationship that broke down, an unhealthy or abusive relationship, or because family or friends caused you to become evicted? ☐ **Y** ☐ N ☐ Refused

IF "YES," THEN SCORE 1 FOR **SOCIAL RELATIONSHIPS.** SCORE:

D. Wellness

15. Have you ever had to leave an apartment, shelter program, or other place you were staying because of your physical health?	☐ Y	☐ N	☐ Refused
16. Do you have any chronic health issues with your liver, kidneys, stomach, lungs or heart?	☐ Y	☐ N	☐ Refused
17. 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?	☐ Y	☐ N	☐ Refused
18. Do you have any physical disabilities that would limit the type of housing you could access, or would make it hard to live independently because you'd need help?	☐ Y	☐ N	☐ Refused
19. When you are sick or not feeling well, do you avoid getting help?	☐ Y	☐ N	☐ Refused
20. *FOR FEMALE RESPONDENTS ONLY:* Are you currently pregnant?	☐ Y	☐ N	☐ N/A or Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **PHYSICAL HEALTH.** **SCORE:**

21. Has your drinking or drug use led you to being kicked out of an apartment or program where you were staying in the past?	☐ Y	☐ N	☐ Refused
22. Will drinking or drug use make it difficult for you to stay housed or afford your housing?	☐ Y	☐ N	☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **SUBSTANCE USE.** **SCORE:**

23. Have you ever had trouble maintaining your housing, or been kicked out of an apartment, shelter program or other place you were staying, because of:

a) A mental health issue or concern?	☐ Y	☐ N	☐ Refused
b) A past head injury?	☐ Y	☐ N	☐ Refused
c) A learning disability, developmental disability, or other impairment?	☐ Y	☐ N	☐ Refused
24. Do you have any mental health or brain issues that would make it hard for you to live independently because you'd need help?	☐ Y	☐ N	☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **MENTAL HEALTH.** **SCORE:**

IF THE RESPONENT SCORED 1 FOR **PHYSICAL HEALTH** AND 1 FOR **SUBSTANCE USE** AND 1 FOR **MENTAL HEALTH**, SCORE 1 FOR **TRI-MORBIDITY**. **SCORE:**

25. Are there any medications that a doctor said you should be taking that, for whatever reason, you are not taking?	☐ Y	☐ N	☐ Refused
26. Are there any medications like painkillers that you don't take the way the doctor prescribed or where you sell the medication?	☐ Y	☐ N	☐ Refused

IF "YES" TO ANY OF THE ABOVE, SCORE 1 FOR **MEDICATIONS.** **SCORE:**

27. *YES OR NO:* Has your current period of homelessness been caused by an experience of emotional, physical, psychological, sexual, or other type of abuse, or by any other trauma you have experienced?	☐ Y	☐ N	☐ Refused

IF "YES", SCORE 1 FOR **ABUSE AND TRAUMA.** **SCORE:**

Scoring Summary

DOMAIN	SUBTOTAL
PRE-SURVEY	/1
A. HISTORY OF HOUSING & HOMELESSNESS	/2
B. RISKS	/4
C. SOCIALIZATION & DAILY FUNCTIONS	/4
D. WELLNESS	/6
GRAND TOTAL:	/17

RESULTS

Score:	Recommendation:
0-3:	no housing intervention
4-7:	an assessment for Rapid Re-Housing
8+:	an assessment for Permanent Supportive Housing/ Housing First

Follow-Up Questions

On a regular day, where is it easiest to find you and what time of day is easiest to do so?	place: _____ time: ___ : ____ or
Is there a phone number and/or email where someone can safely get in touch with you or leave you a message?	phone: (____) _____ - _____ email: _____
Ok, now I'd like to take your picture so that it is easier to find you and confirm your identity in the future. May I do so?	☐ Yes ☐ No ☐ Refused

Communities are encouraged to think of additional questions that may be relevant to the programs being operated or your specific local context. This may include questions related to:

- military service and nature of discharge
- ageing out of care
- mobility issues
- legal status in country
- income and source of it
- current restrictions on where a person can legally reside
- children that may reside with the adult at some point in the future
- safety planning

Appendix A: About the VI-SPDAT

The HEARTH Act and federal regulations require communities to have an assessment tool for coordinated entry - and the VI-SPDAT and SPDAT meet these requirements. Many communities have struggled to comply with this requirement, which demands an investment of considerable time, resources and expertise. Others are making it up as they go along, using "gut instincts" in lieu of solid evidence. Communities need practical, evidence-informed tools that enhance their ability to to satisfy federal regulations and quickly implement an effective approach to access and assessment. The VI-SPDAT is a first-of-its-kind tool designed to fill this need, helping communities end homelessness in a quick, strategic fashion.

The VI-SPDAT

The VI-SPDAT was initially created by combining the elements of the Vulnerability Index which was created and implemented by Community Solutions broadly in the 100,000 Homes Campaign, and the SPDAT Prescreen Instrument that was part of the Service Prioritization Decision Assistance Tool. The combination of these two instruments was performed through extensive research and development, and testing. The development process included the direct voice of hundreds of persons with lived experience.

The VI-SPDAT examines factors of current vulnerability and future housing stability. It follows the structure of the SPDAT assessment tool, and is informed by the same research backbone that supports the SPDAT - almost 300 peer reviewed published journal articles, government reports, clinical and quasi-clinical assessment tools, and large data sets. The SPDAT has been independently tested, as well as internally reviewed. The data overwhelmingly shows that when the SPDAT is used properly, housing outcomes are better than when no assessment tool is used.

The VI-SPDAT is a triage tool. It highlights areas of higher acuity, thereby helping to inform the type of support and housing intervention that may be most beneficial to improve long term housing outcomes. It also helps inform the order - or priority - in which people should be served. The VI-SPDAT does not make decisions; it informs decisions. The VI-SPDAT provides data that communities, service providers, and people experiencing homelessness can use to help determine the best course of action next.

Version 2

Version 2 builds upon the success of Version 1 of the VI-SPDAT with some refinements. Starting in August 2014, a survey was launched of existing VI-SPDAT users to get their input on what should be amended, improved, or maintained in the tool. Analysis was completed across all of these responses. Further research was conducted. Questions were tested and refined over several months, again including the direct voice of persons with lived experience and frontline practitioners. Input was also gathered from senior government officials that create policy and programs to help ensure alignment with guidelines and funding requirements.

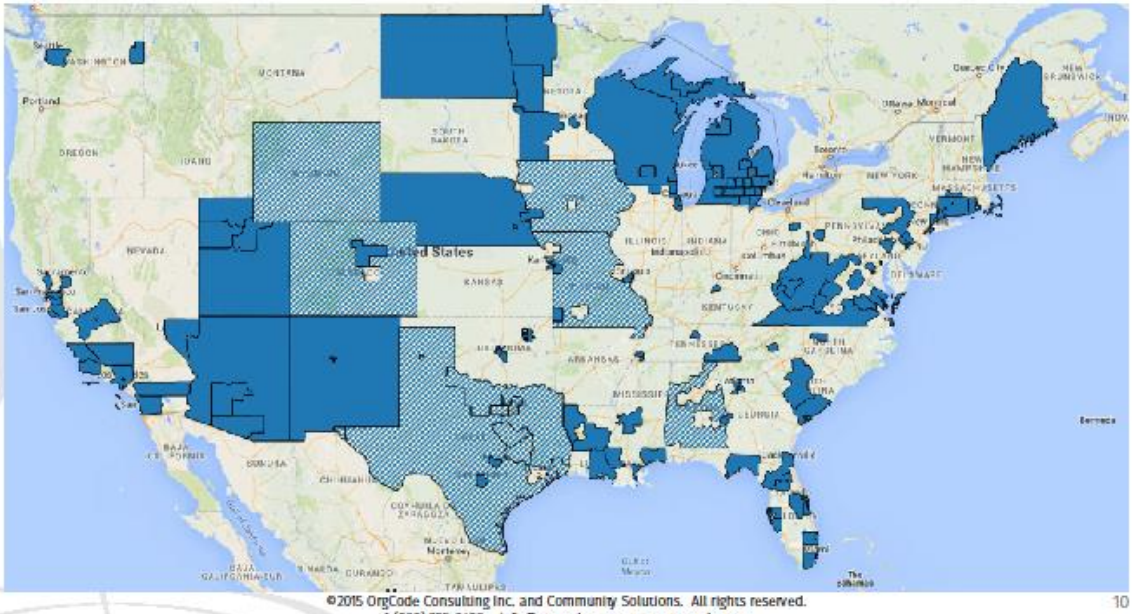
You will notice some differences in Version 2 compared to Version 1. Namely:

- it is shorter, usually taking less than 7 minutes to complete;
- subjective elements through observation are now gone, which means the exact same instrument can be used over the phone or in-person;
- medical, substance use, and mental health questions are all refined;
- you can now explicitly see which component of the full SPDAT each VI-SPDAT question links to; and,
- the scoring range is slightly different (Don't worry, we can provide instructions on how these relate to results from Version 1).

1 (800) 355-0420 info@orgcode.com www.orgcode.com

Appendix B: Where the VI-SPDAT is being used in the United States

Since the VI-SPDAT is provided completely free of charge, and no training is required, any community is able to use the VI-SPDAT without the explicit permission of Community Solutions or OrgCode Consulting, Inc. As a result, the VI-SPDAT is being used in more communities than we know of. It is also being used in Canada and Australia.



1 (800) 355-0420 info@orgcode.com www.orgcode.com

A partial list of continua of care (CoCs) in the US where we know the VI-SPDAT is being used includes:

Alabama
- Parts of Alabama Balance of State

Arizona
- Statewide

California
- San Jose/Santa Clara City & County
- San Francisco
- Oakland/Alameda County
- Sacramento City & County
- Richmond/Contra Costa County
- Watsonville/Santa Cruz City & County
- Fresno/Madera County
- Napa City & County
- Los Angeles City & County
- San Diego
- Santa Maria/Santa Barbara County
- Bakersfield/Kern County
- Pasadena
- Riverside City & County
- Glendale
- San Luis Obispo County

Colorado
- Metropolitan Denver Homeless Initiative
- Parts of Colorado Balance of State

Connecticut
- Hartford
- Bridgeport/Stratford/Fairfield
- Connecticut Balance of State
- Norwalk/Fairfield County
- Stamford/Greenwich
- City of Waterbury

District of Columbia
- District of Columbia

Florida
- Sarasota/Bradenton/Manatee, Sarasota Counties
- Tampa/Hillsborough County
- St. Petersburg/Clearwater/Largo/Pinellas County
- Tallahassee/Leon County
- Orlando/Orange, Osceola, Seminole Counties
- Gainesville/Alachua, Putnam Counties
- Jacksonville-Duval, Clay Counties
- Palm Bay/Melbourne/Brevard County
- Ocala/Marion County
- Miami/Dade County
- West Palm Beach/Palm Beach County

Georgia
- Atlanta County
- Fulton County
- Columbus-Muscogee/Russell County
- Marietta/Cobb County
- DeKalb County

Hawaii
- Honolulu

Illinois
- Rockford/Winnebago, Boone Counties
- Waukegan/North Chicago/Lake County
- Chicago
- Cook County

Iowa
- Parts of Iowa Balance of State

Kansas
- Kansas City/Wyandotte County

Kentucky
- Louisville/Jefferson County

Louisiana
- Lafayette/Acadiana
- Shreveport/Bossier/Northwest
- New Orleans/Jefferson Parish
- Baton Rouge
- Alexandria/Central Louisiana CoC

Massachusetts
- Cape Cod Islands
- Springfield/Holyoke/Chicopee/Westfield/Hampden County

Maryland
- Baltimore City
- Montgomery County

Maine
- Statewide

Michigan
- Statewide

Minnesota
- Minneapolis/Hennepin County
- Northwest Minnesota
- Moorhead/West Central Minnesota
- Southwest Minnesota

Missouri
- St. Louis County
- St. Louis City
- Joplin/Jasper, Newton Counties
- Kansas City/Independence/Lee's Summit/Jackson County
- Parts of Missouri Balance of State

Mississippi
- Jackson/Rankin, Madison Counties
- Gulf Port/Gulf Coast Regional

North Carolina
- Winston Salem/Forsyth County
- Asheville/Buncombe County
- Greensboro/High Point

North Dakota
- Statewide

Nebraska
- Statewide

New Mexico
- Statewide

Nevada
- Las Vegas/Clark County

New York
- New York City
- Yonkers/Mount Vernon/New Rochelle/Westchester County

Ohio
- Toledo/Lucas County
- Canton/Massillon/Alliance/Stark County

Oklahoma
- Tulsa City & County/Broken Arrow
- Oklahoma City
- Norman/Cleveland County

Pennsylvania
- Philadelphia
- Lower Marion/Norristown/Abington/Montgomery County
- Allentown/Northeast Pennsylvania
- Lancaster City & County
- Bristol/Bensalem/Bucks County
- Pittsburgh/McKeesport/Penn Hills/Allegheny County

Rhode Island
- Statewide

South Carolina
- Charleston/Low Country
- Columbia/Midlands

Tennessee
- Chattanooga/Southeast Tennessee
- Memphis/Shelby County
- Nashville/Davidson County

Texas
- San Antonio/Bexar County
- Austin/Travis County
- Dallas City & County/Irving
- Fort Worth/Arlington/Tarrant County
- El Paso City and County
- Waco/McLennan County
- Texas Balance of State
- Amarillo
- Wichita Falls/Wise, Palo Pinto, Wichita, Archer Counties
- Bryan/College Station/Brazos Valley
- Beaumont/Port Arthur/South East Texas

Utah
- Statewide

Virginia
- Richmond/Henrico, Chesterfield, Hanover Counties
- Roanoke City & County/Salem
- Virginia Beach
- Portsmouth
- Virginia Balance of State
- Arlington County

Washington
- Seattle/King County
- Spokane City & County

Wisconsin
- Statewide

West Virginia
- Statewide

Wyoming
- Wyoming Statewide is in the process of implementing

1 (800) 355-0420 info@orgcode.com www.orgcode.com

Appendix B: VI-FSPDAT

Vulnerability Index -
Service Prioritization Decision Assistance Tool
(VI-SPDAT)

Prescreen Triage Tool for Families

AMERICAN VERSION 2.0

1 (800) 355-0420 info@orgcode.com www.orgcode.com

COMMUNITY SOLUTIONS

Welcome to the SPDAT Line of Products

The Service Prioritization Decision Assistance Tool (SPDAT) has been around in various incarnations for over a decade, before being released to the public in 2010. Since its initial release, the use of the SPDAT has been expanding exponentially and is now used in over one thousand communities across the United States, Canada, and Australia.

More communities using the tool means there is an unprecedented demand for versions of the SPDAT, customized for specific client groups or types of users. With the release of SPDAT V4, there have been more current versions of SPDAT products than ever before.

VI-SPDAT Series

The Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) was developed as a pre-screening tool for communities that are very busy and do not have the resources to conduct a full SPDAT assessment for every client. It was made in collaboration with Community Solutions, creators of the Vulnerability Index, as a brief survey that can be conducted to quickly determine whether a client has high, moderate, or low acuity. The use of this survey can help prioritize which clients should be given a full SPDAT assessment first. Because it is a self-reported survey, no special training is required to use the VI-SPDAT.

Current versions available:

- VI-SPDAT V 2.0 for Individuals
- VI-SPDAT V 2.0 for Families
- VI-SPDAT V 2.0 for Youth

All versions are available online at

www.orgcode.com/products/vi-spdat/

SPDAT Series

The Service Prioritization Decision Assistance Tool (SPDAT) was developed as an assessment tool for front-line workers at agencies that work with homeless clients to prioritize which of those clients should receive assistance first. The SPDAT tools are also designed to help guide case management and improve housing stability outcomes. They provide an in-depth assessment that relies on the assessor's ability to interpret responses and corroborate those with evidence. As a result, this tool may only be used by those who have received proper, up-to-date training provided by OrgCode Consulting, Inc. or an OrgCode certified trainer.

Current versions available:

- SPDAT V 4.0 for Individuals
- SPDAT V 4.0 for Families
- SPDAT V 4.0 for Youth

Information about all versions is available online at

www.orgcode.com/products/spdat/

SPDAT Training Series

To use the SPDAT, training by OrgCode or an OrgCode certified trainer is required. We provide training on a wide variety of topics over a variety of mediums.

The full-day in-person SPDAT Level 1 training provides you the opportunity to bring together as many people as you want to be trained for one low fee. The webinar training allows for a maximum of 15 different computers to be logged into the training at one time. We also offer online courses for individuals that you can do at your own speed.

The training gives you the manual, case studies, application to current practice, a review of each component of the tool, conversation guidance with prospective clients – and more!

Current SPDAT training available:

- Level 0 SPDAT Training: VI-SPDAT for Frontline Workers
- Level 1 SPDAT Training: SPDAT for Frontline Workers
- Level 2 SPDAT Training: SPDAT for Supervisors
- Level 3 SPDAT Training: SPDAT for Trainers

Other related training available:

- Excellence in Housing-Based Case Management
- Coordinated Access & Common Assessment
- Motivational Interviewing
- Objective-Based Interactions

More information about SPDAT training, including pricing, is available online at

http://www.orgcode.com/product-category/training/spdat/

1 (800) 355-0420 info@orgcode.com www.orgcode.com

Administration

Interviewer's Name	Agency	☐ Team ☐ Staff ☐ Volunteer
_____	_____	
Survey Date	**Survey Time**	**Survey Location**
DD/MM/YYYY ____/____/_____	__ __ : __ __	_____

Opening Script

Every assessor in your community regardless of organization completing the VI-SPDAT should use the same introductory script. In that script you should highlight the following information:

- the name of the assessor and their affiliation (organization that employs them, volunteer as part of a Point in Time Count, etc.)
- the purpose of the VI-SPDAT being completed
- that it usually takes less than 7 minutes to complete
- that only "Yes," "No," or one-word answers are being sought
- that any question can be skipped or refused
- where the information is going to be stored
- that if the participant does not understand a question that clarification can be provided
- the importance of relaying accurate information to the assessor and not feeling that there is a correct or preferred answer that they need to provide, nor information they need to conceal

Basic Information

PARENT 1

First Name	Nickname	Last Name
_____	_____	_____

In what language do you feel best able to express yourself? _____

Date of Birth	Age	Social Security Number	Consent to participate
DD/MM/YYYY ____/____/_____	_____	_____	☐ Yes ☐ No

PARENT 2

☐ No second parent currently part of the household

First Name	Nickname	Last Name
_____	_____	_____

In what language do you feel best able to express yourself? _____

Date of Birth	Age	Social Security Number	Consent to participate
DD/MM/YYYY ____/____/_____	_____	_____	☐ Yes ☐ No

IF EITHER HEAD OF HOUSEHOLD IS 60 YEARS OF AGE OR OLDER, THEN SCORE 1.

SCORE:

Children

1. How many children under the age of 18 are currently with you? _____ ☐ Refused
2. How many children under the age of 18 are not currently with your family, but you have reason to believe they will be joining you when you get housed? _____ ☐ Refused
3. *IF HOUSEHOLD INCLUDES A FEMALE:* Is any member of the family currently pregnant? ☐ **Y** ☐ N ☐ Refused
4. Please provide a list of children's names and ages:

First Name	Last Name	Age	Date of Birth

IF THERE IS A SINGLE PARENT WITH 2+ CHILDREN, AND/OR A CHILD AGED 11 OR YOUNGER, AND/OR A CURRENT PREGNANCY, THEN SCORE 1 FOR **FAMILY SIZE**.

IF THERE ARE TWO PARENTS WITH 3+ CHILDREN, AND/OR A CHILD AGED 6 OR YOUNGER, AND/OR A CURRENT PREGNANCY, THEN SCORE 1 FOR **FAMILY SIZE**.

SCORE:

A. History of Housing and Homelessness

5. Where do you and your family sleep most frequently? (check one)
   - ☐ Shelters
   - ☐ Transitional Housing
   - ☐ Safe Haven
   - ☐ **Outdoors**
   - ☐ **Other (specify):** _____
   - ☐ **Refused**

IF THE PERSON ANSWERS ANYTHING OTHER THAN "SHELTER", "TRANSITIONAL HOUSING", OR "SAFE HAVEN", THEN SCORE 1.

SCORE:

6. How long has it been since you and your family lived in permanent stable housing? _____ ☐ Refused
7. In the last three years, how many times have you and your family been homeless? _____ ☐ Refused

IF THE FAMILY HAS EXPERIENCED 1 OR MORE CONSECUTIVE YEARS OF HOMELESSNESS, AND/OR 4+ EPISODES OF HOMELESSNESS, THEN SCORE 1.

SCORE:

B. Risks

8. In the past six months, how many times have you or anyone in your family...

a) Received health care at an emergency department/room?	____	☐ Refused
b) Taken an ambulance to the hospital?	____	☐ Refused
c) Been hospitalized as an inpatient?	____	☐ Refused
d) Used a crisis service, including sexual assault crisis, mental health crisis, family/intimate violence, distress centers and suicide prevention hotlines?	____	☐ Refused
e) Talked to police because they witnessed a crime, were the victim of a crime, or the alleged perpetrator of a crime or because the police told them that they must move along?	____	☐ Refused
f) Stayed one or more nights in a holding cell, jail or prison, whether that was a short-term stay like the drunk tank, a longer stay for a more serious offence, or anything in between?	____	☐ Refused

IF THE TOTAL NUMBER OF INTERACTIONS EQUALS 4 OR MORE, THEN SCORE 1 FOR **EMERGENCY SERVICE USE.** **SCORE:**

9. Have you or anyone in your family been attacked or beaten up since they've become homeless?	☐ **Y**	☐ N	☐ Refused
10. Have you or anyone in your family threatened to or tried to harm themself or anyone else in the last year?	☐ **Y**	☐ N	☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **RISK OF HARM.** **SCORE:**

11. Do you or anyone in your family have any legal stuff going on right now that may result in them being locked up, having to pay fines, or that make it more difficult to rent a place to live?	☐ **Y**	☐ N	☐ Refused

IF "YES," THEN SCORE 1 FOR **LEGAL ISSUES.** **SCORE:**

12. Does anybody force or trick you or anyone in your family to do things that you do not want to do?	☐ **Y**	☐ N	☐ Refused
13. Do you or anyone in your family ever do things that may be considered to be risky like exchange sex for money, run drugs for someone, have unprotected sex with someone they don't know, share a needle, or anything like that?	☐ **Y**	☐ N	☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **RISK OF EXPLOITATION.** **SCORE:**

C. Socialization & Daily Functioning

14. Is there any person, past landlord, business, bookie, dealer, or government group like the IRS that thinks you or anyone in your family owe them money?	☐ **Y**	☐ N	☐ Refused
15. Do you or anyone in your family get any money from the government, a pension, an inheritance, working under the table, a regular job, or anything like that?	☐ Y	☐ **N**	☐ Refused

IF "YES" TO QUESTION 14 OR "NO" TO QUESTION 15, THEN SCORE 1 FOR **MONEY MANAGEMENT.** **SCORE:**

16. Does everyone in your family have planned activities, other than just surviving, that make them feel happy and fulfilled?	☐ Y	☐ **N**	☐ Refused

IF "NO," THEN SCORE 1 FOR **MEANINGFUL DAILY ACTIVITY.** **SCORE:**

17. Is everyone in your family currently able to take care of basic needs like bathing, changing clothes, using a restroom, getting food and clean water and other things like that?	☐ Y	☐ **N**	☐ Refused

IF "NO," THEN SCORE 1 FOR **SELF-CARE.** **SCORE:**

18. Is your family's current homelessness in any way caused by a relationship that broke down, an unhealthy or abusive relationship, or because other family or friends caused your family to become evicted?	☐ **Y**	☐ N	☐ Refused

IF "YES," THEN SCORE 1 FOR **SOCIAL RELATIONSHIPS.** **SCORE:**

D. Wellness

19. Has your family ever had to leave an apartment, shelter program, or other place you were staying because of the physical health of you or anyone in your family?	☐ **Y**	☐ N	☐ Refused
20. Do you or anyone in your family have any chronic health issues with your liver, kidneys, stomach, lungs or heart?	☐ **Y**	☐ N	☐ Refused
21. 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 or anyone in your family?	☐ **Y**	☐ N	☐ Refused
22. Does anyone in your family have any physical disabilities that would limit the type of housing you could access, or would make it hard to live independently because you'd need help?	☐ **Y**	☐ N	☐ Refused
23. When someone in your family is sick or not feeling well, does your family avoid getting medical help?	☐ **Y**	☐ N	☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **PHYSICAL HEALTH.** **SCORE:**

1 (800) 355-0420 info@orgcode.com www.orgcode.com

24. Has drinking or drug use by you or anyone in your family led your family to being kicked out of an apartment or program where you were staying in the past?	☐ **Y**	☐ N	☐ Refused	
25. Will drinking or drug use make it difficult for your family to stay housed or afford your housing?	☐ **Y**	☐ N	☐ Refused	
IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **SUBSTANCE USE.**				**SCORE:**
26. Has your family ever had trouble maintaining your housing, or been kicked out of an apartment, shelter program or other place you were staying, because of:				
a) A mental health issue or concern?	☐ **Y**	☐ N	☐ Refused	
b) A past head injury?	☐ **Y**	☐ N	☐ Refused	
c) A learning disability, developmental disability, or other impairment?	☐ **Y**	☐ N	☐ Refused	
27. Do you or anyone in your family have any mental health or brain issues that would make it hard for your family to live independently because help would be needed?	☐ **Y**	☐ N	☐ Refused	
IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **MENTAL HEALTH.**				**SCORE:**
28. *IF THE FAMILY SCORED 1 EACH FOR PHYSICAL HEALTH, SUBSTANCE USE, AND MENTAL HEALTH:* Does any single member of your household have a medical condition, mental health concerns, **and** experience with problematic substance use?	☐ **Y**	☐ N	☐ N/A or Refused	
IF "YES", SCORE 1 FOR **TRI-MORBIDITY.**				**SCORE:**
29. Are there any medications that a doctor said you or anyone in your family should be taking that, for whatever reason, they are not taking?	☐ **Y**	☐ N	☐ Refused	
30. Are there any medications like painkillers that you or anyone in your family don't take the way the doctor prescribed or where they sell the medication?	☐ **Y**	☐ N	☐ Refused	
IF "YES" TO ANY OF THE ABOVE, SCORE 1 FOR **MEDICATIONS.**				**SCORE:**
31. *YES OR NO:* Has your family's current period of homelessness been caused by an experience of emotional, physical, psychological, sexual, or other type of abuse, or by any other trauma you or anyone in your family have experienced?	☐ **Y**	☐ N	☐ Refused	
IF "YES", SCORE 1 FOR **ABUSE AND TRAUMA.**				**SCORE:**

E. Family Unit

32. Are there any children that have been removed from the family by a child protection service within the last 180 days? ☐ **Y** ☐ N ☐ Refused

33. Do you have any family legal issues that are being resolved in court or need to be resolved in court that would impact your housing or who may live within your housing? ☐ **Y** ☐ N ☐ Refused

IF "YES" TO ANY OF THE ABOVE, SCORE 1 FOR **FAMILY LEGAL ISSUES.** **SCORE:**

34. In the last 180 days have any children lived with family or friends because of your homelessness or housing situation? ☐ **Y** ☐ N ☐ Refused

35. Has any child in the family experienced abuse or trauma in the last 180 days? ☐ **Y** ☐ N ☐ Refused

36. *IF THERE ARE SCHOOL-AGED CHILDREN:* Do your children attend school more often than not each week? ☐ Y ☐ **N** ☐ N/A or Refused

IF "YES" TO ANY OF QUESTIONS 34 OR 35, OR "NO" TO QUESTION 36, SCORE 1 FOR **NEEDS OF CHILDREN.** **SCORE:**

37. Have the members of your family changed in the last 180 days, due to things like divorce, your kids coming back to live with you, someone leaving for military service or incarceration, a relative moving in, or anything like that? ☐ **Y** ☐ N ☐ Refused

38. Do you anticipate any other adults or children coming to live with you within the first 180 days of being housed? ☐ **Y** ☐ N ☐ Refused

IF "YES" TO ANY OF THE ABOVE, SCORE 1 FOR **FAMILY STABILITY.** **SCORE:**

39. Do you have two or more planned activities each week as a family such as outings to the park, going to the library, visiting other family, watching a family movie, or anything like that? ☐ Y ☐ **N** ☐ Refused

40. After school, or on weekends or days when there isn't school, is the total time children spend each day where there is no interaction with you or another responsible adult...

a) 3 or more hours per day for children aged 13 or older? ☐ **Y** ☐ N ☐ Refused

b) 2 or more hours per day for children aged 12 or younger? ☐ **Y** ☐ N ☐ Refused

41. *IF THERE ARE CHILDREN BOTH 12 AND UNDER & 13 AND OVER:* Do your older kids spend 2 or more hours on a typical day helping their younger sibling(s) with things like getting ready for school, helping with homework, making them dinner, bathing them, or anything like that? ☐ **Y** ☐ N ☐ N/A or Refused

IF "NO" TO QUESTION 39, OR "YES" TO ANY OF QUESTIONS 40 OR 41, SCORE 1 FOR **PARENTAL ENGAGEMENT.** **SCORE:**

Scoring Summary

DOMAIN	SUBTOTAL
PRE-SURVEY	/2
A. HISTORY OF HOUSING & HOMELESSNESS	/2
B. RISKS	/4
C. SOCIALIZATION & DAILY FUNCTIONS	/4
D. WELLNESS	/6
E. FAMILY UNIT	/4
GRAND TOTAL:	/22

RESULTS	
Score:	**Recommendation:**
0-3	no housing intervention
4-8	an assessment for Rapid Re-Housing
9+	an assessment for Permanent Supportive Housing/ Housing First

Follow-Up Questions

On a regular day, where is it easiest to find you and what time of day is easiest to do so?	place: _____ time: ___ : ____ or
Is there a phone number and/or email where someone can safely get in touch with you or leave you a message?	phone: (____) _____ - _____ email: _____
Ok, now I'd like to take your picture so that it is easier to find you and confirm your identity in the future. May I do so?	☐ Yes ☐ No ☐ Refused

Communities are encouraged to think of additional questions that may be relevant to the programs being operated or your specific local context. This may include questions related to:

- military service and nature of discharge
- ageing out of care
- mobility issues
- legal status in country
- income and source of it
- current restrictions on where a person can legally reside
- children that may reside with the adult at some point in the future
- safety planning

Appendix C: Y-SPDAT for Youth

Youth

Service Prioritization Decision Assistance Tool

(Y-SPDAT)

Assessment Tool for Single Youth

VERSION 1.0

1 (800) 355-0420 info@orgcode.com www.orgcode.com

Disclaimer
The management and staff of OrgCode Consulting, Inc. (OrgCode) do not control the way in which the Service Prioritization Decision Assistance Tool (SPDAT) will be used, applied or integrated into related client processes by communities, agency management or frontline workers. OrgCode assumes no legal responsibility or liability for the misuse of the SPDAT, decisions that are made or services that are received in conjunction with the assessment tool.

A. Mental Health & Wellness & Cognitive Functioning

PROMPTS	CLIENT SCORE:
• *Have you ever had a conversation with a psychiatrist, psychologist, or school counsellor? When was that?* • *Do you feel you are getting all the help you might need with whatever mental health stress you might have?* • *Have you ever hurt your brain or head?* • *Do you have trouble learning or paying attention?* • *Has anyone ever told you you might have ADD or ADHD?* • *Was there ever any special testing done to identify learning disabilities?* • *Has any doctor ever prescribed you pills for anxiety, depression, or anything like that?* • *Do you know if, when pregnant with you, your mother did anything that we now know can have negative effects on the baby?* • *Are there any professionals we could speak with that have knowledge of your mental health?*	**NOTES**

SCORING		
4	**Any** of the following: ☐ Serious and persistent mental illness (2+ hospitalizations in a mental health facility or psychiatric ward in the past 2 years) **and** not in a heightened state of recovery currently ☐ Major barriers to performing tasks and functions of daily living or communicating intent because of a brain injury, learning disability or developmental disability	
3	**Any** of the following: ☐ Heightened concerns about state of mental health, but fewer than 2 hospitalizations, and/or without knowledge of presence of a diagnosable mental health condition ☐ Diminished ability to perform tasks and functions of daily living or communicating intent because of a brain injury, learning disability or developmental disability	
2	While there may be concern for overall mental health or mild impairments to performing tasks and functions of daily living or communicating intent, **all** of the following are true: ☐ No major concerns about safety or ability to be housed without intensive supports to assist with mental health or cognitive functioning ☐ No major concerns for the health and safety of others because of mental health or cognitive functioning ability ☐ No compelling reason for screening by an expert in mental health or cognitive functioning prior to housing to fully understand capacity	**FOR YOUTH** ☐ Age 16 or under and would not otherwise score higher
1	☐ In a heightened state of recovery, has a Wellness Recovery Action Plan (WRAP) or similar plan for promoting wellness, understands symptoms and strategies for coping with them, **and** is engaged with mental health supports as necessary.	☐ Age 17-23 and would not otherwise score higher
0	☐ Age 24+ **and** no mental health or cognitive functioning issues disclosed, suspected or observed	

1 (800) 355-0420 info@orgcode.com www.orgcode.com

B. Physical Health & Wellness

PROMPTS	CLIENT SCORE:
• *How is your health?* • *Do you feel you are getting all the care you need for your health? When was the last time you saw a doctor? What was that for?* • *Do you have a clinic or doctor that you usually go to?* • *Any illness like diabetes, HIV, Hep C or anything like that going on?* • *Do you have any reason to suspect you might be pregnant? Is that impacting your health in any way? Have you talked with a doctor about your pregnancy? Are you following the doctor's advice?* • *Anything going on right now with your health that you think would prevent you from living a full, healthy, happy life?* • *Are there other professionals we could speak with that have knowledge of your health?*	**NOTES**

Note: In this section, a current pregnancy can be considered a health issue.

	SCORING
4	**Any** of the following: ☐ Co-occurring chronic health conditions ☐ Attempting a treatment protocol for a chronic health condition, but the treatment is not improving health ☐ Pallative health condition
3	Presence of a health issue with **any** of the following: ☐ Not connected with professional resources to assist with a real or perceived serious health issue, by choice ☐ Single chronic or serious health concern but does not connect with professional resources because of insufficient community resources (e.g. lack of availability or affordability) ☐ Unable to follow the treatment plan as a direct result of homeless status
2	☐ Presence of a relatively minor physical health issue, which is managed and/or cared for with appropriate professional resources or through informed self-care ☐ Presence of a physical health issue, for which appropriate treatment protocols are followed, but there is still a moderate impact on their daily living
1	Single chronic or serious health condition, but **all** of the following are true: ☐ Able to manage the health issue and live a relatively active and healthy life ☐ Connected to appropriate health supports ☐ Educated and informed on how to manage the health issue, take medication as necessary related to the condition, and consistently follow these requirements.
0	☐ No serious or chronic health condition ☐ If any minor health condition, they are managed appropriately

1 (800) 355-0420 info@orgcode.com www.orgcode.com

C. Medication

PROMPTS	CLIENT SCORE:
• *Have you recently been prescribed any medications by a health care professional?* • *Do you take any medications prescribed to you by a doctor?* • *Have you ever sold some or all of your prescription?* • *Have you ever had a doctor prescribe you medication that you didn't have filled at a pharmacy or didn't take?* • *Were any of your medications changed in the last month? If yes: How did that make you feel?* • *Do other people ever steal your medications?* • *Do you ever share your medications with other people?* • *How do you store your medications and make sure you take the right medication at the right time each day?* • *What do you do if you realize you've forgotten to take your medications?* • *Do you have any papers or documents about the medications you take?*	**NOTES**

SCORING	
4	**Any** of the following: ☐ In the past 30 days, started taking a prescription which **is** having any negative impact on day to day living, socialization or mood ☐ Shares or sells prescription, but keeps **less** than is sold or shared ☐ Regularly misuses medication (e.g. frequently forgets; often takes the wrong dosage; uses some or all of medication to get high) ☐ Has had a medication prescribed in the last 90 days that remains unfilled, for any reason
3	**Any** of the following: ☐ In the past 30 days, started taking a prescription which is **not** having any negative impact on day to day living, socialization or mood ☐ Shares or sells prescription, but keeps **more** than is sold or shared ☐ Requires intensive assistance to manage or take medication (e.g., assistance organizing in a pillbox; working with pharmacist to blister-pack; adapting the living environment to be more conducive to taking medications at the right time for the right purpose, like keeping night-time medications on the bedside table and morning medications by the coffeemaker) ☐ Medications are stored and distributed by a third-party
2	**Any** of the following: ☐ Fails to take medication at the appropriate time or appropriate dosage, 1-2 times per week ☐ Self-manages medications except for requiring reminders or assistance for refills ☐ Successfully self-managing medication for fewer than 30 consecutive days
1	☐ Successfully self-managing medications for more than 30, but less than 180, consecutive days
0	**Any** of the following: ☐ No medication prescribed to them ☐ Successfully self-managing medication for 181+ consecutive days

1 (800) 355-0420 info@orgcode.com www.orgcode.com

D. Substance Use

PROMPTS	CLIENT SCORE:
• *When was the last time you had a drink or used drugs?* • *Is there anything we should keep in mind related to drugs or alcohol?* • *[If they disclose use of drugs and/or alcohol] How frequently would you say you use [specific substance] in a week?* • *Ever get into fights, fall down and bang your head, or pass out when drinking or using other drugs?* • *Have you ever used alcohol or other drugs in a way that may be considered less than safe?* • *Do you ever end up doing things you later regret after you have gotten really hammered?* • *Do you ever drink mouthwash or cooking wine or hand sanitizer or anything like that?* • *Have you engaged with anyone professionally related to your substance use that we could speak with?*	**NOTES**

Note: Consumption thresholds: 2 drinks per day or 14 total drinks in any one week period for men; 2 drinks per day or 9 total drinks in any one week period for women. "Under legal age" refers to under the age at which it is legal to purchase and consume the substance in question.

SCORING		FOR YOUTH
4	☐ In a life-threatening health situation as a direct result of substance use, **or**, In the past 30 days, **any** of the following are true... ☐ Substance use is almost daily (21+ times) **and** often to the point of complete inebriation ☐ Binge drinking, non-beverage alcohol use, or inhalant use 4+ times ☐ Substance use resulting in passing out 2+ times	☐ First used drugs before age 12 ☐ Scores a 2-3 and is under age 15 ☐ Scores a 3 and is under legal age
3	☐ Experiencing serious health impacts as a direct result of substance use, though not (yet) in a life-threatening position as a result, **or**, In the past 30 days, **any** of the following are true... ☐ Drug use reached the point of complete inebriation 12+ times ☐ Alcohol use usually exceeded the consumption thresholds (at least 5+ times), but usually not to the point of complete inebriation ☐ Binge drinking, non-beverage alcohol use, or inhalant use occurred 1-3 times	☐ First used drugs aged 12-15 ☐ Scores a 1 and is under age 15 ☐ Scores a 2 and is under legal age
2	In the past 30 days, **any** of the following are true... ☐ Drug use reached the point of complete inebriation fewer than 12 times ☐ Alcohol use exceeded the consumption thresholds fewer than 5 times	☐ Scores a 1 and is under legal age
1	☐ In the past 365 days, no alcohol use beyond consumption thresholds, **or**, ☐ If making claims to sobriety, no substance use in the past 30 days	
0	☐ In the past 365 days, no substance use	

1 (800) 355-0420 info@orgcode.com www.orgcode.com

E. Experience of Abuse & Trauma

PROMPTS	CLIENT SCORE:
To avoid re-traumatizing the individual, ask selected approved questions as written. Do not probe for details of the trauma/abuse. This section is entirely self-reported. • *"I don't need you to go into any details, but has there been any point in your life where you experienced emotional, physical, sexual or psychological abuse?"* • *"Are you currently or have you ever received professional assistance to address that abuse?"* • *"Does the experience of abuse or trauma impact your day to day living in any way?"* • *"Does the experience of abuse or trauma impact your ability to hold down a job, maintain housing or engage in meaningful relationships with friends or family?"* • *"Have you ever found yourself feeling or acting in a certain way that you think is caused by a history of abuse or trauma?"* • *"Have you ever become homeless as a direct result of experiencing abuse or trauma?"*	**NOTES**

SCORING	
4	☐ A reported experience of abuse or trauma, believed to be a direct cause of their homelessness
3	☐ The experience of abuse or trauma is **not** believed to be a direct cause of homelessness, but abuse or trauma (experienced before, during, or after homelessness) **is** impacting daily functioning and/or ability to get out of homelessness
2	**Any** of the following: ☐ A reported experience of abuse or trauma, but is not believed to impact daily functioning and/or ability to get out of homelessness ☐ Engaged in therapeutic attempts at recovery, but does not consider self to be recovered
1	☐ A reported experience of abuse or trauma, and considers self to be recovered
0	☐ No reported experience of abuse or trauma

F. Risk of Harm to Self or Others

PROMPTS	CLIENT SCORE:
• *Do you have thoughts about hurting yourself or anyone else? Have you ever acted on these thoughts? When was the last time?* • *What was occurring when you had these feelings or took these actions?* • *Have you ever received professional help – including maybe a stay at hospital – as a result of thinking about or attempting to hurt yourself or others? How long ago was that? Does that happen often?* • *Have you recently left a situation you felt was abusive or unsafe? How long ago was that?* • *Have you been in any fights recently - whether you started it or someone else did? How long ago was that? How often do you get into fights?*	**NOTES**

	SCORING
4	**Any** of the following: ☐ In the past 90 days, left an abusive situation ☐ In the past 30 days, attempted, threatened, or actually harmed self or others ☐ In the past 30 days, involved in a physical altercation (instigator or participant)
3	**Any** of the following: ☐ In the past 180 days, left an abusive situation, but no exposure to abuse in the past 90 days ☐ Most recently attempted, threatened, or actually harmed self or others in the past 180 days, but not in the past 30 days ☐ In the past 365 days, involved in a physical altercation (instigator or participant), but not in the past 30 days
2	**Any** of the following: ☐ In the past 365 days, left an abusive situation, but no exposure to abuse in the past 180 days ☐ Most recently attempted, threatened, or actually harmed self or others in the past 365 days, but not in the past 180 days ☐ 366+ days ago, 4+ involvements in physical alterations
1	☐ 366+ days ago, 1-3 involvements in physical alterations
0	☐ Reports no instance of harming self, being harmed, or harming others

G. Involvement in High Risk and/or Exploitive Situations

PROMPTS	CLIENT SCORE:
• *[Observe, don't ask] Any abcesses or track marks from injection substance use?* • *Does anybody force or trick you to do something that you don't want to do?* • *Do you ever do stuff that could be considered dangerous like drinking until you pass out outside, or delivering drugs for someone, having sex without a condom with a casual partner, or anything like that?* • *Do you ever find yourself in situations that may be considered at a high risk for violence?* • *Do you ever sleep outside? How do you dress and prepare for that? Where do you tend to sleep?*	**NOTES**

SCORING		
		YOUTH PREGNANCY
4	**Any** of the following: ☐ In the past 180 days, engaged in 10+ higher risk and/or exploitive events ☐ In the past 90 days, left an abusive situation	☐ Under the age of 24, and has ever become pregnant
3	**Any** of the following: ☐ In the past 180 days, engaged in 4-9 higher risk and/or exploitive events ☐ In the past 180 days, left an abusive situation, but not in the past 90 days	☐ Under the age of 24, and has ever gotten someone else pregnant, and wouldn't otherwise score a 4
2	**Any** of the following: ☐ In the past 180 days, engaged in 1-3 higher risk and/or exploitive events ☐ 181+ days ago, left an abusive situation	
1	☐ In the past 365 days, any involvement in higher risk and/or exploitive events, but not in the past 180 days	
0	☐ In the past 365 days, no involvement in higher risk and/or exploitive events	

H. Interaction with Emergency Services

PROMPTS	CLIENT SCORE:
• *How often do you go to emergency rooms?* • *How many times have you had the police speak to you over the past 180 days?* • *Have you used an ambulance or needed the fire department at any time in the past 180 days?* • *How many times have you called or visited a crisis team or a crisis counselor in the last 180 days?* • *How many times have you been admitted to hospital in the last 180 days? How long did you stay?*	**NOTES**

Note: Emergency service use includes: admittance to emergency room/department; hospitalizations; trips to a hospital in an ambulance; crisis service, distress centers, suicide prevention service, sexual assault crisis service, sex worker crisis service, or similar service; interactions with police for the purpose of law enforcement; interactions with fire service in emergency situations.

SCORING	
4	☐ In the past 180 days, cumulative total of 10+ interactions with emergency services
3	☐ In the past 180 days, cumulative total of 4-9 interactions with emergency services
2	☐ In the past 180 days, cumulative total of 1-3 interactions with emergency services
1	☐ Any interaction with emergency services occurred more than 180 days ago but less than 365 days ago
0	☐ In the past 365 days, no interaction with emergency services

1 (800) 355-0420 info@orgcode.com www.orgcode.com

I. Legal

PROMPTS	CLIENT SCORE:
• *Do you have any "legal stuff" going on?* • *Have you had a lawyer assigned to you by a court?* • *Do you have any upcoming court dates? Do you think there's a chance you will do time?* • *Any involvement with family court or child custody matters?* • *Any outstanding fines?* • *Have you paid any fines in the last 12 months for anything?* • *Have you done any community service in the last 12 months?* • *Is anybody expecting you to do community service for anything right now?* • *Did you have any legal stuff in the last year that got dismissed?* • *Is your housing at risk in any way right now because of legal issues?*	**NOTES**

SCORING		
		JUVENILE DELINQUENCY
4	**Any** of the following: ☐ Current outstanding legal issue(s), likely to result in fines of $500+ ☐ Current outstanding legal issue(s), likely to result in incarceration of 3+ months (cumulatively), inclusive of any time held on remand	☐ The youth is under the age of 18 and has current outstanding legal issue(s) that are likely to result in incarceration
3	**Any** of the following: ☐ Current outstanding legal issue(s), likely to result in fines less than $500 ☐ Current outstanding legal issue(s), likely to result in incarceration of less than 90 days (cumulatively), inclusive of any time held on remand	☐ The youth is under the age of 24 and was ever incarcerated while still a minor, and would not otherwise score a 4
2	**Any** of the following: ☐ In the past 365 days, relatively minor legal issue has occurred and was resolved through community service or payment of fine(s) ☐ Currently outstanding relatively minor legal issue that is unlikely to result in incarceration (but may result in community service)	
1	☐ There are no current legal issues, **and** any legal issues that have historically occurred have been resolved without community service, payment of fine, or incarceration	
0	☐ Has not had any legal issues within the past 365 days, **and** currently no conditions of release	

J. Managing Tenancy

PROMPTS	CLIENT SCORE:
• *Are you currently homeless?* • *Have you ever signed a lease? How did that go?* • *[If the person is housed] Do you have an eviction notice?* • *[If the person is housed] Do you think that your housing is at risk?* • *How is your relationship with your neighbors?* • *How do you normally get along with landlords (or your parents/guardian(s))?* • *How have you been doing with taking care of your place?*	**NOTES**

Note: Housing matters include: conflict with landlord and/or neighbors, damages to the unit, payment of rent on time and in full. Payment of rent through a third party is <u>not</u> considered to be a short-coming or deficiency in the ability to pay rent.

SCORING		
		RUNAWAYS
4	**Any** of the following: ☐ Currently homeless ☐ In the next 30 days, will be re-housed or return to homelessness ☐ In the past 365 days, was re-housed 6+ times ☐ In the past 90 days, support worker(s) have been cumulatively involved 10+ times with housing matters	☐ In the past 90 days, ran away from foster home, group home, or parent's home
3	**Any** of the following: ☐ In the next 60 days, will be re-housed or return to homelessness, but not in next 30 days ☐ In the past 365 days, was re-housed 3-5 times ☐ In the past 90 days, support worker(s) have been cumulatively involved 4-9 times with housing matters	☐ In the past 365 days, ran away from foster home, group home, or parent's home, but not in the past 90 days
2	**Any** of the following: ☐ In the past 365 days, was re-housed 2 times ☐ In the past 180 days, was re-housed 1+ times, but not in the past 60 days ☐ For the past 90 days, was continuously housed, but not for more than 180 days ☐ In the past 90 days, support worker(s) have been cumulatively involved 1-3 times with housing matters	☐ Ran away from foster home, group home, or parent's home, but not in the past 365 days
1	**Any** of the following: ☐ In the past 365 days, was re-housed 1 time ☐ For the past 180 days, was continuously housed, with no assistance with housing matters, but not for more than 365 days	
0	☐ For the past 365+ days, was continuously housed in same unit, with no assistance with housing matters	

1 (800) 355-0420 info@orgcode.com www.orgcode.com

K. Personal Administration & Money Management

PROMPTS	CLIENT SCORE:
• *How are you with taking care of money?* • *How are you with paying bills on time and taking care of other financial stuff?* • *Do you have any street debts?* • *Do you have any drug or gambling debts?* • *Is there anybody that thinks you owe them money?* • *Do you budget every single month for every single thing you need? Including cigarettes? Booze? Drugs?* • *Do you try to pay your rent before paying for anything else?* • *Are you behind in any payments like child support or student loans or anything like that?*	**NOTES**

	SCORING
4	**Any** of the following: ☐ Cannot create or follow a budget, regardless of supports provided ☐ Does not comprehend financial obligations ☐ Does not have an income (including formal and informal sources) ☐ Not aware of the full amount spent on substances, if they use substances ☐ Substantial real or perceived debts of $1,000+, past due or requiring monthly payments
3	**Any** of the following: ☐ Requires intensive assistance to create and manage a budget (including any legally mandated guardian/trustee that provides assistance or manages access to money) ☐ Only understands their financial obligations with the assistance of a 3rd party ☐ Not budgeting for substance use, if they are a substance user ☐ Real or perceived debts of $999 or less, past due or requiring monthly payments
2	**Any** of the following: ☐ In the past 365 days, source of income has changed 2+ times ☐ Budgeting to the best of ability (including formal and informal sources), but still short of money every month for essential needs ☐ Voluntarily receives assistance creating and managing a budget or restricts access to their own money (e.g. guardian/trusteeship) ☐ Has been self-managing financial resources and taking care of associated administrative tasks for less than 90 days
1	☐ Has been self-managing financial resources and taking care of associated administrative tasks for at least 90 days, but for less than 180 days
0	☐ Has been self-managing financial resources and taking care of associated administrative tasks for at least 180 days

L. Social Relationships & Networks

PROMPTS	CLIENT SCORE:
• *Tell me about your friends, family and other people in your life. How often do you get together or chat?* • *How do you get along with teachers, doctors, police officers, case workers, and other professionals?* • *Are there any people in your life that you feel are just using you?* • *Are there any of your closer friends that you feel are always asking you for money, smokes, drugs, food or anything like that?* • *Have you ever had people crash at your place that you did not want staying there?* • *Have you ever been kicked out of where you were living because of something that friends or family did at your place?* • *Have you ever been concerned about not following your lease agreement because of your friends or family?*	**NOTES**

	SCORING
4	**Any** of the following: ☐ In the past 90 days, left an exploitive, abusive or dependent relationship, **or** left home due to family violence or conflict over religious or moral differences, including sexual orientation ☐ Friends, family or other people are placing security of housing at imminent risk, **or** impacting life, wellness, or safety ☐ No friends or family and demonstrates no ability to follow social norms ☐ Currently homeless and would classify most of friends and family as homeless
3	**Any** of the following: ☐ In the past 90-180 days, left an exploitive, abusive or dependent relationship, **or** left home due to family violence or conflict over religious or moral differences ☐ Friends, family or other people are having some negative consequences on wellness or housing stability ☐ No friends or family but demonstrating ability to follow social norms ☐ Meeting new people with an intention of forming friendships, **or** reconnecting with previous friends or family members, but experiencing difficulty advancing the relationship ☐ Currently homeless, and would classify some of friends and family as being housed, while others are homeless
2	**Any** of the following: ☐ More than 180 days ago, left an exploitive, abusive or dependent relationship, **or** left home due to family violence or conflict over religious or moral differences ☐ Developing relationships with new people but not yet fully trusting them ☐ Currently homeless, and would classify friends and family as being housed
1	☐ Has been housed for less than 180 days, **and** is engaged with friends or family, who are having no negative consequences on the individual's housing stability
0	☐ Has been housed for at least 180 days, **and** is engaged with friends or family, who are having no negative consequences on the individual's housing stability

1 (800) 355-0420 info@orgcode.com www.orgcode.com

M. Self Care & Daily Living Skills

PROMPTS	CLIENT SCORE:
• *Do you have any worries about taking care of yourself?* • *Do you have any concerns about cooking, cleaning, laundry or anything like that?* • *Do you ever need reminders to do things like shower or clean up?* • *Describe your last apartment.* • *Do you know how to shop for nutritious food on a budget?* • *Do you know how to make low cost meals that can result in leftovers to freeze or save for another day?* • *Do you tend to keep all of your clothes clean?* • *Have you ever had a problem with mice or other bugs like cockroaches as a result of a dirty apartment?* • *When you have had a place where you have made a meal, do you tend to clean up dishes and the like before they get crusty?*	**NOTES**

SCORING	
4	**Any** of the following: ☐ No insight into how to care for themselves, their apartment or their surroundings ☐ Currently homeless and relies upon others to meet basic needs (e.g. access to shelter, showers, toilet, laundry, food, and/or clothing) on an almost daily basis ☐ Engaged in hoarding or collecting behavior and is not aware that it is an issue in her/his life
3	**Any** of the following: ☐ Has insight into some areas of how to care for themselves, their apartment or their surroundings, but misses other areas because of lack of insight ☐ In the past 180 days, relied upon others to meet basic needs (e.g. access to shelter, showers, toilet, laundry, food, and/or clothing), 14+ days in any 30-day period ☐ Engaged in hoarding or collecting behavior and is aware that it is an issue in her/his life
2	**Any** of the following: ☐ Fully aware and has insight in all that is required to take care of themselves, their apartment and their surroundings, but has not yet mastered the skills or time management to fully execute this on a regular basis ☐ In the past 180 days, relied upon others to meet basic needs (e.g. access to shelter, showers, toilet, laundry, food, and/or clothing), fewer than 14 days in every 30-day period
1	☐ In the past 365 days, accessed community resources 4 or fewer times, **and** is fully taking care of all their daily needs
0	☐ For the past 365+ days, fully taking care of all their daily needs independently

1 (800) 355-0420 info@orgcode.com www.orgcode.com

N. Meaningful Daily Activity

PROMPTS	CLIENT SCORE:
• *How do you spend your day?* • *How do you spend your free time?* • *Does that make you feel happy/fulfilled?* • *How many days a week would you say you have things to do that make you feel happy/fulfilled?* • *How much time in a week would you say you are totally bored?* • *When you wake up in the morning, do you tend to have an idea of what you plan to do that day?* • *How much time in a week would you say you spend doing stuff to fill up the time rather than doing things that you love?* • *Are there any things that get in the way of you doing the sorts of activities you would like to be doing?*	**NOTES**

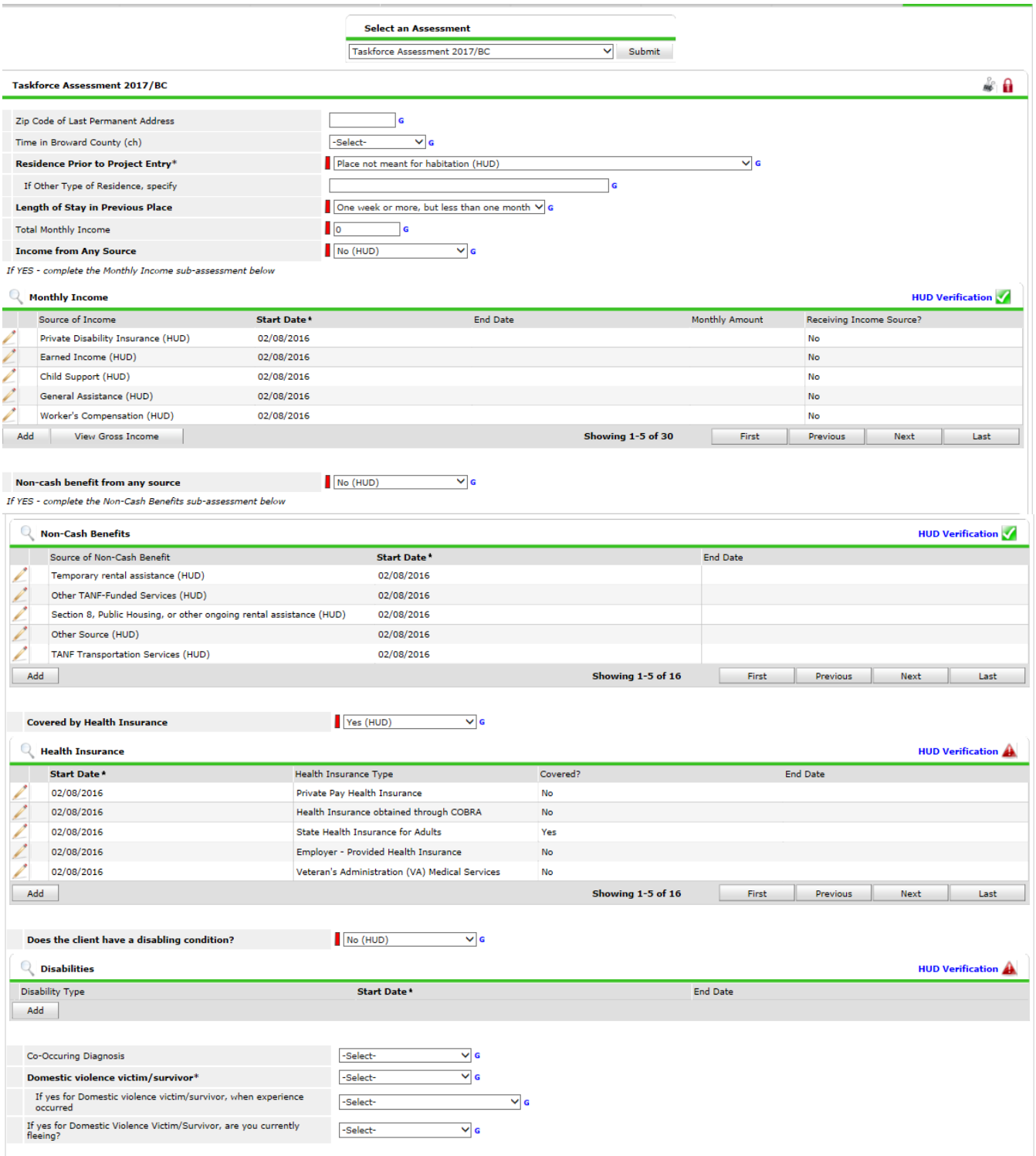
SCORING		
		SCHOOL-AGED YOUTH
4	☐ No planned, legal activities described as providing fulfillment or happiness	☐ Not enrolled in school **and** with no planned, legal activities described as providing fulfillment or happiness
3	☐ Discussing, exploring, signing up for and/or preparing for new activities or to re-engage with planned, legal activities that used to provide fulfillment or happiness	☐ Enrolled in school, but attending class fewer than 3 days per week
2	☐ Attempting new or re-engaging with planned, legal activities that used to provide fulfillment or happiness, but uncertain that activities selected are currently providing fulfillment or happiness, **or** the individual is not fully committed to continuing the activities.	☐ Enrolled in school, and attending class 3 days per week
1	☐ 1-3 days per week, has planned, legal activities described as providing fulfillment or happiness	☐ Enrolled in school and attending class 4 days per week
0	☐ 4+ days per week, has planned, legal activities described as providing fulfillment or happiness	☐ Enrolled in school and maintaining regular attendance

O. History of Homelessness & Housing

PROMPTS	CLIENT SCORE:
• *How long have they been homeless?* • *How many times have they been homeless in their life other than this most recent time?* • *Have they spent any time sleeping on a friend's couch or floor? And if so, during those times did they consider that to be their permanent address?* • *Have they ever spent time sleeping in a car or alleyway or garage or barn or bus shelter or anything like that?* • *Have they ever spent time sleeping in an abandoned building?* • *Were they ever in hospital or jail for a period of time when they didn't have a permanent address to go to when they got out?*	**NOTES**

SCORING	
4	☐ Over the past 10 years, cumulative total of 5+ years of homelessness
3	☐ Over the past 10 years, cumulative total of 2+ years but fewer than 5 years of homelessness
2	☐ Over the past 4 years, cumulative total of 30+ days but fewer than 2 years of homelessness
1	☐ Over the past 4 years, cumulative total of 7+ days but fewer than 30 days of homelessness
0	☐ Over the past 4 years, cumulative total of 7 or fewer days of homelessness

Appendix D: Taskforce Assessment



Select an Assessment

Taskforce Assessment 2017/BC | Submit

Taskforce Assessment 2017/BC

Zip Code of Last Permanent Address	
Time in Broward County (ch)	-Select-
Residence Prior to Project Entry*	Place not meant for habitation (HUD)
If Other Type of Residence, specify	
Length of Stay in Previous Place	One week or more, but less than one month
Total Monthly Income	0
Income from Any Source	No (HUD)

If YES - complete the Monthly Income sub-assessment below

Monthly Income — HUD Verification

Source of Income	Start Date*	End Date	Monthly Amount	Receiving Income Source?
Private Disability Insurance (HUD)	02/08/2016			No
Earned Income (HUD)	02/08/2016			No
Child Support (HUD)	02/08/2016			No
General Assistance (HUD)	02/08/2016			No
Worker's Compensation (HUD)	02/08/2016			No

Add | View Gross Income | Showing 1-5 of 30 | First | Previous | Next | Last

Non-cash benefit from any source	No (HUD)

If YES - complete the Non-Cash Benefits sub-assessment below

Non-Cash Benefits — HUD Verification

Source of Non-Cash Benefit	Start Date*	End Date
Temporary rental assistance (HUD)	02/08/2016	
Other TANF-Funded Services (HUD)	02/08/2016	
Section 8, Public Housing, or other ongoing rental assistance (HUD)	02/08/2016	
Other Source (HUD)	02/08/2016	
TANF Transportation Services (HUD)	02/08/2016	

Add | Showing 1-5 of 16 | First | Previous | Next | Last

Covered by Health Insurance	Yes (HUD)

Health Insurance — HUD Verification

Start Date*	Health Insurance Type	Covered?	End Date
02/08/2016	Private Pay Health Insurance	No	
02/08/2016	Health Insurance obtained through COBRA	No	
02/08/2016	State Health Insurance for Adults	Yes	
02/08/2016	Employer - Provided Health Insurance	No	
02/08/2016	Veteran's Administration (VA) Medical Services	No	

Add | Showing 1-5 of 16 | First | Previous | Next | Last

Does the client have a disabling condition?	No (HUD)

Disabilities — HUD Verification

Disability Type	Start Date*	End Date

Add

Co-Occuring Diagnosis	-Select-
Domestic violence victim/survivor*	-Select-
If yes for Domestic violence victim/survivor, when experience occurred	-Select-
If yes for Domestic Violence Victim/Survivor, are you currently fleeing?	-Select-

Client Location (CoC ID Number) *	FL-600 G
Relationship to Head of Household	Head of household's other relation member (other relation to head of household) G
Approximate date homelessness started:	02 / 01 / 2016 G
Regardless of where they stayed last night - Number of times the client has been on the streets, in ES, or SH in the past three years including today	One time (HUD) G
Total number of months homeless on the street, in ES or SH in the past three years	One month (this time is the first month) (HUD) G
Identified as CHRONIC	-Select- G
Medical Diagnosis (ch)	-Select- G
Survival Kit (ch)	-Select- G
Alert? (ch)	-Select- G
Police Zone (ch)	G
County Zone	-Select- G
City of Current Contact	-Select- G
Zip Code of Current Contact	-Select- G
Type of Location	-Select- G
Location address & description of current contact	G
Previous Shelter (ch)	-Select- G
Previous Shelter - 2 (ch)	-Select- G
Previous Shelter - 3 (ch)	-Select- G
Placement	-Select- G
Chac PTR	-Select- G
Nhac PTR	-Select- G
Shac PTR	-Select- G
Non-confidential notes	G

Date of Initial Contact *	/ / G
Bus Passes Issued	G
Number of Contacts Made With This Client	G

Outreach

Date of Contact	Start Date *	Staying on Street, ES, or SH	End Date

Add

Date of Engagement	/ / G
Housing Move-in Date	/ / G

Contact Information

Client's Phone Number	G
Client's Email Address	G

Emergency Contacts

Contact's Name	Phone Number	Second Phone Number	Contact's Email Address	Share Client Info With Contact?	Relationship to Client

Add

VI-SPDAT v2.0

Start Date *	PRE-SURVEY	A. HISTORY OF HOUSING AND HOMELESSNESS	B. RISKS	C. SOCIALIZATION & DAILY FUNCTIONS	D. WELLNESS	GRAND TOTAL

Add

Print Assessment Save Cancel

Appendix E: Rapid Re-Housing Barrier Assessment

Head of Household Name: _____ **[Client ID No.]:** _____		**Score**
Homelessness	☐ First time homeless ☐ Homeless once before ☐ Homeless several times in past ☐ Experienced chronic homelessness ☐ Is fleeing, or attempting to flee, domestic violence	
Financial/Employment History	☐ Good employment history; no significant barriers except financial; insufficient emergency reserve. Credit history is good, except for a few late utility and credit card payments ☐ History of inconsistent or erratic employment, poor budgeting skills. Credit history shows pattern of late or missed payments ☐ Periods of unemployment, no emergency reserves, lacks or has poor budgeting skills. Credit history includes late payments and possible court judgments for debt, closed bank and/or credit accounts ☐ Multiple, extended periods of unemployment or inability to be employed due to disability. Credit history is poor, late payments, may include judgment for debt to a landlord, closed accounts	

Disability Status	☐ No mental illness, alcohol/substance use dependency, physical or cognitive condition that affects housing retention ☐ No serious mental illness, alcohol/substance use dependency, physical or cognitive condition that affects housing retention. Has some level of impairment that warrants some service ☐ Problems with mental health or alcohol/substance use dependency, physical or cognitive condition that somewhat impacts ability to comply with tenancy requirements ☐ Active and serious mental illness, alcohol/substance use dependency, physical or cognitive condition that impacts ability to access housing and/or comply with tenancy requirements	
Criminal History	☐ Household/Individual has no criminal history ☐ No serious criminal history, but may have a few minor offenses such as moving violations or a misdemeanor ☐ Household has some criminal history, but none involving drugs or serious crimes against persons or property ☐ Criminal history, violations include alcohol/drug offense or crime against persons or property ☐ Extensive criminal background	
Tenant/Rental History	☐ An established local rental history. No evictions ☐ Rental history is limited or out-of-state. May have one or two explainable evictions ☐ Rental history includes up to three evictions ☐ Rental history includes up to five evictions and/or lease violations ☐ Extremely poor rental history, multiple evictions, serious damage to apartment, complaints	

Family Abuse	☐ No abuse issues ☐ History of battery but abuser is not in the area ☐ Recent abuse in the family unit ☐ Current abuse in the family unit	
Family Dynamics	☐ One Parent/Child household ☐ Large family (4+ members) ☐ Head of household under 18 ☐ History DCF/ChildNet ☐ Open Child Protection Case (DCF/ChildNet)	
Misc. Housing Barriers	☐ No High School Diploma ☐ Non-English Speaking ☐ Immigration Status ☐ Pets	
	TOTAL SCORE	

Score Up to 5 = Level 1 Assistance (Light Touch)

The RRH Assessment indicates that the Applicant requires minimal assistance to obtain and retain housing. The applicant will be referred to the County for one of the following RRH programs based on the final assessment score: RRH Light or RRH Heavy.

Scores 6-10 = Level 2 Assistance (Light Touch)

RRH assistance is appropriate. The Applicant's score will assist in housing stability planning under the RRH Program. The household will need routine assistance to obtain and retain housing.

Scores 11-15 = Level 3 Assistance (Heavy Touch)

RRH assistance is appropriate. The Applicant's score will assist in housing stability planning under the RRH Program. The household will need intensive and/or longer assistance to obtain and retain housing.

Scores 11-15 = Level 4 Assistance (Heavy Touch)

RRH assistance is appropriate. The Applicant's score will assist in housing stability planning under the RRH Program. The household will need more intensive and/or longer assistance to obtain and retain housing.

Score 21 or Higher = Level 5 – Not appropriate for RRH intervention

The Applicant's housing and support needs are not appropriate for RRH assistance. The Applicant will be referred back to the Homeless Coordinated Entry Assessment Coordinator for referral to Permanent Supportive Housing placement or other appropriate housing placement.

Appendix F: Homeless Definition

Homeless Definition

CRITERIA FOR DEFINING HOMELESS	**Category 1**	Literally Homeless	(1) Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) Has a primary nighttime residence that is a public or private place not meant for human habitation; (ii) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or (iii) Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution
	Category 2	Imminent Risk of Homelessness	(2) Individual or family who will imminently lose their primary nighttime residence, provided that: (i) Residence will be lost within 14 days of the date of application for homeless assistance; (ii) No subsequent residence has been identified; and (iii) The individual or family lacks the resources or support networks needed to obtain other permanent housing
	Category 3	Homeless under other Federal statutes	(3) Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who: (i) Are defined as homeless under the other listed federal statutes; (ii) Have not had a lease, ownership interest, or occupancy agreement in permanent housing during the 60 days prior to the homeless assistance application; (iii) Have experienced persistent instability as measured by two moves or more during in the preceding 60 days; and (iv) Can be expected to continue in such status for an extended period of time due to special needs or barriers
	Category 4	Fleeing/ Attempting to Flee DV	(4) Any individual or family who: (i) Is fleeing, or is attempting to flee, domestic violence; (ii) Has no other residence; and (iii) Lacks the resources or support networks to obtain other permanent housing

Appendix G: HMIS Release of Information

BROWARD COUNTY CONTINUUM OF CARE (CoC)
CLIENT ACKNOWLEDGEMENT FOR ELECTRONIC DATA COLLECTION
IN HOMELESS MANAGEMENT INFORMATION SYSTEMS (HMIS)

_____
[AGENCY NAME]

IMPORTANT: Do not enter personally identifying information into Homeless Management Information System (HMIS) for clients who are: 1) in Domestic Violence agencies or; 2) currently fleeing or in danger from a domestic violence, dating violence, sexual assault or stalking.

It is up to you whether you want to sign this form. The information you allow us to disclose could later be re-disclosed by the recipient and if that person or organization is not a health plan or health care provider, the information may no longer be protected by Federal privacy regulations. Your decision whether to complete this form will not affect your eligibility for benefits, treatment, payment, or enrollment in other services.

This agency is a partner in the Broward County FL-601 Continuum of Care (CoC) HMIS. Broward CoC HMIS partner agencies work together to provide services to persons and families who are experiencing homelessness. When you request or receive services, we may collect data about you and your household that may be shared with other Broward CoC HMIS partner agencies. Sharing your data allows service providers to see if they have housing services that fit your needs and for the purpose of ensuring effective coordination of services. It does not guarantee that you will receive housing.

Who can have access to your information?

Agencies and/or organizations that participate in the HMIS Database can have access to your data. These agencies and/or organizations may include homeless service funders/providers, housing providers, healthcare providers, and governmental agencies. Additional agencies and/or organizations may join the Broward CoC HMIS at any time and will also have access to your data. The current list of agencies and/or organizations are listed in the attached Exhibit – A.

How will my data be protected?

Your information is protected by the federal HMIS Privacy Standards, is secured by passwords and encryption technology and the HMIS application incorporates industry standard security protocols and is updated regularly to meet these security standards. In addition, each participating organization has signed a Contributing HMIS Organization (CHO) agreement to maintain the security and confidentiality of the information. In some instances, when the participating organization is a health care organization, your information may be protected by the privacy standards of the Health Insurance Portability and Accountability Act (HIPAA).

How do I benefit by providing the requested information and sharing it with other agencies?

By sharing your information with other agencies, you may be able to avoid being screened again, get services faster, and minimize how many times you have to tell your "story." You also help agencies document the need for services and funding.

Client Informed Consent/Authorization for Release of Information (ROI)

When you sign this form, it shows that you understand the following:

- We collect personal information about the people we serve in a computer system called ServicePoint ("SP"). SP is used by agencies which provide homeless prevention, shelter and housing related services in

_____
[AGENCY NAME]

Broward County. Agencies using SP comply with all the requirements related to keeping your personal information private and secure.

- We use the personal information to run our programs and help us improve our services. Also, we are required to collect some personal information by organizations that fund our program.
- Your information will help us in getting the appropriate services for you through our program(s) offered by other agencies.
- You agree to share Protected Personal information and general information obtained during your intake and assessment, which may include but is not limited to: name, date of birth, social security number, demographic information such gender and ethnicity/race, veteran status, residence information (history of homelessness and housing), marital status, household relationships, disability status, self-reporting medical history including any medical health and substance abuse issues, assessment date(s), income sources and amounts, non-cash benefits, case notes, services needed and provided, outcomes of services provided, emergency contact information, and your photo.
- This consent form expires in three (3) years from the date of signature.
- You have the right to revoke this consent at any time by writing to this agency. However, the revocation will not be retroactive to any information that has already been released.
- You have a right to review the information that we have about you. If you find mistakes, you can ask us to correct them.
- You have the right to file a complaint if you feel that your privacy rights have been violated.
- This consent is voluntary. You will not be denied services if you refuse to sign this consent form.

If you would like a copy of our privacy policy, our agency staff will provide one.

Please sign below to show that you have read and understand the rules above.

_____ _____
SIGNATURE OF CLIENT OR GUARDIAN DATE

_____ _____
PRINT NAME DATE

_____ _____
SIGNATURE OF AGENCY WITNESS DATE

_____ _____
PRINT NAME DATE

_____
[AGENCY NAME]

Exhibit - A
Participating Agencies and/or Organizations

- Archways, Inc.
- Broward Behavioral Health Coalition
- Broward County Department of Human Services
- Broward County Elderly and Veterans Division
- Broward County Family Success Division
- Broward County Housing Authority
- Broward County Community Development Corporation, Inc. d/b/a Broward Housing Solutions
- Broward House, Inc.
- Broward Partnership for the Homeless, Inc.
- Broward Regional Health Planning Council, Inc.
- Broward Sheriff's Office, Department of Community Services
- Care Resources
- ChildNet
- Chrysalis Health, Inc.
- City of Fort Lauderdale
- Cooperative Feeding Program, Inc. d/b/a LifeNet 4 Families
- Covenant House Florida, Inc.
- First Call for Help of Broward, Inc.
- FLITE Center
- Henderson Behavioral Health, Inc.
- Hope South Florida, Inc.
- Keystone Halls, Inc.
- Lutheran Services Florida, Inc.
- Miami Rescue Mission, Inc. d/b/a Broward Outreach Center
- North Broward Hospital District d/b/a Broward Health
- Purpose Built Families Foundation, Inc. d/b/a Operations Sacred Trust
- South Broward Hospital District d/b/a Memorial Healthcare Systems
- TaskForce Fore Ending Homelessness, Inc.
- The Salvation Army
- United Way of Broward County, Inc.
- U.S. Department of Veterans Affairs
- Volunteers of America, Inc.

Client initials: _____ Date: _____

Appendix H: CPD 14-012 Federal Notice on Prioritization

U.S. Department of Housing and Urban Development
Office of Community Planning and Development

Special Attention of:	**Notice: CPD-14-012**
All Secretary's Representatives	**Issued: July 28, 2014**
All Regional Directors for CPD	**Expires:** This Notice is effective until it is amended, superseded, or rescinded
All CPD Division Directors	
Continuums of Care (CoC)	
Recipients of the Continuum of Care (CoC) Program	**Cross Reference:** 24 CFR Parts 578 and 42 U.S.C. 11381, *et seq.*

Subject: Notice on Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing and Recordkeeping Requirements for Documenting Chronic Homeless Status

Table of Contents

I. Purpose

This Notice provides guidance to Continuums of Care (CoC) and recipients of Continuum of Care (CoC) Program (24 CFR part 578) funding for permanent supportive housing (PSH) regarding the order in which eligible households should be served in **all** CoC Program-funded PSH. This Notice also establishes recordkeeping requirements for all recipients of CoC Program-funded PSH that includes beds that are required to serve persons experiencing chronic homelessness as defined in 24 CFR 578.3, in accordance with 24 CFR 578.103.

A. Background

In June 2010, the Obama Administration released *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness* (*Opening Doors*), in which HUD and its federal partners set goals to end Veteran and chronic homelessness by 2015, and end family and youth homelessness by 2020. Ending chronic homelessness is the first goal of *Opening Doors* and is a top priority for HUD. Although progress has been made there is still a long way to go. In 2013, there were still 109,132 people identified as chronically homeless in the United States. In order to meet the first goal of *Opening Doors*–ending chronic homelessness–it is critical that CoCs ensure that limited resources awarded through the CoC Program Competition are being used in the most effective manner and that households that are most in need of assistance are being prioritized.

Since 2005, HUD has encouraged CoCs to create new PSH dedicated for use by persons experiencing chronic homelessness (herein referred to as dedicated PSH). As a result, the number of dedicated PSH beds for persons experiencing chronic homelessness has increased from 24,760 in 2007 to 51,142 in 2013. This increase has contributed to a 25 percent decrease in the number of chronically homeless persons reported in the Point-in-Time Count between 2007 and 2013. Despite the overall increase in the number of dedicated PSH beds, this only represents 30 percent of all CoC Program-funded PSH beds.

To ensure that all PSH beds funded through the CoC Program are used as strategically and effectively as possible, PSH needs to be targeted to serve persons with the highest needs and greatest barriers towards obtaining and maintaining housing on their own–persons experiencing chronic homelessness. HUD's experience has shown that many communities and recipients of CoC Program-funded PSH continue to serve persons on a "first-come, first-serve" basis and/or based on tenant selection processes that screen-in those who are most likely to succeed. These approaches to tenant selection have not been effective in reducing chronic homelessness, despite the increase in the number of PSH beds nationally.

B. Goal of this Notice

The overarching goal of this Notice is to ensure that the homeless individuals and families with the most severe service needs within a community are prioritized in PSH, which will also increase progress towards the Obama Administration's goal of ending chronic homelessness. In order to guide CoCs in ensuring that all CoC Program-funded PSH beds are used most effectively, this Notice establishes an order of priority which CoCs are strongly encouraged to adopt and incorporate into the CoC's written standards and

coordinated assessment system. With adoption by CoCs and incorporation into the CoC's written standards, **all** recipients of CoC Program-funded PSH must then follow this order of priority, consistent with their current grant agreement, which will result in this intervention being targeted to the persons who need it the most. Such adoption and incorporation will ensure that persons are housed appropriately and in the order provided in this Notice.

HUD seeks to achieve three goals through this Notice:

1. Establish an order of priority for dedicated and prioritized PSH beds which CoCs are encouraged to adopt in order to ensure that those persons with the most severe service needs are given first priority.

2. Inform the selection process for PSH assistance not dedicated or prioritized for chronic homelessness to prioritize persons who do not yet meet the definition of chronic homelessness but are most at risk of becoming chronically homeless.

3. Provide uniform recordkeeping requirements for all recipients of CoC Program-funded PSH for documenting chronically homeless status of program participants when required to do so as well as provide guidance on recommended documentation standards that CoCs may require of its recipients of CoC Program-funded PSH if the priorities included in the Notice are adopted by the CoC.

C. Applicability

The guidance in this Notice is provided to all CoCs and all recipients and subrecipients–the latter two groups referred to collectively as recipients of CoC Program-funded PSH. CoCs are encouraged to incorporate the order of priority described in this Notice into their written standards, in accordance with the CoC Program interim rule at 24 CFR 578.7(a)(9) and 24 CFR 578.93, for CoC Program-funded PSH. Upon incorporation of the order of priority into written standards CoCs may then require recipients of CoC Program-funded PSH to follow the order of priority in accordance with the CoC's revised written standards and this Notice and in a manner consistent with their current grant agreement.

D. Key Terms

1. **Housing First.** Housing First is an approach in which housing is offered to people experiencing homelessness without preconditions (such as sobriety, mental health treatment, or a minimum income threshold) or service participation requirements and in which rapid placement and stabilization in permanent housing are primary goals. PSH projects that use a Housing First approach promote the acceptance of applicants regardless of their sobriety or use of substances, completion of treatment, or participation in services. HUD encourages all recipients of CoC Program-funded PSH to follow a Housing First approach to the maximum extent practicable. Any recipient that indicated that they would follow a Housing First approach in the FY 2013 CoC Project Application must do so for both the FY 2013 and FY 2014 operating year(s), as the CoC score for the FY 2013–FY 2014 CoC Program Competition was affected by the extent in which project applications indicated that they would follow this approach and this requirement will be incorporated into the recipient's FY 2013 and FY 2014 grant agreement.

HUD recognizes that this approach may not be applicable for all program designs, particularly for those projects formerly awarded under the SHP or SPC programs which were permitted to target persons with specific disabilities (e.g., "sober housing").

2. **Chronically Homeless.** The definition of "chronically homeless" currently in effect for the CoC Program is that which is defined in the CoC Program interim rule at 24 CFR 578.3, which states that a chronically homeless person is:

   (a) An individual who:

      i. Is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

      ii. Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions in the last 3 years; and

      iii. Can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000 (42 U.S.C. 15002)), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability;

   (b) An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition [as described in Section I.D.2.(a) of this Notice], before entering that facility; or

   (c) A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) of this definition [as described in Section I.D.2.(a) of this Notice, including a family whose composition has fluctuated while the head of household has been homeless.

3. **Severity of Service Needs.** This Notice refers to persons who have been identified as having the most severe service needs.

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

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

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

Severe service needs as defined in paragraphs i. and ii. above should be identified and verified through data-driven methods such as an administrative data match or through the use of a standardized assessment tool that can identify the severity of needs such as the Vulnerability Index (VI), the Service Prioritization Decision Assistance Tool (SPDAT), or the Frequent Users Service Enhancement (FUSE). The determination must not be based on a specific diagnosis or disability type, but only on the severity of needs of the individual.

(b) In states where there is an alternate criteria used by state Medicaid departments to identify high-need, high cost beneficiaries, CoCs and recipients of CoC Program-funded PSH may use similar criteria to determine if a household has severe service needs instead of the criteria defined paragraphs i. and ii. above. However, such determination must not be based on a specific diagnosis or disability type.

II. Dedication and Prioritization of Permanent Supportive Housing Strategies to Increase Number of PSH Beds Available for Chronically Homeless Persons

There are two significant ways in which CoCs can increase progress towards ending chronic homelessness in their communities using only their existing CoC Program-funded PSH:

A. Increase the number of CoC Program-funded PSH beds that are dedicated to persons experiencing chronic homelessness.

Dedicated PSH beds are required through the project's grant agreement to only be used to house persons experiencing chronic homelessness unless there are no persons within the CoC that meet that criteria. If this occurs, the recipient may then follow the order of priority in this Notice if it is adopted by the CoC. The bed will continue to be a dedicated bed, however, so when that bed becomes vacant again it must be used to house a chronically homeless person unless there are still no persons who meet that criterion within the CoC's geographic area. These PSH beds are reported as "CH Beds" on a CoC's Housing Inventory Count (HIC). A CoC may increase the number of CoC Program-funded PSH beds that are dedicated to persons experiencing chronic homelessness when it's recipients of non-dedicated CoC Program-funded PSH request a grant amendment to dedicate one or more of its beds for this purpose. A recipient of CoC Program-funded PSH is prohibited from changing the designation of the bed from dedicated to non-dedicated without a grant agreement amendment. Similarly, if a recipient of non-dedicated PSH intends to dedicate one or more of its beds to the chronically homeless it may do so through a grant agreement amendment.

B. Prioritize non-dedicated PSH beds for use by persons experiencing chronic homelessness.

Prioritization means implementing an admissions preference for chronically homeless persons for CoC Program-funded PSH beds. In the FY 2013-FY 2014 CoC Program Competition, CoCs were scored on the extent to which they were willing to commit to prioritizing chronically homeless persons in a percentage of their non-dedicated PSH beds with the highest points going to CoCs that committed to prioritize the chronically homeless

in 85 percent or more of their non-dedicated CoC Program-funded PSH. Further, project applicants for CoC Program-funded PSH had to indicate the number of non-dedicated beds that would be prioritized for use by persons experiencing chronic homelessness. These projects are now required to prioritize chronically homeless persons in their non-dedicated CoC Program-funded PSH beds for FY 2013 and FY 2014, as the project application is incorporated into the grant agreement. PSH beds that were included in the calculation for the CoCs commitment in the CoC Application cannot revise their FY 2014 application to reduce the number of prioritized beds; however, recipients of PSH that are currently not dedicated to the chronically homeless may choose to prioritize additional beds in the FY 2014 CoC Project Application. All recipients of CoC Program-funded PSH are encouraged to prioritize the chronically homeless as beds become vacant to the maximum extent practicable. CoCs will be expected to meet or exceed the goals established in the FY 2013/FY 2014 CoC Application and should continue to prioritize persons experiencing chronic homelessness in their CoC Program-funded PSH until there are no persons within the CoC's geographic area who meet that criteria. Further, to the extent that CoCs incorporate this order of priority into the CoCs written standards, recipients of CoC Program-funded PSH will also be required to follow this criterion included in those standards.

III. Order of Priority in CoC Program-funded Permanent Supportive Housing

A. Order of Priority in CoC Program-funded Permanent Supportive Housing Beds Dedicated to Persons Experiencing Chronic Homelessness and Permanent Supportive Housing Prioritized for Occupancy by Persons Experiencing Chronic Homelessness

1. As of the date of this Notice, CoCs are encouraged to revise their written standards to include the following order of priority for CoC Program-funded PSH that is either dedicated or prioritized for use by the chronically homeless. If adopted into the CoCs written standards, recipients of CoC Program-funded PSH would then be required to follow the order of priority when selecting participants for housing in accordance with the CoC's revised written standards in accordance with this Notice and in a manner consistent with their current grant agreement. For CoC Program-funded PSH that is dedicated or prioritized for persons experiencing chronic homelessness, the following order of priority is strongly encouraged:

   (a) **First Priority–Chronically Homeless Individuals and Families with the Longest History of Homelessness and with the Most Severe Service Needs.** A chronically homeless individual or head of household as defined in 24 CFR 578.3 for whom both of the following are true:

      i. The chronically homeless individual or head of household of a family has been homeless and living in a place not meant for human habitation, a safe haven, or in an emergency shelter for at least 12 months either continuously or on at least four separate occasions in the last 3 years, where the cumulative total length of the four occasions equals at least 12 months; and

ii. The CoC or CoC Program recipient has identified the chronically homeless individual or head of household, who meets all of the criteria in paragraph (1) of the definition for chronically homeless, of the family as having severe service needs (see Section I.D.3. of this Notice for definition of severe service needs).

(b) Second Priority–Chronically Homeless Individuals and Families with the Longest History of Homelessness. A chronically homeless individual or head of household, as defined in 24 CFR 578.3, for which both of the following are true:

i. The chronically homeless individual or head of household of a family has been homeless and living in a place not meant for human habitation, a safe haven, or in an emergency shelter for at least 12 months either continuously or on at least four separate occasions in the last 3 years, where the cumulative total length of the four occasions equals at least 12 months; and,

ii. The CoC or CoC program recipient has **not** identified the chronically homeless individual or the head of household, who meets all of the criteria in paragraph (1) of the definition for chronically homeless, of the family as having severe service needs.

(c) Third Priority–Chronically Homeless Individuals and Families with the Most Severe Service Needs. A chronically homeless individual or head of household as defined in 24 CFR 578.3 for whom both of the following are true:

i. The chronically homeless individual or head of household of a family has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter on at least four separate occasions in the last 3 years, where the total length of those separate occasions equals less than one year; and

ii. The CoC or CoC program recipient has identified the chronically homeless individual or the head of household, who meets all of the criteria in paragraph (1) of the definition for chronically homeless, of the family as having severe service needs.

(d) Fourth Priority–All Other Chronically Homeless Individuals and Families. A chronically homeless individual or head of household as defined in 24 CFR 578.3 for whom both of the following are true:

i. The chronically homeless individual or head of household of a family has been homeless and living in a place not meant for human habitation, a safe haven, or in an emergency shelter for on at least four separate occasions in the last 3 years, where the cumulative total length the four

occasions is **less than** 12 months; and

ii. The CoC or CoC program recipient has **not** identified the chronically homeless individual or the head of household, who meets all of the criteria in paragraph (1) of the definition for chronically homeless, of the family as having severe service needs.

2. Where a CoC or a recipient of CoC Program-funded PSH beds that are dedicated or prioritized is not able to identify chronically homeless individuals and families as defined in 24 CFR 578.3 within the CoC, the order of priority in Section III.B. of this Notice, as adopted by the CoC, may be followed.

3. Recipients of CoC Program-funded PSH should follow the order of priority above while also considering the goals and any identified target populations served by the project. For example, a CoC Program-funded PSH project that is permitted to target homeless persons with a serious mental illness that has been identified as a project that will prioritize a portion or all of its turnover beds to persons experiencing chronic homelessness should follow the order of priority under Section III.A.1. of this Notice to the extent in which persons with serious mental illness meet the criteria.

4. Recipients must exercise due diligence when conducting outreach and assessment to ensure that persons are served in the order of priority in this Notice. HUD recognizes that some persons–particularly those living on the streets or in places not meant for human habitation–might require significant engagement and contacts prior to their entering housing and recipients are not required to keep units remain vacant where there are persons who meet a higher priority within the CoC and who have not yet accepted the PSH opportunities offered to them. Street outreach providers should continue to make attempts to engage those persons and the CoC and CoC Program-funded PSH providers are encouraged to follow a Housing First approach to the maximum extent practicable and for those projects that indicated in the FY 2013 CoC Project Application that they would follow a Housing First approach will be required to do so for both the FY 2013 and FY 2014 operating year(s), as the CoC score for the FY 2013 – FY 2014 CoC Program Competition was affected by the extent in which project applications indicated that they would follow this approach and this requirement will be incorporated into the recipient's FY 2013 and FY 2014 grant agreement. For eligibility in dedicated or prioritized PSH serving chronically homeless households, the individual or head of household must meet all of the applicable criteria to be considered chronically homeless per 24 CFR 578.3.

B. Order of Priority in Permanent Supportive Housing Beds Not Dedicated or Prioritized for Persons Experiencing Chronic Homelessness

1. As of the date of this Notice, CoCs are encouraged to revise their written standards to include the following priorities for non-dedicated and non-prioritized PSH beds. If adopted into the CoCs written standards, recipients of CoC Program-funded PSH would then be required to follow the order of priority when selecting participants for housing in accordance with the CoC's revised written standards included in this Notice and in a

manner consistent with their current grant agreement. CoCs that adopt this order of priority are encouraged to include in the written standards a policy that would allow for recipients of non-dedicated and non-prioritized PSH to offer housing to chronically homeless individuals and families first, but minimally would be required to place otherwise eligible households in an order that prioritizes, in a nondiscriminatory manner, those who would benefit the most from this type of housing, beginning with those most at risk of becoming chronically homeless. For eligibility in non-dedicated and non-prioritized PSH serving non-chronically homeless households, any household member with a disability may qualify the family for PSH.

(a) **First Priority–Homeless Individuals and Families with a Disability with the Most Severe Service Needs.**

An individual or family that is eligible for CoC Program-funded PSH who has been living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter for any period of time, including persons exiting an institution where they have resided for 90 days or less but were living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter immediately prior to entering the institution **and** has been identified as having the most severe service needs.

(b) **Second Priority–Homeless Individuals and Families with a Disability with a Long Period of Continuous or Episodic Homelessness.** An individual or family that is eligible for CoC Program-funded PSH who has been living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least 6 months or on at least three separate occasions in the last 3 years where the cumulative total is at least 6 months. This includes persons exiting an institution where they have resided for 90 days or less but were living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter immediately prior to entering the institution and had been living or residing in one of those locations for at least 6 months or on at least three separate occasions in the last 3 years where the cumulative total is at least 6 months.

(c) **Third Priority–Homeless Individuals and Families with Disability Coming from Places Not Meant for Human Habitation, Safe Havens, or Emergency Shelters.** An individual or family that is eligible for CoC Program-funded PSH who has been living in a place not meant for human habitation, a safe haven, or an emergency shelter. This includes persons exiting an institution where they have resided for 90 days or less but were living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter immediately prior to entering the institution.

(d) **Fourth Priority–Homeless Individuals and Families with a Disability Coming from Transitional Housing.** An individual or family that is eligible for CoC Program-funded PSH who is coming from transitional housing, where prior to residing in the transitional housing lived on streets or in an emergency shelter, or

safe haven. This priority also includes homeless individuals and homeless households with children with a qualifying disability who were fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking and are living in transitional housing–all are eligible for PSH even if they did not live on the streets, emergency shelters, or safe havens prior to entry in the transitional housing.

2. Recipients of CoC Program-funded PSH should follow the order of priority above, as adopted by the CoC, while also considering the goals and any identified target populations served by the project. For example, in CoC Program-funded PSH where the beds are not dedicated or prioritized and which is permitted to target homeless persons with a serious mental illness should follow the order of priority under Section III.B.1. of this Notice, as adopted by the CoC, to the extent in which persons with serious mental illness meet the criteria.

3. Due diligence should be exercised when conducting outreach and assessment to ensure that persons are served in the order of priority in this Notice, and as adopted by the CoC. HUD recognizes that some persons–particularly those living on the streets or in places not meant for human habitation–might require significant engagement and contacts prior to their entering housing and recipients are not required to keep units vacant where there are persons who meet a higher priority within the CoC and who have not yet accepted the PSH opportunities offered to them. Street outreach providers should continue to make attempts with those persons using a Housing First approach to place as few conditions on a person's housing as possible.

IV. Using a Coordinated Assessment and a Standardized Assessment Tool or Process to Determine Eligibility and Establish a Prioritized Waiting List

A. Coordinated Assessment Requirement

Provisions at 24 CFR 578.7(a)(8) requires that each CoC, in consultation with recipients of Emergency Solutions Grants (ESG) program funds within the CoC's geographic area, establish and operate either a centralized or coordinated assessment system that provides an initial, comprehensive assessment of the needs of individuals and families for housing and services. CoCs that adopt the order of priority in Section III of this Notice into the CoC's written standards are strongly encouraged to use their coordinated assessment system in order to ensure that there is a single prioritized waiting list for all CoC Program-funded PSH within the CoC. Under no circumstances shall the order of priority be based upon diagnosis or disability type, but instead on the severity of needs of an individual or family.

B. Written Standards for Creation of a Single Prioritized Waiting List for PSH

CoCs are also encouraged to include in their policies and procedures governing their coordinated assessment system, a requirement that all CoC Program-funded PSH accept referrals only through a single prioritized waiting list that is created through the CoCs coordinated assessment process. Adopting this into the CoC's policies and procedures for coordinated assessment would further ensure that CoC Program-funded PSH is being used most effectively, which is one of the goals in this Notice. This would also allow for

recipients of CoC Program funds for PSH to maintain their own waiting lists, but all households would be referred olds to each of those project-level waiting lists based on where they fall on the prioritized list and not on the date in which they first applied for housing assistance.

C. Standardized Assessment Tool Requirement

CoCs must utilize a standardized assessment tool, in accordance with 24 CFR 578.3, or process. Appendix A of this Notice–*Coordinated Assessment Tool and Implementation: Key Considerations*–provides recommended criteria for a quality coordinated assessment process and standardized assessment tool.

D. Nondiscrimination Requirements

CoCs and recipients of CoC Program-funded PSH must continue to comply with the nondiscrimination provisions of Federal civil rights laws, including, but not limited to, the Fair Housing Act, Section 504 of the Rehabilitation Act, Title VI of the Civil Rights Act, and Titles II or III of the Americans with Disabilities Act, as applicable.

V. Recordkeeping Requirements

This Notice establishes recordkeeping requirements for all recipients of CoC Program-funded PSH that are required to document a program participant's status as chronically homeless as defined in 24 CFR 578.3 and in accordance with 24 CFR 578.103. Further, HUD expects that where CoCs have adopted the orders of priority in Section III. of this Notice into their written standards, the CoC as well as recipients of CoC Program-funded PSH, will maintain evidence of implementing these priorities.

A. CoC Records

In addition to the records required in 24 CFR 578.103, it is recommended that the CoC should supplement such records with the following:

1. **Evidence of written standards that incorporate the priorities in Section III. of this Notice, as adopted by the CoC.** A CoC adopting the priorities in Section III of this Notice, may be evidenced by written CoC, or subcommittee, meeting minutes where written standards were adopted that incorporate the prioritization standards in this Notice, or an updated, approved, governance charter where the written standards have been updated to incorporate the prioritization standards set forth in this Notice.

2. **Evidence of a standardized assessment tool.** Use of a standardized assessment tool may be evidenced by written policies and procedures referencing a single standardized assessment tool that is used by all CoC Program-funded PSH recipients within the CoC's geographic area.

3. **Evidence that the written standards were incorporated into the coordinated assessment policies and procedures.** Incorporating standards into the coordinated assessment policies and procedures may be evidenced by updated policies and

procedures–that incorporate the updated written standards for CoC Program-funded PSH developed and approved by the CoC.

B. Recipient Recordkeeping Requirements

In addition to the records required in 24 CFR 578.103, recipients of CoC Program-funded PSH that is required by grant agreement to document chronically homeless status of program participants in some or all of its PSH beds must maintain the following records:

1. **Written Intake Procedures.** Recipients must maintain and follow written intake procedures to ensure compliance with the definition of chronically homeless per 24 CFR 578.3. These procedures must establish the order of priority for obtaining evidence as: (1) third-party documentation, (2) intake worker observations, and (3) certification from the person seeking assistance. Records contained in an HMIS or comparable database used by victim service or legal service providers are acceptable evidence of third-party documentation and intake worker observations if the HMIS retains an auditable history of all entries, including the person who entered the data, the date of entry, and the change made; and if the HMIS prevents overrides or changes of the dates entries are made.

2. **Evidence of Chronically Homeless Status.** Recipients of CoC Program-funded PSH whose current grant agreement includes beds that are dedicated or prioritized to the chronically homeless must maintain records evidencing that the individuals or families receiving the assistance in those beds meets the definition for chronically homeless at 24 CFR 578.3. Such records must include evidence of the homeless status of the individual or family (paragraphs (1)(i) and (1)(ii) of the definition), the duration of homelessness (paragraph (1)(ii) of the definition), and the disabling condition (paragraph (1)(iii) of the definition). When applicable, recipients must also keep records demonstrating compliance with paragraphs (2) and (3) of the definition.

   (a) Evidence of homeless status. Evidence of an individual or head of household's current living situation may be documented by a written observation by an outreach worker, a written referral by housing or service provider, or a certification by the household seeking assistance that demonstrates that the individual or head of household is currently homeless and living in a place not meant for human habitation, in an emergency shelter, or a safe haven. For paragraph (2) of the definition for chronically homeless at 24 CFR 578.3, for individuals currently residing in an institution, acceptable evidence includes:

      i. Discharge paperwork or a written or oral referral from a social worker, case manager, or other appropriate official of the institution, stating the beginning and end dates of the time residing in the institution that demonstrate the person resided there for less than 90 days. All oral statements must be recorded by the intake worker; or

      ii. Where the evidence above is not obtainable, a written record of the intake worker's due diligence in attempting to obtain the evidence described in the paragraph i. above and a certification by the individual seeking

assistance that states that they are exiting or have just exited an institution where they resided for less than 90 days; and

iii. Evidence that the individual was homeless and living in a place not meant for human habitation, a safe haven, or in an emergency shelter, and met the criteria in paragraph (1) of the definition for chronically homeless in 24 CFR 578.3, immediately prior to entry into the institutional care facility.

(b) Evidence of the duration of the homelessness. Recipients documenting chronically homeless status must also maintain the evidence described in paragraph i. or in paragraph ii. below, and the evidence described in paragraph iii. below:

i. Evidence that the homeless occasion was continuous, for at least one year.

Using any combination of allowable documentation described in Section V.B.2.(a) of this Notice, recipients must provide evidence that the homeless occasion was continuous, for a year period, without a break in living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter. For the purposes of this Notice, a break is considered at least seven or more consecutive nights not residing in a place not meant for human habitation, in shelter, or in a safe haven.

At least 9 months of the 1-year period must be documented by one of the following: (1) HMIS data, (2), a written referral, or (3) a written observation by an outreach worker. In only rare and the most extreme cases, HUD would allow a certification from the individual or head of household seeking assistance in place of third-party documentation for up to the entire period of homelessness. Where third-party evidence could not be obtained, the intake worker must obtain a certification from the individual or head of household seeking assistance, and evidence of the efforts made to obtain third-party evidence as well as documentation of the severity of the situation in which the individual or head of household has been living. An example of where this might occur is where an individual has been homeless and living in a place not meant for human habitation in a secluded area for more than 1 year and has not had any contact with anyone during that entire period.

Note: A single encounter with a homeless service provider on a single day within 1 month that is documented through third-party documentation is sufficient to consider an individual or family as homeless for the entire month unless there is any evidence that the household has had a break in homeless status during that month (e.g., evidence in HMIS of a stay in transitional housing).

ii. **Evidence that the household experienced at least four separate homeless occasions over 3 years.**

Using any combination of allowable documentation described in Section V.B.2.(a) of this Notice, the recipient must provide evidence that the head of household experienced at least four, separate, occasions of homelessness in the past 3 years.

Generally, at least three occasions must be documented by either: (1) HMIS data, (2) a written referral, or (3) a written observation. Any other occasion may be documented by a self-certification with no other supporting documentation.

In only rare and the most extreme cases, HUD will permit a certification from the individual or head of household seeking assistance in place of third-party documentation for the three occasions that must be documented by either: (1) HMIS data, (2) a written referral, or (3) a written observation. Where third-party evidence could not be obtained, the intake worker must obtain a certification from the individual or head of household seeking assistance, and must document efforts made to obtain third-party evidence, and document of the severity of the situation in which the individual has been living. An example of where this might occur is where an individual has been homeless and living in a place not meant for human habitation in a secluded area for more than one occasion of homelessness and has not had any contact with anyone during that period.

iii. **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 of 2000 (42 U.S.C. 15002), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability.** Evidence of this criterion must include one of the following:

(1) Written verification of the condition from a professional licensed by the state to diagnose and treat the condition;

(2) Written verification from the Social Security Administration;

(3) Copies of a disability check (e.g., Social Security Disability Insurance check or Veterans Disability Compensation);

(4) 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

(5) Other documentation approved by HUD.

C. **Recordkeeping Recommendations for CoCs that have Adopted the Order of Priority in this Notice.**

Where CoCs have incorporated the order of priority in this Notice into their written standards, recipients of CoC Program-funded PSH may demonstrate that they are following the CoC-established requirement by maintaining the following evidence:

1. **Evidence of Cumulative Length of Occasions.** For recipients providing assistance to households using the selection priority in Sections III.A.1.(a) and (b) of this Notice, the recipient must maintain the evidence of each occasion of homelessness as required in Section V.B.2.(b)(2) of this Notice, which establishes how evidence of each occasion of homelessness, when determining whether an individual or family is chronically homeless, may be documented. However, to properly document the length of time homeless, it is important to document the start and end date of each occasion of homelessness and these occasions must cumulatively total a period of 12-months. In order to properly document the cumulative period of time homeless, at least 9 months of the 12-month period must be documented through third-party documentation unless it is one of the rare and extreme cases described in Section V.B.2.b.ii. of this Notice. For purposes of this selection priority, a single encounter with a homeless service provider on a single day within one month that is documented through third-party documentation is sufficient to consider an individual or family as homeless for the entire month unless there is any evidence that the household has had a break in homeless status during that month (e.g., evidence in HMIS of a stay in transitional housing).

2. **Evidence of Severe Service Needs.** Evidence of severe service needs is that by which the recipient is able to determine the severity of needs as defined in Section I.D.3. of this Notice using data-driven methods such as an administrative data match or through the use of a standardized assessment conducted by a qualified professional.

3. **Evidence that the Recipient is Following the CoC's Written Standards for Prioritizing Assistance.** Recipients must follow the CoC's written standards for prioritizing assistance, as adopted by the CoC. In accordance with the CoC's adoption of written standards for prioritizing assistance, recipients must in turn document that the CoC's revised written standards have been incorporated into the recipient's intake procedures and that the recipient is following its intake procedures when accepting new program participants into the project.

VI. Questions Regarding this Notice

Questions regarding this notice should be submitted to HUD's Ask A Question at: www.onecpd.info/get-assistance/my-question.

Appendix A

Coordinated Assessment Process and Standardized Assessment Tool: Key Considerations

A coordinated assessment process is intended to increase and streamline access to housing and services for households experiencing homelessness, matches appropriate levels of housing and services based on their needs, and prioritizes persons with severe service needs for the most intensive interventions. HUD will be issuing guidance regarding the minimum requirements for establishing and operating a coordinated assessment system, as required by 24 CFR 578.7(a)(8), separately. Meanwhile, this Appendix is intended to help inform CoC efforts to implement an effective coordinated assessment *process* and qualities of an effective standardized assessment tool. As stated in Section III of this Notice, the use of both a coordinated assessment process and assessment tool(s) are critical to effectively implement the order of priority described in Section III.A. and III.B., if adopted by the CoC and incorporated into the CoCs written standards.

Recommendations for Effective Implementation of a Coordinated Assessment Process

The coordinated assessment process must incorporate and defer to any funding requirements established under the CoC Program interim rule, ESG Program interim rule, or a Notice of Funding Availability under which a project is awarded. In addition, the following are recommended as the minimum criteria for the effective implementation of a coordinated assessment process.

1. **Standardized**–The assessment process should rely upon a standardized method and criteria to determine the appropriate type of intervention for individuals or families. This standardized process could encompass the CoC-wide use of a standardized assessment tool, as well as data driven methods.

2. **Improves data management**–Individual tracking, resource allocation and planning, system monitoring, and reporting to the community and to funders is improved by use of a common, coordinated assessment tool.

3. **Non-directive**–The recommendations of the tool can be overridden by the judgment of qualified professionals, especially in where there are extenuating circumstances that are not assessed by the tool are relevant to choosing appropriate interventions. Discretion must be exercised in a nondiscriminatory manner consistent with fair housing and civil rights laws and should be subject to appropriate review and documentation (see Section V. of this Notice for the recordkeeping requirements), to ensure it is applied judiciously.

4. **Mainstream resources**–Effective coordinated assessment facilitates meaningful coordination between the homeless response system and the intake processes for mainstream systems. Connections should be made to public housing authorities, multifamily housing, health and mental health care, the workforce development system, and with other mainstream income and benefits as appropriate and applicable.

5. **Align Interventions**–The various types of interventions that are available are aligned and used strategically.

6. **Leverage local attributes and capacity**–The physical and political geography, including the capacity of partners in a community, and the opportunities unique to the community's context, should inform local coordinated assessment implementation.

7. **Assess program capacity**–Assess the variety and capacity of programs in the community to identify and fill critical gaps in housing and service resources and to ensure that a there is a range of options needed for a coordinated assessment system to work well.

8. **Outreach**–The coordinated assessment system should ensure that connections and ongoing engagement occurs with those not accessing services and housing on their own. Often, these are the highest need and most at-risk people in communities.

9. **Privacy protections**–Protections should be in place to ensure proper use of the information with consent from the client. Assessment should also be conducted in a private location.

10. **Fair Housing and Civil Rights**—Protections should be in place to ensure compliance with all civil rights requirements, including, but not limited to, the Fair Housing Act, Title VI of the Civil Rights Act of 1964, and Section 504 of the Rehabilitation Act of 1973. The assessment tool should not seek disability-related information that is unnecessary for determining the need for housing-related services. The coordinated assessment process should ensure that program participants are informed of rights and remedies available under applicable federal, state, and local fair housing and civil rights laws, in accordance with the requirement at 24 CFR 578.93(c)(3).

11. **Training**–Initial and ongoing training on the use of the assessment tool should be provided to those parties that will be administering the assessment.

12. **Accessible and well-advertised**–The assessment must be well advertised and easily accessed by people seeking services or housing. This can happen in a variety of ways: access to services can be centralized, a one-stop shop approach. Access can be coordinated, leveraging outreach capacity and linking or integrating with mainstream systems. The assessment must be conducted in a manner that is accessible for individuals with disabilities, ensures meaningful program access for persons with Limited English Proficiency, and is affirmatively marketed in order to reach eligible persons who are least likely to seek assistance in the absence of special outreach, in accordance with 24 CFR 578.93(c)(1).

13. **Prioritization**–When resources are scarce, the coordinated assessment process should prioritize who will receive assistance based on their needs. Coordinated assessment should never result in long waiting lists for assistance. Instead, when there are many more people who are assessed to receive an intervention than there are available openings, the process should refer only individuals with the greatest needs.

14. **Inform system change efforts**–Information gathered during the coordinated assessment process should identify what types of programs are most needed in the community and be used by the CoC and other community leaders to allocate resources.

Recommended Qualities of a Good Standardized Assessment Tool

While HUD requires that CoCs use a standardized assessment tool, it does not endorse any specific tool or approach, there are universal qualities that any tool used by a CoC for their coordinated assessment process should include.

1. **Valid**–Tools should be evidence-informed, criteria-driven, tested to ensure that they are appropriately matching people to the right interventions and levels of assistance, responsive to the needs presented by the individual or family being assessed, and should make meaningful recommendations for housing and services.

2. **Reliable**–The tool should produce consistent results, even when different staff members conduct the assessment or the assessment is done in different locations.

3. **Inclusive**–The tool should encompass the full range of housing and services interventions needed to end homelessness, and where possible, facilitate referrals to the existing inventory of housing and services.

4. **Person-centered**–Common assessment tools put people–not programs–at the center of offering the interventions that work best. Assessments should provide options and recommendations that guide and inform client choices, as opposed to rigid decisions about what individuals or families need. High value and weight should be given to clients' goals and preferences.

5. **User-friendly**–The tool should be brief, easily administered by non-clinical staff including outreach workers and volunteers, worded in a way that is easily understood by those being assessed, and minimize the time required to utilize.

6. **Strengths-based**–The tool should assess both barriers **and** strengths to permanent housing attainment, incorporating a risk and protective factors perspective into understanding the diverse needs of people.

7. **Housing First orientation**–The tool should use a Housing First frame. The tool should not be used to determine "housing readiness" or screen people out for housing assistance, and therefore should not encompass an in-depth clinical assessment. A more in-depth clinical assessment can be administered once the individual or family has obtained housing to determine and offer an appropriate service package.

8. **Sensitive to lived experiences**–Providers should recognize that assessment, both the kinds of questions asked and the context in which the assessment is administered, can cause harm and risk to individuals or families, especially if they require people to relive difficult experiences. The tool's questions should be worded and asked in a manner that is sensitive to the lived and sometimes traumatic experiences of people experiencing homelessness. The tool should minimize risk and harm, and allow individuals or families to refuse to answer questions. Agencies administering the assessment should have and follow protocols to address any psychological impacts caused by the assessment and should administer the assessment in a private space, preferably a room with a door, or, if outside, away from others' earshot. Those administering the tool should be trained to recognize signs of trauma or anxiety.

Additionally, the tool should link people to services that are culturally sensitive and appropriate and are accessible to them in view of their disabilities, *e.g.*, deaf or hard of hearing, blind or low vision, mobility impairments

9. **Transparent**–The relationship between particular assessment questions and the recommended options should be easy to discern. The tool should not be a "black box" such that it is unclear why a question is asked and how it relates to the recommendations or options provided.

Appendix I: Employment Assessment NEEDS TO BE ADDED

Homelessness Assessment Survey For Employment – BC

Name of Person Conducting the interview	
Individual's Name	
Address/Shelter or PO Box Number	
Client's Phone Number	
Client's Email Address	
What is the best way to contact you?	
Do you have a caseworker?	YES / NO
If yes, what is their name and where do they work?	
U.S. Military Veteran? (Answered in Profile tab)	
Are you currently working?	YES / NO
Do you want to work?	YES / NO
If yes, what KIND of job are you looking for?	Temporary Permanent Seasonal Full Time Part Time Volunteer Seasonal To Permanent
What TYPE of job are you looking for?	

Tell me a little bit about your qualifications:	
Highest Level of Education Attained	10th Grade (HUD) 11th Grade (HUD) 12th Grade, no diploma (HUD) 5th or 6th Grade (HUD) 7th or 8th Grade (HUD) 9th Grade (HUD) Client doesn't know (HUD) Client refused (HUD) College Degree GED (HUD) Graduate Degree High School Diploma (HUD) Less than High School No Schooling Completed (HUD) Nursery school to 4th grade (HUD) Post-secondary school (HUD) Some College Some High School Some Technical School Technical School Certification
What did you do on some of your previous jobs?	
Do you have any licenses or certifications?	YES / NO
If yes, tell me about them:	
Can you type?	YES / NO
Are you familiar with any computer software like Microsoft Office?	YES / NO

If yes, which ones?	
Do you have a resume?	YES / NO
Are you comfortable filling out an application?	YES / NO
Do you need clothes for a job interview?	YES / NO
Do you have reliable transportation?	YES / NO
What is your mode of transportation?	
How far would you be willing to travel to work?	
Do you have any income now?	YES / NO
If yes, what is the source of income?	SSI Employment Income SSIP Pension SSDI Child Support Veteran Benefits Unemployment Benefits Medicare Food Stamps Social Security GA TANF None Other
Total Household Monthly Income (from all sources)?	
Taking into account all forms of income, what wage would you be willing to accept?	

Do you have any of the following in your belongings (with you):	Social Security Card Driver's License Birth Certificate Permanent Residency Card Military ID Military Discharge Papers (DD214)
Besides housing, what do you need help with to find and keep a job? (Check all that apply)	Childcare Training Transportation Housing Getting along with others Interview Skills Substance Abuse Education Felony Work History Legal Status Language
Do you have any health or other issues that may affect what jobs you can do?	YES / NO
Health Issues, please describe:	
Mental health issues, please describe:	
Other, please describe:	