

Indiana Balance of State Coordinated Entry Policies and Procedures



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Coordinated Entry Process

The purpose of this Coordinated Entry Policies and Procedures (Policy) is to guide the operation of the Indiana Balance of State Continuum of Care Coordinated Entry process. A Coordinated Entry (CE) process represents a new approach to coordination and management of a Continuum of Care's (CoC) housing crisis response system. CE enables each Region to effectively and efficiently connect people in crisis to interventions that will rapidly end their homelessness. The CE approach also aligns with the Indiana Balance of State (BOS) goals to transform crisis response systems to improve outcomes for people experiencing a housing crisis.

In 2009, the McKinney-Vento Homeless Assistance Act was amended by the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act. Among other actions, the HEARTH Act consolidated several of HUD's separate homeless assistance programs into a single grant program, the Continuum of Care Program (CoC Program), and it codified the CoC planning process into law.

The CoC program interim rule (24 CFR 578) released by HUD in 2012 requires the establishment of a "centralized or coordinated assessment system," hereafter referred to as Coordinated Entry. The rule defines Coordinated Entry as:

A centralized or coordinated process designed to coordinate program participant intake/assessment and provision of referrals. [Such a] system covers the [Region's] geographic area, is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool. (24 CFR part 578.3)

Both the CoC Program interim rule and the Emergency Solutions Grants (ESG) program interim rule (**24 CFR part 576**) released in 2011 require that projects operated by recipients and sub-recipients of CoC Program or ESG grant funds must participate in the established Coordinated Entry process (CE).

Coordinated Entry Vision

Households experiencing a housing crisis or homelessness will be quickly assessed and offered appropriate interventions that align with their needs and will resolve the crisis. CE will align available resources effectively to end homelessness in Indiana.

Mission Statement

The mission of the Indiana Balance of State Continuum of Care's Coordinated Entry process is to rapidly connect households that are facing or are at-risk of facing homelessness with the most appropriate need-based interventions.

Why Coordinated Entry?

Coordinated Entry refers to the process used to assess and assist in meeting the housing needs of people at risk of homelessness and people experiencing homelessness. Key elements and benefits of Coordinated Entry include:

Element of a CE System	Benefits
Designated intake/assessment locations	Clear points of access for households; prevents Clients from seeking services at agencies that cannot help them; can reduce new entries into homeless system through diversion and prevention efforts.

Standardized assessment tools	Each household assessed utilizing the Standardized Assessment Tool (VI-SPDAT), prioritizes most vulnerable in entire community population.
Centralized Prioritization List	Centralized Prioritization List in each Region; households no longer manage their status on multiple wait lists; collaboration among service agencies.
Matching needs to interventions	Needs-first approach in lieu of “First Come First Served” interventions. Households no longer determine their eligibility for each agency individually; greater housing match accuracy
Targeted & coordinated referrals	Tailored to household match; agency knows to expect Client; Client knows what to prepare ahead of time; coordinated across Region

The implementation of Coordinated Entry is now a requirement for homeless service providers that receive Emergency Solutions Grant funding and CoC Program funding from IHCD or directly from the U.S. Department of Housing and Urban Development (HUD) and is considered a national best practice. When implemented effectively, Coordinated Entry can also improve a Region’s ability to improve its performance on its Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act outcomes and accelerate the Region’s progress on ending homelessness.

Why Now?

Reforming the current system of care for households experiencing homelessness has been a primary goal for the state of Indiana. The Indiana Balance of State Continuum of Care will develop and implement a Coordinated Entry system that prioritizes those who are chronically homeless using a Housing First approach with emphasis on the sub-populations of Veterans, Families with children and Youth.

Coordinated Entry Design Principles

The goal of the CE is to establish an order of priority to ensure that those persons with the most severe service needs and greatest barriers towards obtaining and maintaining housing on their own are given first priority to available housing and to provide each household with adequate services and supports to meet their housing needs. Below are the guiding principles that will help Indiana Balance of State Continuum of Care meet these goals.

- **Client Choice:** Households will be given information about the services and programs available to them and be given the right to choose which services and programs in which they want to participate. Households will also be engaged as key and valued partners in the implementation and evaluation of CE through focus groups, surveys, and other methods designed to obtain their input on the effectiveness of the Coordinated Entry process.
- **Collaboration:** Because CE is being implemented system wide, it requires a great deal of collaboration between the Region, homeless services providers, mainstream assistance agencies (e.g., Social Services, hospitals, and jails), funders, and other key partners. This spirit of collaboration will be fostered through open communication, transparent work by a strong governing council (the Indiana Balance of State Coordinated Entry Steering Committee), consistently scheduled meetings between partners, and consistent reporting on the performance of CE.
- **Accurate Data:** Collecting Data about people experiencing homelessness is a key component of Coordinated Entry. Data from the assessment process that reveals what resources households need the most will be used to assist with funding decisions. To capture this data accurately, each

provider must ensure that data is entered into the Homeless Management Information System (HMIS) in a timely manner (with the exception of some special populations and special cases outlined later in this Policy). Providers must obtain a participant's consent to share and store his or her data for purposes of assessing and referring participants through the coordinated entry process. Participants must also be free to decide what information they provide during the assessment process. Providers are prohibited from denying assessment or services to a participant if the participant refuses to provide certain pieces of information, unless the information is necessary to establish or document program eligibility per the applicable program regulation or Federal statute requires collection, use, storage, and reporting of a participant's personally identifiable information (PII) as a condition of program participation.

- **Performance-Driven Decision Making:** Decisions about and modifications to CE will be driven primarily by the need to improve the performance and key outcomes of the process related to delivery of services for the homelessness in the Indiana Balance of State Continuum of Care. These outcomes include reducing new entries into homelessness, reducing lengths of episodes of homelessness, and reducing repeat entries into homelessness. Changes may also be driven by a desire to improve process-oriented outcomes, including reducing the amount of wait time for an assessment.
- **Housing First:** Coordinated Entry will support a housing first approach and will thus work to connect households with the appropriate permanent housing opportunities, as well as any necessary supportive services, as quickly as possible without preconditions or service participation requirements.
- **Prioritizing the Hardest-to-House:** Coordinated Entry referrals will prioritize those households that appear to be the hardest to house or the hardest to serve for program beds and services. This approach is most likely to reduce the average length of episodes of homelessness and result in better housing outcomes for all.

Definitions

Balance of State (BOS): The Indiana Balance of State (BOS) consists of 91 counties which are grouped into 16 Regions. Each Region includes from 1 to 10 counties.

CA/CAS/CE/CES: Coordinated Access/Coordinated Access System/Coordinated Entry/Coordinated Entry System all pertain to the Coordinated Entry system.

Centralized Point of Access: A central location within a geographic area where individuals and families present to receive homeless housing and services.

Chronically homeless: the target population for the first phase of Indiana BOS's CE system. Chronically homeless is defined by HUD as "an individual or family with a disabling condition who has been continuously homeless for a year or more or has had at least four episodes of homelessness in the past three years." (*24 CFR Parts 91 & 578*) SEE EXHIBIT H.

The Indiana Balance of State Coordinated Entry Steering Committee: A Committee that has been established to provide guidance for the Indiana BOS CoC in creating, implementing, and updating Policies and Procedures for the CE process statewide. The committee consists of Regional Chairs, Lead Agencies, and IHEDA staff.

De-Centralized Point of Access: Two or more locations within a geographic area where individuals and families present to receive homeless housing and services

Diversion: Light touch case management approach to ending homelessness that encourages and helps households to come up with their own solutions to housing crises. Diversion is not a program; Diversion is a process that enables the client to identify ways to end their housing crises. Diversion is empowering

Homeless Management Information System (HMIS): is the information system designated by the Continuum of Care to comply with HUD's requirements and used to record, analyze, and transmit client and activity data in regard to the provision of shelter, housing, and services to individuals and families who are homeless or at risk of homelessness. Each Continuum of Care is responsible for selecting a Homeless Management Information System (HMIS) software solution that complies with HUD's data collection, management, and reporting standards." (24 CFR part 578.3 and 578.7)

Household: The Clients, consumers, participants, etc., served through the CE. The Household may consist of one person or multiple family members that live together in the same housing unit.

Lead Agency: An agency in each of the 16 Regions that will serve as the Managing Entity of its Region's Prioritization List. The Lead Agency will lead the implementation of Coordinated Entry and will commit resources and staffing to administer assessments, analyze assessment results and support referrals to housing interventions. Lead Agencies will also serve on the Indiana Balance of State Coordinated Entry Steering Committee, as the systems are launched, managed and evaluated.

Lead Agency Prioritization List Manager: Main contact person at a Lead Agency is responsible for updating, monitoring, and managing the Prioritization List for his or her Region.

Project/Program/Provider: Refers to any homeless services provider in the CoC. Currently only those providers currently receiving CoC Program funding and ESG funding are required to participate. Other homeless service providers in Indiana are encouraged to participate voluntarily in their Region's CE.

Region: The Indiana BOS CoC is made up of 16 Regions. Each Region contains from 1 to 10 counties. **SEE EXHIBIT A.**

VI-SPDAT (Vulnerability Index-Service Prioritization Decision Assistance Tool as created and owned by Community Solutions and OrgCode Consulting, Inc.): Standardized Assessment Tool(s) used by all CE Access Points to determine a household's current housing situation, housing and service needs, risk of harm, risk of future or continued homelessness, and other adverse outcomes. Staff administering the VI-SPDAT Standardized Assessment Tool(s) must complete required training through OrgCode, creator of the tool(s).

Coordinated Entry Framework of Core Elements Management Roles

The Coordinated Entry system is being established in all Regions with overall program management support from the Indiana Balance of State Continuum of Care. The Regions will focus on quickly connecting households experiencing chronic homelessness to permanent housing interventions. Each Region will develop centralized or de-centralized access points for households, managed by Lead Agencies. These designated Regional access points will be the sole locations where homeless or those at-risk of

homelessness will be directed for intake/assessment prior to being admitted to any homeless service provider.

Lead and Participating Agencies

A Lead Agency from each of the 16 Regions will serve as the Managing Entity of its Region's Prioritization List. The Lead Agency for each Region will lead the implementation of the Coordinated Entry and will commit resources and staffing to administer intakes/assessments, analyze assessment results and support referrals to housing interventions. The Lead Agency for each Region will also serve on the Indiana Balance of State Coordinated Entry Steering Committee, as the systems are launched, managed, and evaluated. Provider will support the implementation of Coordinated Entry (CE) and may commit resources and staffing, serve as entry points, and support data collection, analysis, and referrals.

Standardized Access and Intake/Assessment

Providers that are considered access points to CE must administer the Single or Family VI-SPDAT or the TAY-VISPDAT (for youth age 16 – 24) according to HUD standards. The intake/assessment process must be standardized across each Region, with uniform decision-making across all intake/assessment locations and staff. CE will use a Client-centered approach, allowing Clients to refuse to answer intake/assessment questions and/or referrals. Reasonable accommodations must be undertaken to ensure individuals with disabilities, language barriers or literacy barriers are able to fully participate in the intake/assessment process. Providers may utilize interpretation services available via telephone or in-person to assist those whose primary language is something other than English. Staff will take the necessary steps to accommodate those clients with disabilities as well as literacy barriers in the intake/assessment process by making the necessary adjustments.

To ensure transparency in Client care, coordination and decision making, each Client that receives a comprehensive intake/assessment and referral to a Permanent Supportive Housing Project (PSH) or Rapid Re-housing (RRH) will be provided written documentation that confirms that the intake/assessment has been performed and the category of housing for which the Client is eligible **SEE EXHIBIT B**. Referrals for PSH or RRH are valid for five days. If a client fails to accept the referral within the five days after the date listed on the date of the Coordinated Entry Receipt, the housing unit will be offered to the next eligible client on the Prioritization List.

Regions must employ a progressive assessment approach. Progressive assessment stages the sequencing of assessment questions such that clients are asked only those questions directly related to service enrollment and prioritization decisions necessary to determine eligibility to receive housing services.

Intake/Assessment

It is prohibited for any ESG or CoC-funded provider of rapid rehousing or permanent supportive housing to admit or serve a Client without the Client going through the Coordinated Entry process and receiving a referral to that agency, **unless the designated Coordinated Entry Access Sites are closed or immediate shelter is necessary in order to ensure the safety of the Client/Household**. A Client that needs shelter after hours when a physical intake/assessment site is closed must be referred via telephone to the nearest provider offering an emergency shelter or a domestic violence shelter. The provider must perform its standard intake/assessment to ensure client meets eligibility requirements.

CE intake/assessment staff in Indiana must administer the VI-SPDAT in its CE. The process is as follows:

1. CE intake/assessment staff explains the assessment process to the Client and answers any questions presented by household/Client.
2. The CE intake/assessment staff conducting the assessment will present the household/Client with the Consent Form in either a paper form or electronically. CE assessment staff will review the form with the Client and explain what data will be requested, how it will be shared, to whom it will be provided/shared, and the Client's rights regarding the use of their data. CE intake/ assessment staff will be responsible for ensuring Clients understand their rights as far as the release of the Client's information, data and confidentiality. If the household/Client signs the Consent Form, the CE intake/assessment staff will also sign the Consent Form. **SEE EXHIBIT C.**
3. CE intake/assessment staff completes the VI-SPDAT per instructions and scores each assessment per scoring instructions.
4. If a Client is assessed and no further contact with the Client takes place for at least 90 days, the original intake/assessment agency staff will make three attempts to contact the Client on three separate dates. If intake/assessment agency staff is unable to contact client following the three attempts, the intake/assessment agency staff will exit the Client from CE. If the Client is successfully contacted, the intake/assessment agency staff will work with the Client to schedule an appointment to complete an updated assessment (VI-SPDAT) to capture any changes in the Client's status since Client's previous assessment.

A note on data collection: If a **Client indicates on the Client release of information ("ROI") form that he or she does not agree to enter his or her data into the Homeless Management Information System ("HMIS") or share it with other HMIS providers, his or her data should NEVER be entered into HMIS.**

Prioritization

The State of Indiana has determined that an effective CE ensures that people with the highest vulnerability, most severe service needs and longest history of time homeless receive priority for any type of housing and homeless assistance available in the Region, including PSH, Rapid Re-housing ("RRH"), and other interventions.

Each Region must define ONE minimum VI-SPDAT score or score range associated with referrals to resources such as RRH, Transitional Housing (TH), or PSH in the Region.

Individuals and families will be referred to RRH according to the following prioritization criteria:

Seventy-five percent of available RRH resources must be filled with individuals or families that meet or exceed the minimum VI-SPDAT score established by that Region for RRH. Regions may enact more rigorous standards.

Individuals and families will be referred to TH according to the following prioritization criteria:

At least 75% of available TH units within a Region must be filled with households that meet the minimum VI-SPDAT score established by that Region for TH AND meet the criteria of at least one of the priority groups identified below:

- Youth: All individuals up to the age of 24 who present as a household. This can include unaccompanied youth (household size of one), and multiple youth who are seeking assistance together.
- Youth Parents: Women and men up to the age of 24 who are the parent of at least one child and are seeking assistance with that child or children.

- Domestic Violence survivors: Individuals and families with at least one person who identifies a domestic violence incident as the primary reason causing their housing crisis. Includes youth up to age 24 who are survivors of human trafficking, sexual assault, domestic violence or stalking.
- Persons being released from correctional facilities that were homeless before entering prison/jail.
- Pregnant women: Women who are pregnant, regardless of age or whether they have any additional children.
- Persons in the early stages of AOD (alcohol or drug) addiction recovery: Individuals and families with at least one person who recently began receiving services to assist in their recovery from alcohol or other drug addiction. This can include (but is not limited to) people who were recently released from a treatment center or other institution.
- Veterans (choosing Grant and Per Diem - GPD).

Individuals and families will be referred to PSH according to specific prioritization protocols established by the Region which must include the following attributes:

- Chronic homelessness as defined by HUD (**SEE EXHIBITS F and G**) (forms pertaining to proof/history of homelessness/chronic homelessness)).
- longest history of homelessness
- most severe service needs as determined by the VI-SPDAT score

If a Client is eligible for PSH and no units are readily available, the Client may be housed with RRH assistance and will maintain his or her chronically homeless status for the purpose of eligibility for other PSH programs dedicated to serving the chronically homeless, such as HUD-VASH and CoC funded PSH (so long as they meet any other additional eligibility criteria for these programs). Clients maintain their chronically homeless status during the time period they are receiving RRH assistance. RRH is a model for helping homeless individuals and families quickly obtain and maintain permanent housing, and it can be appropriate to use as a bridge to other permanent housing programs. It is important to note that although the clients in RRH are considered chronically homeless for purposes of eligibility for other programs, the housing itself is still considered permanent housing; therefore, these clients are not considered chronically homeless (or homeless) for counting purposes, and must not be included in the CoC's sheltered Point-in-Time ("PIT") count. (**HUD FAQ ID 530**) **SEE EXHIBITS D and H.**

Referral Standards

Regions must establish written protocols in accordance with HUD guidelines for referrals that explicitly identify the VI-SPDAT score or score range associated with referrals to each Region component type including PSH, TH, RRH, and self-resolve strategies. Regions must adopt locally specific prioritization criteria and referral protocols based on the local capacity in the Region and the inventory and availability of housing and services in the Region. The referral process must be standardized and administered consistently; however, the prioritization of housing and services will vary over time due to fluctuating Client demand, changes in availability of housing and services in the Region, and dynamic Client needs and preferences.

Clients must be provided the ability to enroll in Region component types that are less intensive than the CE referral choice offered. The applicability and accuracy of VI-SPDAT score ranges may vary among Regions based on local Region design, resource availability, and funding requirements. Prioritization processes and tools will be assessed and updated annually by each Region based on analysis of actual score prevalence rates and available Region inventory.

When offering referral options to Clients, the following information shall be provided:

- Information about the referred housing providers and housing types using resources such as web pages and Region inventory information;
- Client's right to reject a referral;
- Right to choose options less intensive than the CE referral offered;
- Guidance regarding the possible impact associated with accepting, rejecting, or changing the project type recommended for the household by the CE intake/assessment and prioritization process.

Referral Criteria for All Region Projects

Each Region must define a referral criterion for all projects within the Region's geographic area. The referral criteria must identify all the eligibility and exclusionary criteria used by a program to make enrollment determinations for referred persons or households. Established guidelines must describe acceptable time frames for reviewing and communicating referral decisions (i.e., whether the Client is either accepted or denied enrollment). If a potential Client is not offered enrollment, the reason for rejection must be clearly communicated and documented in HMIS. The referral criteria must be published at least annually and support the identification of and connection to appropriate housing and services for all Client's assessed.

Referral Process

- Referrals will only be made to programs with open housing units.
- CE intake/assessment staff will notify the household if multiple permanent housing interventions are matches. If there are multiple matches, the household can choose which housing agency the household will pursue.
- The application for the permanent housing opening will be completed by the agency that receives the Client referral.
- The household is referred by CE intake/assessment staff at the intake/assessment site to a PSH project if there is availability. CE intake/assessment staff prepares referral packet:
 - Copy of Client assessment(s) or HMIS data,
 - Copy of ROI,
 - The referral packet is submitted to the PSH project by secure fax or secure email and includes a referral checklist/cover page (cover page should include the name or number of household, proof that CE contacted PSH project regarding Client's arrival or to set up appointment for Client, contact info of referring CE staff, proof that CE staff updated HMIS for this household),
 - CE intake/assessment staff should keep some form of confirmation that information was sent.
 - The CE intake/assessment staff must provide the household appropriate directions, contact information, any referral forms that a required and transportation assistance (if eligible) to the referred agency.
 - The household must meet with the PSH project intake/assessment staff for case management services and housing intake/assessment. It is critical at this point for CE intake/assessment staff to secure a reliable mode of contact with the Client.
- If a household is referred HMIS will be updated so that the household is no longer included in the Prioritization List.
- If CE intake/assessment staff cannot reach intake/assessment staff at the PSH project, another PSH project that meets the household's composition will be chosen for the referral.

- If no PSH project has immediate availability, the household will remain on the Prioritization List until a unit opens or CE intake/assessment staff has no contact with the Client for 90 days.
- If a household does not follow up with the PSH project within three days of its scheduled appointment, the PSH project will notify CE intake/assessment staff who will try to follow up with the household. If there is no contact with the household within two additional business days, that household will lose this opportunity and the next eligible Client on the Prioritization List will be offered the housing. Households will remain on the Prioritization List if CE intake/assessment staff is unable to contact them within three days or if Client rejects a housing referral opportunity. Clients that reject three opportunities presented to them for permanent housing will be removed from the Prioritization List. Clients that are unable to be located will be removed from the list after ninety days.

Prioritization Standards

The matching process and eventual referral linkage process will consider a set of prioritization criteria for each project type. The order of a Client's priority on the Prioritization List must not, under no circumstances, be based on disability type or diagnosis. Regions must establish priority for each project type based on the severity of the needs, length of time homeless, or sub-population characteristics, depending on the specific Region component type. Regions that do not adopt and comply with these priority standards must provide documentation that demonstrates different local needs that warrant an alternative approach to service strategy prioritization.

Referrals will also be based on each program's admissions eligibility criteria, including populations served. For example, programs that serve only single adult men will only receive single adult male referrals.

Agencies participating in Coordinated Entry must submit all their eligibility criteria to the Coordinated Entry Region's Lead Agency before they can participate in the Coordinated Entry process. Any changes to a program's eligibility criteria or target population must be sent immediately to the Coordinated Entry Region's Lead Agency and Regional Chair to make sure referral protocol is updated accordingly. Criteria that agencies may have that are not bound to local law or strict funders' requirements will be reviewed by the Coordinated Entry Lead Agency and Regional Chair along with data about people who have remained in emergency shelter for more than 45 days or are living on the street. If the Lead Agency or Regional Chair has a concern that a program's requirements may be contributing to "screening out" or excluding households from needed services, the Lead Agency and/or Regional Chair may request to meet with the provider to discuss their criteria. If the Lead Agency and/or Regional Chair can clearly show a link between underserved populations and a provider's eligibility criteria, and the provider is unwilling to modify the criteria, the Lead Agency and/or Regional Chair may recommend to the Regional Planning Council and Coordinated Entry Steering Committee that the provider be de-prioritized for CoC or other sources of funding.

Prioritization List Management and Notification of Referral

Prioritization List management and notification of referrals will be the responsibility of Lead Agency staff members. Lead Agency staff members may be assigned or may periodically trade-off responsibility among Lead Agency staff members for alerting the Client's case manager when an opening has become available for them in a specific program. When it is a Lead Agency staff member's given time (day, week or month) to take on this responsibility, they will need to check program availability at least weekly to see if new openings are becoming available and contact the Client's case manager to notify them of an opening in a program.

Special Populations

There are many sub-populations of people coming through the Coordinated Entry process that may have special needs or need to be directed to specific resources to have their needs met. While this document includes specific instructions for some of those populations, intake/assessment staff members who believe that a Client is eligible for another specific resource should contact the Lead Agency or Regional Chair for assistance.

Post-Referral Procedure

Once a Client has entered into a shelter or other crisis housing, the program should make sure the Client is connected to a case manager. Both the case manager and the Client will receive updates on where the Client stands on the Prioritization List, if the Client is waiting for a longer-term intervention.

Provider Declines Referral

Declined referral procedures can be found in **EXHIBIT E**

Client Declines Referral

1. If a Client declines a referral this must be communicated back to the Prioritization List Manager, assessment and referral provider, and/or Client advocate within three business days.
2. All Client declined referrals must be reviewed by the Prioritization List Manager, assessment and referral provider, and/or Client advocate designated by the Region.
3. When a declined referral is communicated to the housing referral provider or designee, the Client's CE HMIS record must be updated to reflect the reason for denial.
4. A Client who denies three sequential referrals will be encouraged to participate in a case conferencing meeting with the Lead Agency Prioritization List Manager, assessment and referral provider, and/or Client advocate, and will be removed from the Prioritization List. If the Client seeks housing assistance later, CE intake/assessment staff may enter a new CE enrollment for the Client and complete the CE intake/assessment.
5. If a program receives a referral for a Client removed previously from the program for any reason, (including but not limited to: violence, illegal activity, threats, or damage to property) the Client may be re-assessed by the program for re-admittance into the program following a ninety day period and on a case-by-case basis.

Grievance Procedures

Grievance procedures can be found in **EXHIBIT E**.

Coordinated Entry Statewide Policy on Transfers around the State

When a household has been assessed in one Region and requests that its assessment be transferred to another Region the following processes will be used (*Note: per a Client's choice they may be included in two Prioritization Lists at the same time or he or she may choose to switch from one Region's list to the another Region's list. It is not recommended that a Client be included in more than two lists at one time.*):

HMIS (shared) Client process:

1. The person who was made aware of the household's request will notify his or her Region's Prioritization List ("PL") Manager.
2. The PL Manager will determine if an ROI is needed to share information with the new Region's Prioritization List Manager or if the HMIS ROI is adequate.

3. New Region's PL Manager will check the CE eligibility requirements for the Region's housing stock where the household would like to go.
4. If the household appears eligible, the original PL Manager will send the referral to the receiving PL Manager through HMIS for review (using the HMIS referral function).
5. PL Manager of the receiving Region will review the Client's record in HMIS and either contact the household for further information or assign the appropriate access point within the Region the task of connecting with the household.
6. Once all information is obtained the Client will be accepted or declined in HMIS.
7. If accepted, the Client will be added to the receiving Region's Prioritization List.
8. If the Client wishes to be included only in the new Region's list, then the Client's original referral will be closed by the original Region's PL Manager.
9. If the Client chooses to be included in both Region's Prioritization Lists the PL Managers for both Regions must coordinate how they will communicate with the other Region regarding the Client.
10. The original Region's PL Manager will notify the Client of the outcome of the referral.

Non-HMIS (not shared) Client process:

1. The person who was made aware of the household's request will notify his or her Region's PL Manager.
2. The PL Manager will obtain an ROI to speak to the other Region regarding the Client transfer and will ensure that any agency that will need Client information to execute the transfer is covered by the ROI.
3. New Region's PL Manager will check the CE eligibility requirements for the Region's housing stock in the Region where the household would like to transfer.
4. If the household appears to be eligible, the original PL manager will e-mail or fax the CE Assessment to the receiving Region via secure e-mail or secure fax for review.
5. The PL Manager of the receiving Region will review the Client's CE Assessment and either contact the household for further information or assign the appropriate access point in the Region with the task of connecting with the household.
6. Once all information is obtained the Client is accepted or declined the new Region will inform the referring PL Manager of the outcome.
7. If accepted, Client will be added to the receiving Region's Prioritization List.
8. If the Client wishes to be only included in the new Region's list, then the Client's original referral will be closed by the original Region's Prioritization List Manager.
9. It is the receiving PL Manager's responsibility to document that the household is on multiple lists using a method appropriate for its non-shared list structure so that if the Client is referred to a housing program the CE Lead Agency can notify the other Region(s).
10. The original Region's PL Manager will notify the Client of the outcome of the referral.

Additional Guidelines:

Households may be included in up to two IN Region's Prioritization Lists at one time. A Client may be included in more than two Prioritization Lists at the PL Manager's discretion and preferably only in situations where appropriate housing is limited due to family size, health, or safety.

The Client should want to live in the Region he or she are requesting to be transferred or added to. Filling housing vacancies takes time and effort and this process hopes to prevent households from being placed on all lists because they are willing to live "anywhere" in the state.

Staff should have conversations with Clients regarding Client choice and accessibility and resources in the community in which they wishing to be transferred to. Clients should be notified that county residency may be required for some referrals. If the Region that the Client would like to transfer to has eligibility criteria that does not allow the Client to access its CE, then the Client must be informed that they are not eligible for CE in that Region.

Participation Requirements

HUD and VA have recently established guidance that instructs all HUD funded projects to participate in their CoC's Coordinated Entry system. A project includes any homeless prevention or homeless assistance program regardless of funding source. However, projects that receive HUD funding (CoC Program, ESG) or VA funding (SSVF, GPD, VASH) must further comply with the specific participation requirements as established by the corresponding CoC jurisdiction. Entitlement cities receiving direct funding from HUD are active participants in their Region's CE process which includes being active members of their CE Regional Planning Council.

The State of Indiana has established minimum statewide requirements for CE participation for all state-funded providers, including but not limited to those funded by Emergency Solutions Grant ("ESG"), and TH.

At a minimum CE participation includes the following for all Regions in Indiana:

- CoC projects must publish written standards for Client eligibility and enrollment determination
- CoC projects must communicate project vacancies (bed and/or unit) to the Coordinated Assessment administrative entity (Region's Prioritization List Manager) established by Region leadership.
- Persons experiencing a housing crisis must access CoC services and housing using Region defined access points.
- CoC projects must enroll only those Clients referred according to the Region's designated referral strategy.
- CoC projects must participate in the Region's Coordinated Assessment planning and management activities as established by CoC leadership.

Governance and Oversight

Indiana Balance of State Continuum of Care Board of Directors

The Indiana Balance of State Coordinated Entry process will have three levels of governance, roles, and responsibilities. The CE is governed by the Indiana Balance of State Continuum of Care Board of Directors. The Board will be responsible for:

- Evaluating the efficiency and effectiveness of the CE process;
- Providing general oversight of CE;
- Recommending and approving changes or improvements to the process, based on performance data.

Indiana Balance of State Coordinated Entry Steering Committee

The second level of governance for the system is the Indiana Balance of State Coordinated Entry Steering Committee. The Indiana Balance of State Coordinated Entry Steering Committee is responsible for:

- Providing general oversight and management of CE;
- Investigating and resolving consumer and provider complaints or concerns about the process, which are not resolved at the local level. Providing information and feedback to the Indiana Balance of State Continuum of Care Board of Directors;
- Evaluating the efficiency and effectiveness of the CE process;
- Reviewing performance data from the CE process; and
- Recommending changes or improvements to the process, based on performance data, to the Indiana Balance of State Continuum of Care Board of Directors.

Local Coordinated Entry Steering Committee (Regional Planning Council)

The third level of governance for the CE process is the local community Regional Planning Council. The Steering Committee is responsible for:

- Providing local oversight and management of CE;
- Investigating and resolving consumer and provider complaints or concerns about the process.
- Providing information and feedback to the Indiana Balance of State Coordinated Entry Steering Committee
- Evaluating the efficiency and effectiveness of the CE process;
- Reviewing performance data from the CE process; and
- Recommending changes or improvements to the process, based on performance data, to the Indiana Balance of State Coordinated Entry Steering Committee.

Low Barrier Policy

The term “low barrier” refers to minimal eligibility and enrollment obstacles resulting in homeless persons being engaged and enrolled in homeless assistance projects regardless of perceived barriers such as lack of income, lack of sobriety, presence of criminal records, or historical non-compliance with program requirements. No Client may be turned away from crisis response services or homeless designated housing due to lack of income, lack of employment, disability status, domestic violence status, or substance use unless the project’s primary funder or local government jurisdiction requires the exclusion or a previously existing and documented neighborhood covenant/good neighbor agreement has explicitly limited enrollment to Clients with a specific set of attributes or characteristics.

Funders restricting access to projects based on specific Client attributes or characteristics will need to provide documentation to the Region providing a justification for their enrollment policy. Projects offering Prevention and/or Short-Term Rapid Re-housing assistance (i.e. 0 – 6 months of financial assistance) may choose to apply some income standards for their enrollment determinations.

Fair and Equal Access

Each Region must ensure that each client has fair and equal access to CE programs and services. Fair and equal access means that people can easily access the coordinated entry process, whether in person, by phone, or some other method, and that the process for accessing help is well known. Marketing strategies may include direct outreach to people on the street and other service sites, informational flyers left at service sites and public locations, announcements during CoC or other coalition meetings, and educating mainstream service providers. If the entry point includes one or more physical locations, they are accessible to people with disabilities, and easily accessible by public transportation, or there is another method, e.g., toll-free or 211 phone number, by which people can easily access them. Each Region will ensure fair and equal access to programs and services for every Client regardless of actual or perceived

race, color, religion, national origin, age, gender identity, pregnancy, citizenship, familial status, household composition, disability, Veteran status, sexual orientation, or domestic violence status. To ensure fair access by individuals with disabilities, physical and communication accessibility barriers must be addressed by appropriate accommodation within each Region. Each Region's written policies and procedures must establish protocols for fair and equal access to Region housing and services.

If an individual's self-identified gender or household composition creates challenging dynamics among residents within a facility, the program should make every effort to accommodate the individual or assist the individual in locating alternative accommodations that is appropriate and responsive to the individual's needs, if it is amenable to the Client.

Emergency Services

Access points must provide directly or plan through other means to ensure universal access to emergency services/crisis response services for Clients seeking emergency assistance during each hour of the day and every day of the year. Each Region must document its planned after-hours emergency services approach. Access to after-hours crisis response may include telephone crisis hotline access, 211, coordination with law enforcement, and/or emergency medical care. 211 is partnering with the IN BOS CoC to provide intakes/assessments and referrals for Clients seeking assistance during hours an intake/assessment site may be closed. 211 will advertise for CE. ICADV (Indiana Coalition Against Domestic Violence) network will also provide written marketing materials available for those persons with barriers that prevent them from hearing about CE through traditional avenues. Advertising will be accessible, focused on safety and Client centered. Written materials will be made available at locations where known homeless persons visit such as: hospitals, clinics, libraries, food pantries, grocery stores, state parks, etc...

Safety Planning

Each Region must provide necessary safety and security protections for persons fleeing or attempting to flee domestic violence, stalking, and dating violence. These protections ensure that people fleeing domestic violence have safe and confidential access to the coordinated entry process and domestic violence services, and that any data collection adheres to the Violence Against Women Act (VAWA). Safety planning guidelines and examples of trauma-informed approaches to care coordination will be fully developed in partnership with the Indiana Coalition Against Domestic Violence ("ICADV"). ICADV will supply Safety Plan Cards to all Regions and all Regions will have the Safety Plan Cards available at every CE Intake/Assessment site. A Safety Plan Card contains a brief Safety Plan on the front and a List of Resources on the back.

Inclusivity of Sub-populations

All sub-populations including chronically homeless individuals and families, Veterans, youth, persons and households fleeing domestic violence, transgendered persons, and refugees and new immigrants must be provided equal access to crisis response services in a Region regardless of the characteristics and attributes of their specific sub-populations.

Outreach

All outreach activities, projects, or initiatives in a Region must be integrated with the Region's CE design, serving as an engagement resource or designated access point for the Region's resources, services, and housing.

Stakeholder Inclusion

Regions must support the implementation, expansion, and ongoing operation and evaluation of CE by regularly gathering stakeholder input and creating opportunities to receive feedback. Each Region must develop a plan to collect stakeholder feedback semi-annually and at least annually and will engage participants from CE to collect stakeholder feedback which includes: all component types in the Region, such as referral sources, individuals and families experiencing homelessness that have received services through CE including those who have been successfully housed, those who declined services/housing, those awaiting housing or who have been just recently connected to homeless services and programs, those successfully diverted, funders of homeless response systems, Clients that have decided to stop or exit CE, and mainstream system providers. This feedback can be gathered semi-annually through surveys, focus groups, and annually by other means and will engage the providers in the Region that are funded by ESG or CoC. Each Region must use the standardized list of questions for collecting Stakeholder feedback. The standardized list of questions is included in the “Coordinated Entry State Evaluation” section of this Policy will be used to improve the process

Full Coverage

The full geography of the IN BOS CoC must be covered by CE services including access to crisis response services, intake/assessment of Clients, and referral options.

Privacy Protections

CE operations and staff must abide by all State of Indiana privacy protections as defined by the Indiana Balance of State Continuum of Care Board of Directors and its sub-committees. Client consent protocols, data use agreements, data disclosure policies, and any other privacy protections offered to a Client as a result of his or her participation in HMIS will be the same protection offered as a part of CE.

List of Resources

Each CE Lead Agency will maintain a list of all available resources in the Region, including each project’s/program’s eligibility criteria and number of available beds (including seasonal beds). The list of resources must be updated annually and available to the public.

Coordinated Entry Training

Each Region must develop and implement an annual CE training plan to ensure all participating partners are knowledgeable of Region-specific participation and performance expectations, are following statewide guidelines and protocols for CE operations, and are striving to achieve national best practices and promising approaches for the most effective Coordinated Entry System. Needs or gaps in training effectiveness will be assessed annually as part of each Region’s evaluation of CE processes.

Elements of locally specific training may include the following:

- CE access points and access protocols;
- CE intake/assessment tools, processes, and uses of intake/assessment information to coordinate Client care;
- General eligibility requirements for all Region projects;
- Prioritization standards and protocols for how Client’s placement on Prioritization Lists will be managed;
- Referral processes and protocols (rather than specific referral policies which will likely be more standardized across the state);

- Data collection, data management, data sharing and reporting requirements and responsibilities.

Elements of standardized approaches across all Regions in Indiana will be reinforced by state-level training and capacity building opportunities and may include but are not limited to the following:

- Effective strategies for VI-SPDAT assessment, score analysis, and referral determinations;
- Effective Client engagement techniques for challenging or difficult to engage Clients (e.g. motivational interviewing, Housing First approaches);
- Trauma-informed care throughout the CE process;
- Intake/Assessment practices and approaches that honor the lived experience of the specific culture or sub-population accessing emergency services;
- Co-occurring issues of substance use disorders, mental illness, physical disability, chronic health conditions, and sexual assault and family violence;
- Domestic and sexual violence 101, exploring dynamics of violence and how violence impacts a person's executive decision making and functioning;
- Information specific to working with immigrant/refugee and undocumented people and families as it relates to domestic and sexual violence;
- Strategies for culturally competent CE practices and mitigating historical inequities among racial, ethnic, and cultural minorities;
- Maintaining high quality data collection and reporting practices;
- Strategies for maintaining Client confidentiality and privacy while coordinating care among multiple Region partners;
- Linkage of CE practices to achieving HUD's Region system performance measures.
- Effectively implementing the Equal Access Rule

Training on topics related to culturally appropriate engagement, intake/assessment practices and programming should be designed and conducted by members of communities representing the specific culture or sub-population impacted.

Trainings will be available remotely via webinar or posted online along with in-person training events.

Data Sharing

All Regions must comply with the data sharing policies developed by the Indiana Balance of State Continuum of Care Board of Directors and its sub-committees.

HMIS and Data Collection

Each Region will use a data collection system as designated by the Region to manage data related to CE operations. It is recommended that Regions collect data in the HMIS system designated by the CoC. At a minimum, data collected from CE participants must include all data necessary to generate an accurate and complete Coordinated Entry Annual Performance Report (APR). The data required for entry into HMIS includes the following HUD Universal Data Elements: Name, Social Security Number, Date of Birth, Ethnicity, Race, Gender, Veteran Status, Disabling Condition, Residence Prior to Program Entry, Zip Code, Length of Stay at Previous Residence and Homeless Cause. Data must be entered HMIS on a regular and consistent basis. "Regular and consistent" means within a five (5) business days period of intake/assessment or discharge. Use of the designated HMIS will allow for providers to gather data accurately and ensure they are collecting the data points required for the APR.

The Coordinated Entry APR data will be derived from the HUD Universal Data Elements (UDEs) as amended by HUD and select Project-Specific Data Elements (PSDEs).

Regions may independently explore and utilize other HMIS functions and services in support of CE operations.

Mainstream Services

Each Region must implement a screening protocol to assess each Client's potential eligibility for the following mainstream resources or services:

- Housing
- Medical benefits
- Nutrition assistance
- Income supports

Monitoring and Reporting of Coordinated Entry

Each Region must adhere to the *CE Monitoring and Reporting Plan*. The *CE Monitoring and Reporting Plan* includes requirements for reports on performance objectives related to CE utilization, efficiency, and effectiveness. The specific *CE Monitoring and Reporting Plan* will be published by the CE Steering Committee and reviewed semi-annually and annually. The Plan will be updated, as needed, annually.

The *CE Monitoring and Reporting Plan* will include the following narrative and management report sections to be submitted annually by each Regional Chairperson:

1. *Narrative*: A narrative description of the status of CE implementation during the reporting period. The narrative must be no longer than one page in length and identify the Region's experience of barriers and challenges related to implementation and management of Coordinated Entry and identify plans for expansion and improvements in the upcoming reporting period. *Narrative to include items 1 through 5 as shown on page 22 of this Policy*
2. *Coordinated Entry Annual Performance Report*: A HMIS or data-generated CE APR covering the twelve-month period coinciding with the State's fiscal year (currently from July 1 to June 30) for the annual report). The CE APR will include the following performance indicators:
 - A. The number of individuals receiving CE services:
 - i. Number of families and individuals completing initial triage/diversion screen
 - ii. Number of families and individuals completing Client intake/assessment
 - iii. Number of families and individuals completing comprehensive/housing assessment
 - B. Demographics and attributes of persons/households receiving CE assistance
 - C. Number of persons and individuals by VI-SPDAT score (4-7 and 8+)
 - D. Number of persons and individuals receiving CE referrals to the following
 - i. Self-Resolve
 - ii. Rapid Re-housing
 - iii. Transitional Housing
 - iv. Permanent Supportive Housing (PSH)
 - v. All other (VASH, Section 8, Self Resolve, etc.)
 - E. Destination of persons and individuals to each service strategy as a result of CES referral
 - i. Rapid Re-housing

- ii. Transitional Housing
- iii. Permanent Supportive Housing (PSH)
- iv. All other (VASH, Section 8, Self Resolve, etc.)
- F. Length of time from completion of CE (Client intake/assessment to program entry)
 - i. Average length of time from intake/assessment to referral for each component type
 - ii. Average length of time waiting on prioritization list for each component type
- G. Number of persons who waited for each Region component type for greater than 30 days

The following schedule identifies specific Region reporting requirements, including required data, report structure, and submission deadlines. July 1, 2017 – June 30, 2018 is first period to be evaluated and reports are due August 31, 2018.:

Region CE Evaluation Component	Format	Reporting Period	Due Date
Region Annual Report	Narrative and CE APR	July 1 – June 30	August 31
Annual Region Stakeholder feedback (Region partners)	Narrative report incorporating data from surveys, questionnaires, or focus group meetings	July 1 – June 30	August 31
Annual Region Stakeholder feedback (participants in CE)	Narrative report incorporating feedback from Client focus groups, participant advisory groups, surveys, or questionnaires	July 1 – June 30	August 31

Coordinated Entry Statewide Evaluation

The Coordinated Entry process will be evaluated annually to ensure it is operating at maximum efficiency. Evaluation will be carried out primarily through the Regional Planning Councils, the Indiana Balance of State Coordinated Entry Steering Committee and any consultants or third parties engaged to assist them.

Evaluation mechanisms will include the following (see table above):

- *A monthly review of metrics from the Coordinated Entry process.*
 - Total number of individuals/families receiving CE services
 - Total number of individuals/families completing CE intake/assessment
 - Number of individuals/families by VI-SPDAT score (4-7 and 8+)
 - Number of individuals/families receiving CE referrals to RRH, TH, PSH and Other
 - Length of time from completion of CE Client intake/assessment to program entry
- *Each Region will conduct an Annual Coordinated Entry Evaluation with people experiencing homelessness that have been through the Coordinated Entry process.* The standardized questions to be used while conducting the Client Evaluations of the CE process are as follows:
 - Do you feel the assessor understood the things that made it hard for you to find housing?
 - What would you change about the questions that were asked during your housing intake/assessment?

- Was the Coordinated Entry process explained to you during your intake/assessment? Are there things you would change about the process?
- Is the program you were offered and accepted a “good fit” for you? Does it solve your housing needs?
- Did the CE process meet your expectations and/or expected timelines?
- Each Region will conduct an Annual Coordinated Entry Evaluation with providers in the Region who are ESG or CoC funded and participating in the Coordinated Entry process. The standardized questions to be used while conducting the Partner Agencies Stakeholder Feedback and Evaluation of the CE process are as follows:
 - Is the VI-SPDAT successfully capturing the barriers of our clients?
 - What would you change to make CE more successful?
 - Was the intake/assessment process smooth for your clients? If not, what changes should be made?
 - If you are a PSH provider, how quickly are you receiving referrals when a unit becomes available?
 - Is CE successful in your Region with selecting and housing clients who are the most vulnerable in the community?

These results will be submitted in writing to the Coordinated Entry Analyst annually by January 31 and August 31.

- *Each Region’s Lead Agency will submit an Annual Report on Coordinated Entry and homelessness assistance system outcomes to the Coordinated Entry Analyst by January 31 and August 31. This report will include trends from the month-to-month analysis of Coordinated Entry data, the total number of intake/assessments and referrals made, successes to be shared, and a note from the Regional Planning Council’s Chair on the process’s progress. A member of the Regional Planning Council will present major findings from this report at the Region meeting the month it is released. Regional Planning Council members may ask for City or County staff assistance in writing and producing this report.*

A comprehensive system evaluation of CE must be performed annually to ensure that both qualitative and quantitative information is collected and used to identify opportunities for continuous system improvement. Results of the statewide evaluation of CE operations may be shared with funders and policy makers.

NARRATIVE/Areas of inquiry should include but not be limited to the following:

1. CE Coverage
 - A. Which Region projects are participating? What does participation mean (listing vacancies, accepting referrals)?
 - B. Are all geographic areas of the Region covered by CE processes? (non-HMIS)
2. System Gaps
 - A. What is the actual demand for Region crisis response services?
 - B. Is demand effectively managed by the available resources and Region assets?
 - C. What is the distribution of referrals by project type?
 - D. What are rates and reasons for referral rejections?
3. Intake/Assessment Process
 - A. Is participant intake/assessment data complete, accurate, and timely for referral process?
 - B. Is the intake/assessment process respectful of participant preferences, culturally appropriate, and/or trauma informed? (non-HMIS)

- C. When referred, do participants get accepted/enrolled?
 - D. When referred, do participants accept referral options?
 - E. What is the length of time from referral to placement in housing?
 - F. Are prioritized populations being successfully referred and enrolled in available housing and services?
4. Is there intake/assessment information collected that is not readily used to inform case planning or care coordination? (non-HMIS)
5. Access Consistency
- A. Does the relationship between referrals and eligibility vary in terms of presenting program participants' race, household size, age or gender of children, or geography (such as rural vs. urban)?
 - B. If the Region has established different access points for singles, families, survivors of domestic violence, and youth are those sub-populations experiencing variance in rates of referral and enrollment when compared to other groups?
 - C. Do rates of return to homelessness vary by program participant characteristics or site?

Domestic Violence and Coordinated Entry

Coordinated Entry for Domestic Violence Survivors

Domestic Violence survivors are a special population in the housing crisis response system and bring many distinct and challenging circumstances related to confidentiality and safety. Indiana Housing and Community Development Authority (IHCDA), Indiana Coalition Against Domestic Violence (ICADV) and the Indiana Balance of State Continuum of Care (IN BOS CoC) have collaborated to create a CE process to overcome these barriers.

The CE process for Domestic Violence Survivors (includes those fleeing or attempting to flee domestic violence, dating violence, sexual assault, human trafficking, or stalking). (This sub-population includes Youth age 16 to 24 who are survivors of sex/human trafficking). Process utilizes trauma-informed practices, is safety focused, and provides confidential data collection consistent with federal, state, and local laws. Youth age 16 to 24 present with unique vulnerabilities due to the trauma of domestic violence, sexual assault, human trafficking and stalking that may require specialized wrap around services. The provider serving these youth clients will work with other youth services to ensure a comprehensive safety and recovery plan is available that fully meets the needs of the youth client.

Trauma Informed Practices are sensitive to the lived experience of all people presenting for services. Domestic Violence and sexual assault are often very traumatic for individuals and households, including children. The violence and harassment can continue and often escalates when a survivor is leaving their relationship and reaching out for housing resources.

Client safety will be immediately assessed upon the Client's disclosure stating they are a survivor of domestic violence, dating violence, sexual assault, trafficking, or stalking. The Indiana Coalition Against Domestic Violence (ICADV) and the IN BOS CoC Board of Directors recognize and understand the highly sensitive nature of information gathered from individuals experiencing domestic violence. These two groups have worked together to create an Additional intake/assessment to Determine Client's Danger Level. The Additional intake/assessment to Determine Client's Danger Level is used in conjunction with the VI-SPDAT for CE intake/assessment prioritization.

Domestic Violence Additional Assessment to Determine Client's Danger Level

The additional intake/assessment is used to determine the Client's danger level and an appropriate housing and/or crisis intervention as needed. The three questions on the Domestic Violence Additional Intake Assessment were taken from the Lethality Assessment Tool developed by the Maryland Network Against Domestic Violence based on Jacquelyn Campbell's Danger Assessment. The three questions are:

1. Has your partner ever used a weapon against you or your children or threatened you or your children with a weapon?
2. Do you believe your partner is capable of killing you or your children?
3. Has your partner threatened to kill you or your children?

If Client answers "yes" to one of these questions, their Danger Digit score will be a "1". Two "yes" answers will be a score of "2" and three "yes" answers will be a score of "3". This information is used in conjunction with the VI-SPDAT to prioritize the Client for housing. By creating a way for Domestic Violence survivors to be added to the Prioritization List for permanent housing, the Clients gain access to resources such as rapid re-housing and permanent supportive housing while maintaining their confidentiality and anonymity. If the Additional intake/assessment to Determine Client's Danger Level is administered and the score obtained by a Non-Domestic Violence Provider (Homeless Provider Agency), the Client will be informed they are currently at a Homeless Provider Agency Coordinated Entry Access Site. The Client will be asked if they would like to be directed to an access point that is designated for serving victims of domestic violence (DV). The Client's safety and preference for shelter are to be immediately addressed during this initial phase of contact.

At this point if the Client chooses to be referred to a Victim Services provider, the CE Assessment staff member will explain to the Client the need for a signed Release of Information in order for staff to contact and share the Client's basic information with the nearest victim service provider. If the Client agrees to sign the ROI, the CE Assessment staff will contact the DV service provider and refer the Client for assistance. If the Client needs transportation, the CE Assessment staff will contact 211 for transportation assistance to the DV service provider.

If the Client chooses to enter emergency shelter with a Domestic Violence provider, once the Client enters emergency shelter, the Client's DV provider case manager will begin working on a housing plan with the Client within 14 days. The Client will be given the opportunity to fully participate in the CE process by choosing first, IF they want to participate in CE. If the Client chooses to participate in CE, the Client's next step will be choosing the level of PPI the Client consents to sharing. If the Client chooses not to participate in the CE process while in the DV shelter, the DV case manager will work with the Client to resolve homelessness utilizing other mainstream resources, DV RRH, or diversion. The DV provider will document the Client's refusal or acceptance to participate in the Coordinated Entry process by documenting the Client's reason(s) via case note in *DV ClientTrack* (part of HMIS specific to DV providers).

The Client may also, instead of being referred, choose to participate in the CE intake/assessment Process with the current Homeless Services Provider. CE intake/assessment staff will present the Client with the *Client Consent* or *HMIS Client Consent* form. CE intake/assessment staff will review the form with the Client ensuring the Client understands their rights and, if necessary, how their information will be used and shared in HMIS:

- If the Client agrees to Option 1 on the Consent Form (stating that their information may go into HMIS), CE intake/assessment staff will proceed with normal CE intake/assessment procedures and enter the Client's information into HMIS. The Client will then be prioritized for housing and placed on the Prioritization List.
- If the Client agrees to Option 2 (stating that they will share information but do not want it entered into HMIS) on the Consent Form, CE intake/assessment staff will proceed by completing a paper CE intake/assessment (VI-SPDAT, Family VI-SPDAT or TAY-VISPDAT) with the Client's information. The Client's information will NOT be entered into HMIS and the CE intake/assessment staff will work with the Client to find a solution to the Client's current need utilizing paper documents only.
- If the Client agrees to Option 3 (stating they do not want to provide any information at all) and will provide no information to the CE intake/assessment staff, the Client is notified of the option to be placed into CE as an anonymous Client. The Client will be referred to a domestic violence provider who will then explain CE to the Client and lead the Client through the necessary enrollment steps to remain anonymous. If the Client chooses the anonymous process, the Client's Personal Protected Information will not be shared. The DV provider will adhere to the step by step process outlined in the "Updated CE Process for Funded DV Providers using DV ClientTrack" for enrolling a Client anonymously in to the CE process using the HMIS system. That they may be unable to receive certain services from the agency if the Client's eligibility to receive the services cannot be verified.
- If Client is in danger once sheltered or housed, and requests to be moved for safety reasons or it becomes apparent to shelter staff that Client is in danger, the CM will use the Emergency Transfer Plan to ensure the Client's Safety and Confidentiality. The Emergency Transfer Plan is in the IN BOS CoC Policies and Procedures. The CM will contact the Lead Agency for assistance with implementing the Emergency Transfer Plan.

For clarification on the above listed Client Consent options **SEE EXHIBIT C.**

- Clients will not be terminated from the program for the following reasons:
 - Failure to participate in supportive services
 - Failure to make progress on a service plan
 - Loss of income or failure to improve income
 - Any other activity not covered in a lease agreement typically found for unassisted persons in the project's geographic area
- Clients will not be screened out of CE due to:
 - Having too little or little income
 - Active or history of substance use
 - Having a criminal record with exceptions for state-mandated restrictions
 - History of victimization (e.g. domestic violence, sexual assault, childhood abuse)
- The CE process for DV survivors utilizes Housing First principles
- All projects serving households with children or youth must have a staff person that is designated to ensure children or youth are enrolled in school and connected to the appropriate services within the community. Policies and practices must be consistent with and not restrict the exercise of rights provided by subtitle B of title VII of the McKinney-Vento Act (42 U.S.S. 11431, et seq), and other laws (e.g. Head Start, part C of the individuals with Disabilities Education Act) relating to the provision of educational and related services to individuals and families experiencing homelessness.
Reminder: Failure to comply with Federal education assurances may result in Federal sanctions and affect the likelihood of receiving funding through the CoC Program Competition.

- IHCD is developing a formal housing counselling program state-wide. We are working with the sub-recipients and ICADV to ensure we obtain and train landlords about the safety, security and confidentiality needs of survivors. The survivors have a voice and they will choose a desired housing location enabling them to be in control. Each survivor household can stay connected to case management and receive nonjudgmental assistance. Policies are currently in place outlining the process for a Client/survivor to move to another Region within the IN BOS CoC or to move outside of the state.
- Once a survivor is stably and successfully housed in a safe, secure location, the case manager will work with the survivor to connect them to employment opportunities. If the survivor does not have adequate education, then referrals to basic education (Adult Basic Education) through the State Department of Education may be provided first. We also work with local community colleges and Ivy Technical College to assist with advanced educational opportunities for those Clients seeking to complete a degree in higher education. Our partners at Work Force Development are working alongside us and offer job training.

EXHIBIT A: Coordinated Entry Region Map

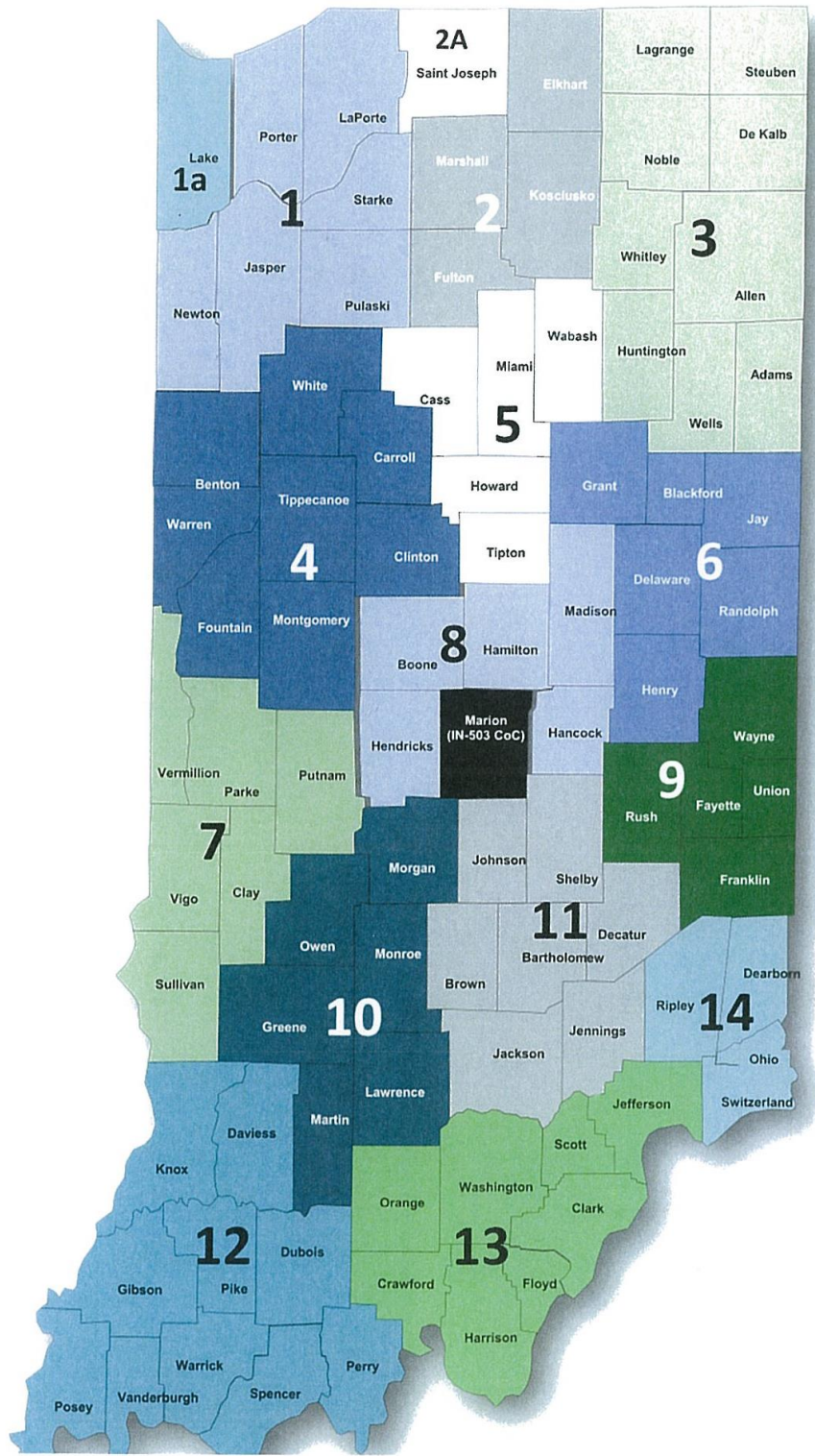


EXHIBIT B: Coordinated Entry Receipt

COORDINATED ENTRY RECEIPT


This receipt is proof that you have completed a VI-SPDAT and supplemental assessment in our region.

ASSESSING AGENCY	Assessor:	Email:
	Agency:	Phone:
SIGNATURE		Date:

RECIPIENT NAME	DATE OF ASSESSMENT	YOU ARE ELIGIBLE FOR THE FOLLOWING TYPE OF HOUSING:
		<input type="checkbox"/> Transitional Housing <input type="checkbox"/> Rapid Re-housing <input type="checkbox"/> Permanent Supportive Housing
Indiana HMIS Release of Information (Consent Form) was signed? <input type="checkbox"/> Yes <input type="checkbox"/> No		

What you need to know:

1. This receipt places your household on a housing list for ALL homeless programs in the region. You do not need to contact each program separately.
2. Persons are selected for open units based on need and eligibility versus first-come first-serve criteria.
3. It is your responsibility to let me or my agency know if your contact information or housing status changes (i.e. if you no longer need housing or are evicted from housing). We will try and contact you if selected, but there will be a short response time to accept or decline the offer. If we cannot reach you, another household will be selected.
4. If your household is selected, you will still be required to verify your eligibility AND find a landlord (For Rapid Re-housing) willing to rent to you . Agencies can help with limited housing search (i.e. search suggestions, rental lists). If you are selected for a fixed site program the property managers will still do a background check. Fixed site projects have less strict entry requirements, but still require background checks to help assure the safety of other tenants.
5. You have the right to turn down an offer of housing. Your household will remain on the Region’s Priority list, but there is no guarantee when your name will be selected the next time. Valid reasons to turn down housing are: location, type (wanting fixed vs. scattered site), or conflict with the agency.
6. Finally, due to the high demand for housing and limited program openings, wait times vary from 1 week to months or even a year. You are encouraged to continue to seek out other non-homeless options (job training, emergency assistance, public housing, food baskets, social services, etc.).

TYPE OF HOUSING	DESCRIPTION	
Transitional Housing	<ul style="list-style-type: none"> • Housing with support services for up to 24 months. • For persons <u>in transition</u> who will be successful with short-term assistance. • A Housing Stability Plan is required. 	
Rapid Re-Housing	<ul style="list-style-type: none"> • Housing with support services for short term (0-3 months), medium term (4-8) months or long-term (9-24 months) • For persons who will be successful with short-term assistance, with ability to maintain stability after assistance ends. 	
Permanent Supportive Housing	<ul style="list-style-type: none"> • Housing with support services without a timeline (if eligibility criteria and needs exist). • For persons with a disability coming from homelessness. • Some programs may also require chronic homeless status. 	

THANK YOU AND PLEASE REMEMBER TO UPDATE YOUR CONTACT INFORMATION IF IT CHANGES!

EXHIBIT C: Client Consent Form**Client Consent**

HMIS Client Consent

Purpose of this form: This Agency uses the Homeless Information Management System ("HMIS"). HMIS is a database and case management system that collects and maintains information on the characteristics and service needs of clients. The system collects and stores client-level data that can be utilized to generate unduplicated and aggregate reports for the U.S Department of Housing and Urban Development ("HUD") that can be analyzed to determine the use and effectiveness of the services being provided by Agency. When you request or receive services, we may collect and share your Protected Personal Information ("PPI") including data on your household such as:

*First name and last names, dates of birth, Social Security Numbers, gender, ethnicity, race, veteran status, prior residence, contact information and program status.

*Your service needs, income, government benefits, education, employment, destination, disability, general health, as well as pregnancy, HIV/AIDS, behavioral health, mental health, legal and history of domestic violence, dating violence, sexual assault, and stalking.

How will my PPI be used?

Your data will be entered into the HMIS to generate reports that can be analyzed to determine the use and effectiveness of the services being provided by the Agency. The ways in which this Agency may use or disclose your information are discussed in our Notice of Privacy Practices, which is posted in this Agency near the intake stations (or comparable location) for review by clients.

How will my PPI be protected?

*We are required to protect the privacy of your PPI by complying with the privacy practices described in our Privacy Policy.

*Your information is protected by passwords and encryption technology. Each Agency and user must sign an agreement to maintain the security and confidentiality of your information. Any person or Agency that uses the HMIS and violates the terms of the agreement may lose its access rights and may be subject to other negative consequences.

How will my PPI be shared and disclosed?

The PPI we collect can be shared and disclosed under the following circumstances:

- * Shared with other HMIS service providers.
- * To provide or coordinate services to you and your household.
- * For HMIS administrative purposes.
- * When required by law or for law enforcement purposes or to prevent a serious threat to health or safety.
- * Reports to HUD, audits and management functions.

I UNDERSTAND THAT:

* The Agency may not refuse or decline certain services to me if I refuse or am unable to provide information; however, some information may be required by the applicable program to determine eligibility for housing or services, to assess needed services, or to fulfill reporting requirements. Therefore, I am not required to sign this consent. I may request a copy of this consent.

* This consent permits any HMIS service provider to add or update my information in the HMIS database, without asking me to sign another consent form.

* This consent expires in three (3) years. I have the right to revoke this consent at any time in writing. PPI that I previously authorized to be shared cannot be entirely removed from the HMIS database and will remain accessible to the limited number of organization(s) that provided me with direct service.

* This Agency has posted a Notice of Privacy Practices, and I may request a paper copy of the Notice from this Agency. I acknowledge that I have been given an opportunity to read and/or request a copy of the Notice and that I have read the Notice. The Notice describes ways in which my personal information may be used and disclosed. Every effort will be made to ensure the proper use and security of my information.

EXHIBIT C: Client Consent Form

Client Informed Consent

By Signing this form:

- * I agree that this Agency and its employees and agents can enter all of my information into the HMIS and share my PPI with other HMIS Service Providers
- I will provide my information to the Agency but I do not agree to allow the agency to enter any of my information into the HMIS or share my PPI with other HMIS service providers
- I do not agree to provide any information to this Agency and I understand that I may not be able to receive certain services from this Agency if my eligibility to receive these services cannot be verified

Client Signature:

Client Name:

* _____

Date:

* _____

Case Manager Signature:

Case Manager Name:

* _____

Date:

* _____

Restriction Options

- Restriction: * Restrict to Organization
 Restrict to MOU/InfoRelease

EXHIBIT D: Coordinated Entry Prioritization Policy

Indiana Balance of State 502 Continuum of Care

Coordinated Entry Prioritization Policy

The Indiana Balance of State Continuum of Care Board of Directors adopts the following policy and guidance around Coordinated Entry and Prioritizing the most vulnerable persons experiencing homelessness.

HOUSING INTERVENTION	TARGET POPULATION	PRIORITIZATION
Diversion	All Homeless Persons Seeking Housing Assistance	
Permanent Supportive Housing**	Literally homeless	<ol style="list-style-type: none"> 1. VI-SPDAT Score (8+) 2. Greatest Needs/Most Vulnerable 3. Longest History of Homelessness 4. Case Conference with Regional Planning Council
Rapid Re-Housing SSVF	Persons Literally Homeless Veterans Experiencing Homelessness	<ol style="list-style-type: none"> 1. VI-SPDAT Score (4+) 2. Greatest Needs/Most Vulnerable 3. Longest History of Homelessness 4. Case Conference with Regional Planning Council 5. *Regional Prioritization Veterans, Youth, Families, Single Adults, Domestic Violence Survivors
Emergency Shelter	Persons Literally Homeless and Not Diverted	<ol style="list-style-type: none"> 1. First Come, First Served
Referrals to Mainstream Resources/Prevention	At Risk of Homelessness	<ol style="list-style-type: none"> 1. VI-SPDAT (0-3)

If a person is prioritized for PSH and no PSH is available, person should be considered for RRH as a bridge to PSH. In this situation the person does not lose Chronic Homeless status and can be moved to PSH when a unit becomes available. **Please see following page for excerpt from CPD-16-11, Issued July 25, 2016: Prioritizing Chronically Homeless Persons in CoC Program-funded Permanent Supportive

Housing Beds Not Dedicated or Not Prioritized for Occupancy by Persons Experiencing Chronic Homelessness

Recipients of CoC Program-funded PSH that is not dedicated or prioritized for the chronically homeless are required to follow this order of priority when selecting participants for housing, in a manner consistent with their current grant agreement.

(a) First Priority-Homeless Individuals and Families with a Disability with Long Periods of Episodic Homelessness and Severe Service Needs

An individual or family that is eligible for CoC Program-funded PSH who has experienced fewer than four occasions where they have been living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter but where the cumulative time homeless is at least 12 months **and** has been identified as having severe service needs.

(b) Second Priority-Homeless Individuals and Families with a Disability with Severe Service Needs.

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

(c) Third Priority-Homeless Individuals and Families with a Disability Coming from Places Not Meant for Human Habitation, Safe Haven, or Emergency Shelter Without Severe Service Needs.

An individual or family that is eligible for CoC Program-funded PSH who is residing in a place not meant for human habitation, a safe haven, or an emergency shelter where the individual or family has not been identified as having severe service needs. The length of time in which households have been homeless should be considered when prioritizing households that meet this order of priority, but there is not a minimum length of time required.

(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 currently residing in a transitional housing project, where prior to residing in the transitional housing had lived in a place not meant for human habitation, in an emergency shelter, or safe haven. This priority also includes individuals and families residing in transitional housing who were fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking and prior to residing in that transitional housing project even if they did not live in a place not meant for human habitation, an emergency shelter, or a safe haven prior to entry in the transitional housing.

*****U.S. Department of Housing and Urban Development Office of Community Planning and Development, Notice CPD-16-11, Section III.B.1***

Revised 1.10.19**EXHIBIT E: Declined Referrals and Grievance Procedures**

Provider Declines Referral

There may be rare instances where program staff do not accept a referral from the Coordinated Entry process. Refusals are acceptable only in certain situations, including:

- The person does not meet the program's eligibility criteria;
- The person would be a danger to others or themselves if allowed to stay at this program; and
- The person has previously caused serious conflicts within the program and was banned (e.g. was violent with another consumer or program staff).

If program staff determines a consumer is not eligible for their program after they have received the referral from Coordinated Entry, the consumer should be sent back to their initial intake/assessment point for staff to determine a place for them to sleep that night (if they do not already have one). If intake/assessment hours are over for the day, the consumer should be referred to population-appropriate emergency shelter. Within 4-8 hours of their re-entry into shelter, a representative from the program that refused them, the intake/assessment staff member, and the person experiencing homelessness must meet to determine the best next step for the consumer. Any cases that are unable to be resolved to the consumer's satisfaction will be referred to the Coordinated Entry Steering Committee to be addressed as soon as possible. If a program is consistently refusing referrals (more than 1 out of every 4) they will need to meet with the Regional Planning Council to discuss the issue that is causing the refusals.

Provider Grievances

Providers should bring any concerns about Coordinated Entry to the Regional Planning Council, unless they believe a consumer is being put in immediate or life-threatening danger, in which case they should deal with the situation immediately. A summary of concerns should be provided via email to the chair of the Regional Planning Council. The chair should then schedule for that provider's representative to come to the next available Regional Planning Council meeting so the issue can be resolved. If the issues need more immediate resolution, the chair will oversee determining the best course of action to resolve the issue.

Consumer Grievances

The intake/assessment staff member or the intake/assessment staff supervisor should address any complaints by consumers as best as they can in the moment. Complaints that should be addressed directly by the intake/assessment staff member or intake/assessment staff supervisor include

complaints about how they were treated by intake/assessment staff, intake/assessment center conditions, or violation of data agreements. Any other complaints should be referred to the chair of the Regional Planning Council for resolution as above. Any complaints filed by a consumer should note their name and contact information so the chair can contact them and offer them the chance to appear before the committee to discuss them.

- I. If the Regional Planning Council is unable to reach a decision and plan for resolution, the Regional Chair will forward the grievance information to the Coordinated Entry Analyst, via secure email or fax. The Coordinated Entry Analyst will then present the grievance for review by the Coordinated Entry Steering Committee during the next monthly phone call/meeting.
2. If the Coordinated Entry Steering Committee is unable to reach a decision and plan for resolution, the Coordinated Entry Analyst will then forward the grievance to the IN BOS CoC Board of Directors for review during the board's next monthly meeting.
3. The IN BOS CoC Board of Directors decision is final and will be communicated back to the Regional Chair of the grievance's originator. The Regional Chair will then communicate the final decision to the agency/program and client involved.

EXHIBIT F: Examples of Eligibility Worksheets/Documentation Forms

Participant Eligibility Worksheet (Homeless Documentation form)

Project Name _____

Participant Name _____

Date of Intake _____

**Type of Homelessness Documentation: Check the appropriate type of documentation used to verify
Attach it to this worksheet. Maintain all in the participant file.**

Client Signature _____

Date _____

EXHIBIT F: Examples of Eligibility Worksheets/Documentation Forms

Participant Eligibility Worksheet (Imminent Risk Homeless Documentation form)

	Homeless Status	Type of Documentation	Documentation attached
1	Sleeping in a place not designed for or used as a regular sleeping accommodation, including a car, park, abandoned building, bus or train station, airport, camping round, etc.	A signed and dated general certification from an outreach worker verifying that the services are going to homeless persons and indicates where the persons served reside.	
1	Person living in a shelter designed to provide temporary living arrangements (including emergency shelter, congregate shelters, transitional housing, and hotels/ motels paid for by charitable organizations or by government programs).	Staff should provide written information obtained from third party regarding the participant’s whereabouts, and, then sign and date the statement. Written referral from the agency.	
1	Persons exiting where they resided 90 days or less AND were residing in an Emergency shelter or place not meant for human habitation immediately prior to entering the institutions.	Written verification from the institution’s staff that the participant has been residing in the institution for less than 90 days; and information on the previous living situation as being homeless in shelter or streets.	
4	Fleeing or is attempting to flee domestic violence AND No Subsequent residence has been identified AND No Resources or support networks to obtain permanent housing.	Written verification if available. Self-report is okay.	

Self-Declaration of homelessness (use only if 3rd party is unavailable):

Use reverse if more space needed.

Project Name _____
Participant Name _____
Date of Intake _____

Homeless or At Risk: Circle the appropriate type of criteria & documentation to verify. Maintain all in the participant file

	At Risk Homeless Status	Type of Documentation	Documentation Attached
2	<p>(2) An individual or family who will imminently lose their primary nighttime residence provided that:</p> <p>(i) The primary nighttime residence will be lost within 14 days of the date of application for homeless assistance;</p> <p>(ii) No subsequent residence has been identified; AND</p> <p>(iii) The individual or family lacks the resources or support networks, <i>e.g.</i>, family, friends, faith-based or other social networks, needed to obtain other permanent housing;</p> <p>These may include: At Risk of Homelessness:</p> <p>a) Has moved because of economic reasons 2 or more times during the 60 days immediately preceding the application for assistance; OR</p> <p>b) Is living in the home of another because of economic hardship; OR</p> <p>c) Has been notified that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance; OR</p> <p>d) Lives in a hotel or motel and the cost is not paid for by charitable organizations or by Federal, State, or local government programs for low-income individuals; OR</p> <p>e) Lives in an SRO or efficiency apartment unit in which there reside more than 2 persons or lives in a larger housing unit in which there reside more than one and a half persons per room; OR</p> <p>f) Is exiting a publicly funded institution or system of care; OR</p> <p>g) Otherwise lives in housing that has characteristics associated with instability and</p>	<p>1. At least one of the following stating that the household must leave within 14 days:</p> <p>A court order resulting from an eviction notice or equivalent notice, or a formal eviction notice;</p> <p>For individuals in hotels or motels that they are paying for, evidence that the individual or family lacks the necessary financial resources to stay for more than 14 days; or</p> <p>An oral statement by the individual or head of household stating that the owner or renter of the residence will not allow them to stay for more than 14 days.</p> <p>The intake worker must verify the statement either through contact with the owner or renter, or documentation of due diligence in attempting to obtain such a statement.</p> <p>2. Certification by the individual or head of household that no subsequent residence has been identified.</p> <p>3. Self-certification or other written documentation that the individual or head of household lacks the financial resources and support networks to obtain other housing.</p>	

	an increased risk of homelessness, as identified in the recipient's approved Con Plan		
	Self-Declaration of imminent risk of homelessness (use only if 3rd party is unavailable) or DV person.		

Staff Signature

Client Signature Date

EXHIBIT F: Examples of Eligibility Worksheets/Documentation Forms

Instructions: This suggested template may be sent to homeless service providers requesting their verification of the chronically homeless status of an individual known to them. This template letter may be copied onto letterhead or recreated with the same content and printed on letterhead.

Date: _____

To:

Dear _____,

This letter is to confirm that (Tenant name) is currently staying at the (shelter/program name) as of (entry date) and can stay until (anticipated exit date).

(Tenant name) has also stayed at this shelter on the following occasion(s):

Please enter any past entry and exits dates (e.g.: 01/01/2013 – 03/01/2015) on each line

Please do not hesitate to contact me if you have any questions.

Sincerely,

Staff signature

Name
Staff title
Agency name
Agency/shelter address
Agency/shelter phone number
Agency/shelter fax number

EXHIBIT G: PSH Forms

Certification of (Chronic) Homeless Status

Tenant Name: _____

Instructions: This form provides a suggested timeline to analyze whether or not the chronology of a person's history meets the time frame for the definition of chronic homelessness. This should capture both experiences of homelessness and breaks of seven (7) days or more. A household can self-certify up to three (3) months of episodes of homeless and still be considered as documented with third party verification.

Third party documentation is required from at least one of the following sources:

- Certification letter(s) from an emergency shelter for the homeless. Attach to this form
- Certification letter(s) from a homeless service provider or outreach worker. Attach to this form
- Certification letter(s) from any other health or human service provider. Attach to this form

Definition: a household experiencing chronic homelessness as: a homeless person/family with a disability **AND** has been continuously homeless for twelve (12) months or more. (HUD defines "homeless" as "a person sleeping in a place not meant for human habitation [e.g. living on the streets] OR living in an emergency shelter.) **OR** has had four (4) episodes of homelessness in the last three (3) years, where the total of these episodes equals at least twelve (12) months. (An episode of homelessness is defined by a break of seven [7] days or more.)

Time Period (Entry/Exit dates)	Location (shelter name or housing)	3 rd Party/Self-Certify
Example: 01/01/05 – 02/27/05	ABC Shelter, Indianapolis	3 rd party
Example: 02/28/05 – 3/10/05	Staying with a friend, Indianapolis	Self-Certify

By signing below, I am self-certifying that the above information regarding my housing and stays in shelter programs is true and accurate to the best of my knowledge. I have been informed that this assistance is funded by the United States Department of Housing and Urban Development (HUD). I have been informed that I am subject to the laws and statutes of HUD in regard to making untrue statements.

Tenant Signature

Date

Staff Signature

Date

EXHIBIT G: PSH Forms

Permanent Supportive Housing Verification of Disability Form

SECTION A:

This section must be completed in order to be considered for PSH rental assistance.

Name of Tenant: _____

Disability: May only accept persons experiencing homelessness with a qualifying disability.

For the purpose of qualifying for occupancy in the program, the tenant must have a mental, emotional, and/or physical impairment that meets the following criteria:

1. As a result of his/her disability, the need for treatment is expected to be of a long, continued, and indefinite duration; **AND**
2. The disability substantially impedes his/her ability to live independently; **AND**
3. Is of such nature that the disability could be improved by more suitable housing conditions.

If the tenant is disabled by chronic problems with alcohol and/or drugs, the person's disability must meet the following criteria:

Problematic use/abuse of alcohol and or/drugs that 1) has occurred for at least 12 months **and** 2) has caused serious difficulties in interpersonal relationships as evidenced by disruptions in employment, loss of housing, and/or loss of role in family structures or other important relationships.

SECTION B:

Documentation: Verification is required to come from a professional who is licensed by the state to diagnose and treat the condition. It must be a credentialed psychiatric title or medical doctor (MD), Licensed Physician's Assistance (PA), and/or Licensed Nurse Practitioner (NP), or medical professional trained to make such a determination (example: Ph.D.). Persons with a LCSW, MSW, ACSW, BSW titles do not qualify. The possession of a title such as case manager or substance abuse counselor does not by itself qualify a person to make a determination. **"Self-certification" is also unacceptable.**

In my opinion, the above reference tenant is disabled as defined in Section A above

Signature: _____

Name: _____

Title: _____

Date: _____

Qualifications / Degree(s) of individual verifying disability: _____

Agency _____

Address _____

Telephone: _____

EXHIBIT G: PSH Forms

SECTION B Continued

OR Other ways to document disability:

- Social Security Administration (SSA) can verify persons receiving disability benefits **OR**
- VA Disability Check **OR**
- Supplemental Security Income (SSI) **or** Social Security Disability Insurance (SSDI) checks

Circle Appropriate Verification of Disability. Attach appropriate documentation

1. SSA verification: Letter of statement
2. VA Disability Check: Attach copy of check
3. SSI/SSDI Check: Attach copy of check

Intake staff-recorded observation of disability may be used to document disability status as long as the disability is confirmed by the aforementioned evidence **within 45 days of the application for assistance.**

Intake Staff Name & Title: _____

Agency: _____

Date: _____

Within 45 days of this signature, the professional licensed certification or the disability check documentation must be attached.

EXHIBIT G: PSH Forms

**Permanent Supportive Housing Program Agreement
Recommendations, Requirements, and Examples**

This document includes recommendations and that can be used in your agreement with Tenants. However, it also includes requirements that must be used in your program agreements.

Recommendations:

- Do not set rules that cannot be enforced.
- Use a Housing First model: at its foundation, the "housing first" strategy operates under the philosophy that safe, affordable housing is a basic human right and a prerequisite for effective psychiatric and substance abuse treatment. Key components of the housing first model include (1) a simple application process that does not require numerous site visits and excessive documentation; (2) a harm reduction approach in which tenants are not required to be clean and sober in order to obtain or keep their housing; and (3) no conditions of tenancy that exceed the normal conditions under which any leaseholder would be subject, including participation in treatment or other services.

Requirements:

- Both the case manager and tenant must sign and date the agreement; a copy of the agreement should be maintained in the tenant's file and a signed copy should be given to the tenant.
- Provide information to Tenants regarding the termination and appeals process at the beginning of the enrollment process.
- Due process. In terminating assistance to a Tenant, there will be a formal process that recognizes the rights of individuals receiving assistance under the due process of law. This process, at a minimum, will consist of:
 - Providing the Tenant with a written copy of the program rules and the termination process before the Tenant begins to receive assistance;
 - Providing a written notice to the Tenant containing a clear statement of the reasons for termination;
 - A review of the decision to terminate, in which the Tenant is given the opportunity to present written or oral objections before a person other than the person (or a subordinate of that person) who made or approved the termination decision; and
 - Providing written notice of the final decision to the Tenant within 10 days of the final decision.

Example of Grounds for Termination of Assistance:

- Termination of Assistance. A Tenant's assistance may be terminated if it violates program requirements or conditions of occupancy.
- The Tenant's rental assistance will be terminated under the following circumstances:
 - The Tenant is evicted from the residence due to a violation of the landlord/tenant agreement by the Tenant or those family members living with the Tenant.
 - The Tenant engages in illegal activity that endangers the premises.
 - If the Tenant moves to another HUD-assisted project, or another subsidized permanent housing unit, or moves out of the unit without providing notice.
 - If the Tenant is hospitalized for either medical or psychiatric reasons or incarcerated in prison/jail for more than 90 days.
 - If the Tenant terminates the agreement.
 - If the Tenant submits inaccurate information.
 - If the Tenant does not pay its portion of the rental assistance.
 - If the Tenant sublets the premises to another person.

Example of a Signature Block:

Tenant: _____ Date: _____

Case Manager: _____ Date: _____

Case Manager Phone: _____ E-mail: _____

EXHIBIT G: PSH Forms

Housing Plan

Today's Date: ____ / ____ / ____ <small style="margin-left: 40px;">month day year</small> (Review annually at recertification; at minimum)	Tenant: _____ <small style="margin-left: 100px;">first last</small>
Goal #1: _____ Action Steps: 1) _____ 2) _____ 3) _____ 4) _____ Person(s) responsible: _____	
Goal #2: _____ Action Steps: 1) _____ 2) _____ 3) _____ 4) _____ Person(s) responsible: _____	
Goal #3: _____ Action Steps: 1) _____ 2) _____ 3) _____ 4) _____ Person(s) responsible: _____	
Goal #4: _____ Action Steps: 1) _____ 2) _____ 3) _____ 4) _____ Person(s) responsible: _____	
Goal #5: _____ Action Steps: 1) _____ 2) _____ 3) _____ 4) _____ Person(s) responsible: _____	

Tenant: _____ Date: _____

PSH Staff: _____ Date: _____

EXHIBIT G: PSH Forms

Income Information

Annual gross income must be reassessed at least annually. However, if there is a substantial decrease in the participant's income during the year, the participant may request that the income be recalculated to reflect the change and potentially the amount of assistance received.

Documentation and Verification of Income: As a condition of participation in the program, we are required to have third party documentation for **each** household member and they agree to supply such certification, release, information, or documentation to verify the member's income.

The income of each household member over the age of 18 must be included. In addition, if children under the age of 18 are receiving social security assistance, that income must be counted.

Attached to this application provide third party documentation of the following applicable income documentation:

- Wage verification – Copies of at least 3 paystubs or written verification from employer
- Pension Verification – Copy of check or bank statement showing deposit
- Social Security Verification – Copy of check, SSA award letter, or bank statement showing deposit
- TANF Verification – Print out showing monthly benefit amount
- Child Support Verification – Print out showing monthly benefit amount
- Banking Verification – Copy of last statement

Deductions from income can be considered from the following two sources:

- Medical Expenses/Spend-Down Verification – Documentation of out of pocket non reimbursable medical expenses paid by the applicant
- Child Care Expenses – Letter from center of how much child care has been paid, if the child care is provided by a family member or a home provider, the letter must be notarized.

I certify that all of the information and the amount of my income and financial resources on this application are correct and true. I have been informed that this assistance is funded by the United States Department of Housing and Urban Development (HUD). I understand that I am legally responsible for the statements I made to receive assistance to pay my rent. I have been informed that I am subject to the laws and statutes of HUD in regard to making untrue statements.

 Tenant's Signature Date Sub-recipient Representative Date

EXHIBIT G: PSH Forms**Zero Income Affidavit**

I, _____, have applied for rental assistance through the HUD Permanent Supportive Housing program. Program regulations require verification of all income from participating households of each household member over the age of 18 without any income.

Income includes but is not limited to:

- Gross wages, salaries, overtime pay, commissions, fees, tips and bonuses
 - Net income from operation of a business or from rental or real personal property
 - Interest, dividends and other net income of any kind for real personal property
 - Periodic payments received from Social Security, annuities, insurance policies, retirement funds, pensions, disability or death benefits and other similar types of period receipts
 - Lump sum payment(s) for the delayed start of a periodic payment (except as provided in 24 CFR 5.609 (b)(5))
 - Payments in lieu of earnings, such as unemployment and disability compensation, worker's compensation, and severance pay
 - Public assistance
 - Alimony and child support payments (whether through the court system or not)
 - Regular pay, special pay and allowances of a head of household or spouse who is a member of the Armed Forces (whether or not living in the dwelling)
 - Regular monetary gifts from family and/or friends
- I have stated during this verification process that I have no income at this time. I have not received income since _____ (date). I do not expect to receive any income until _____. I applied for (other financial assistance) on _____ (date).

I understand that any misrepresentation of information or failure to disclose information requested on this form may disqualify me from participation in the PSH program, and may be grounds for termination of assistance. WARNING: It is unlawful to provide false information to the government when applying for federal public benefit programs per the Program Fraud Civil Remedies Act of 1986, 31 U.S.C. §§ 3801-3812.

I certify that the above information is true and correct. I also understand that it is my responsibility to report all changes to my household composition or income in writing to within ten (10) business days of such change.

Signature: _____

Date: _____

Witness: _____

Date: _____

Case Manager Notes:

EXHIBIT H: Chronic Homeless Verification Information

Aligning the PSH and CE processes for documenting chronic homelessness and how/when to house households that do not meet that definition

PSH projects that dedicate or prioritize beds for chronically homeless individuals or families must maintain and follow written intake procedures:

Establish the following order of priority for obtaining evidence:

- Third-party
- Intake worker observation
- Certification from the person seeking assistance (Self-Certification)

Self-Certification: Each PSH program can have no more than 25% of households served in an operating year self-certify their chronic homeless status. Households can self-certify up to, but not over, three months of homelessness and not count towards this 25% maximum.

If a third-party cannot be obtained:

Document

Written record of intake workers due diligence to obtain

AND

The intake worker's documentation of the living situation

AND

The individual's self-certification of the living situation

Documenting breaks:

Breaks are defined as at least seven nights not residing in an emergency shelter, safe haven, **or** as residing in a place meant for human habitation (e.g., staying with a friend, in a hotel/motel paid for by program participant).

Stays in institution of fewer than 90 days do not constitute a break and **do** count toward total time homeless

Evidence of a break can be documented by:

- Third-party evidence
- The self-report of the individual seeking assistance (100% of breaks can be documented by self-report).

Documenting institutional stays:

Obtain discharge paperwork or a written or oral referral from a social worker, case manager, or other appropriate official stating the beginning and end dates of the time residing in the institutional care facility.

If that information is not attainable, create a written record of intake workers due diligence to obtain **AND** the individual's signed self-certification that they are exiting an institutional care facility where they resided for less than 90 days.