Palm Beach County Continuum of Care
Written Standards of Operating Policies & Procedures
For
Coordinated Intake & Assessment

TABLE OF CONTENTS

INTRODUCTION

National research has highlighted Coordinated Intake & Assessment as a key factor in the success of ending homelessness. Coordinated Intake & Assessment can enhance the quality of client screening and assessment and better target program assistance where it can be most effective. As a result, the system for preventing and ending homelessness is less fragmented and scarce resources are used more efficiently.

What is Coordinated Intake & Assessment?

Coordinated Intake & Assessment for Palm Beach County CoC is a centralized access point through the Homeless Resource Center (HRC), outreach, and telephone based centralized intake model. Initial screening can be conducted for all populations at one of the outreach locations or through a Navigator over the phone. Coordinated Intake & Assessment includes the following core components:

- Information so that people will know where or how to access intake for homeless prevention or housing services;
- A screening and assessment process and tools to gather and verify information about the person and his/her housing and service needs and program eligibility and priority;
- Information about programs and agencies that can provide needed housing or services;
- A process and tools for referral of the person to an appropriate program(s) or agencies; and assistance in making program admissions decisions.

While most housing and services are made available through other agencies, a variety of services may be provided on site at the “HRC” or by a “Navigator”. These services typically meet basic client needs and may include diversion services, showers, laundry, assessment, referral, shelter, bus pass and/or access to mainstream resources.

KEY TERMS

A number of key terms are subject to varying interpretations and thus should be defined for purposes of this document. They are as follows:

- **Acuity List –** A list that represents the prioritization of persons who are in need of homeless services or housing interventions, in rank order based on highest level of need to lowest.
- **Admission –** Process to admit a client into a program.
- **Assessment –** A process that reveals the past and current details of an individual's/household's strength, and needs, in order to match the client to appropriate services and housing. For the purpose of this document, assessment will refer to a process (whether at primary screening and intake or at entry to a housing program) that reveals a client's eligibility, needs, barriers and strengths.
- **By-Name List –** A list that represents the persons or households who are in need of permanent housing.
- **Central Point of Access –** For the purpose of this document, Central Point of Access is the Homeless Resource Center where individuals or families can go to for intake and assessment of homeless and housing services for which they may qualify.
- **Chronic Homelessness –** A chronically homeless individual is someone who has experienced homelessness for one continuous year or longer, or who has experienced at least four episodes of homelessness in the last three years that add up to 12 months or more and has a disability. A family with an adult member who meets this description would also be considered chronically homeless.
- **Coordinated Assessment –** Relates to the utilization of the same assessment tool across multiple systems to connect clients to services as a means for a coordinated entry system. For the purpose of this document, that tool is the SPDAT (Service Prioritization Decision Assistance Tool) based on population, Individual, Family, or Transition Age Youth.
- **Coordinated Intake Provider Network –** is a consortium of partners that includes homeless service providers, advocacy groups, government agencies, and homeless individuals who are working together to address the housing and support needs of the homeless in Palm Beach County.
- **Coordinated Systems –** Within our community, coordinated systems is defined as interconnected network of systems that services homeless and at risk households, and consists of coordinated intake and assessment, diversion, prevention, rapid re-housing, transitional housing, permanent supportive housing and other tailored programs and services, and linkages to mainstream resources.

- **Diversion**- An approach that supports individuals and families by assisting them in identifying immediate alternative housing arrangements and, if necessary, connecting them with financial and other services to help them return to permanent housing.
- **Document Ready –** This term indicates that an individual's status has been documented through verification of homelessness and/or chronic homelessness through HMIS data, letters from outreach providers or shelters, confirmation documents provided by hospitals or treatment programs, or self-certification up to 30 days and/or verification of disability through SHP form, disability income, or psychiatric and/or medical diagnosis.
- **Fiscal Agent –** For the purpose of this document, the entity that coordinates funding and provides oversight to the coordinated intake and assessment system.
- **FUSE –** Palm Beach County FUSE (Frequent User System Engagement): A multiple systems approach to housing unsheltered community members who have high rates of criminal justice contacts, homeless service utilization, and admission to detox and crisis stabilization services. This small subpopulation consists of the top utilizers of services that result in high public costs.
- **HEARTH ACT –** The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) act of 2009 that includes Emergency Solutions Grant (ESG) and Continuum of Care (CoC) grants.
- **HMIS –** Homeless Management Information System is a centralized database designated to create an unduplicated accounting of homelessness that includes housing and services.
- **Homeless –** HUD definition as of January 2012; is an individual or family who lacks a fixed regular, and adequate nighttime residence, which includes a primary nighttime residence of: a place not designed for or ordinarily used as a regular sleeping accommodation (including car, park, abandoned building, bus/train station, airport or camping grounds); a publicly or privately operated shelter or transitional housing, including a hotel or motel paid for by government or charitable organizations. In addition a person is considered homeless if he or she is being discharged from an institution where he or she has been a resident for 90 days or less and the person resided in shelter (but not transitional housing) or place not meant for human habitation immediately prior to entering the institution.
- **Homeless Resource Center –** The agency identified as the primary administrator of coordinated intake and assessment. For the purpose of this document, that is the Philip D. Lewis Center and the partners administering the coordinated assessment process; Gulfstream Goodwill Industries, Adopt-A-Family and all Homeless Outreach Teams.
- **Housing First –** Evidence-Based programming for housing homeless individuals and families according to the provisions of a standard lease without requiring services other than case management in order to attain and retain housing.

- **Housing Ready –** A case management/housing approach that places homeless households into permanent housing only when determined the household was ready. Until that time, households are placed into long-term shelter or transitional housing programs. The approach is being replaced by the Evidence Based Practice of Housing First and "rapid re-housing."
- **Housing Stability (formerly Prevention) –** Assistance that can aid households in preserving their current housing situation by providing assistance to households that otherwise would become homeless.
- **HUD –** The Department of Housing and Urban Development; the United States federal department that administers federal program dealing with homelessness. HUD oversees HEARTH-funded programs.
- **Information –** Specific facts about a program, such as its location, services provided, eligibility requirements, hours of operation, and contact information
- **Intake –** the general process between the client's initial point of contact and screening for eligibility. This step involves primary assessment of needs, strengths and resources to refer households into appropriate services
- **Linkage or Access to Mainstream Resources –** An approach to help people stabilize their housing for the long term by linking them to resources for which they are eligible within their community.
- **Navigation –** The process of assessing eligibility in order to connect or refer individuals for services.
- **Navigator –** An intake worker whose responsibility is to provide coordinated intake and assessment for individuals or families seeking housing services.
- **Outcome –** The specific result of what was provided from a specific activity or service; in relation to HUD/HEARTH, a specific result as detailed by HUD/HEARTH funding requirements.
- **Outreach –** An outreach worker whose responsibility it is to identify individuals and families who are sleeping in places not meant for human habitation and engage with these individuals with the goal of connecting them to housing resources through coordinated intake and assessment.
- **Prioritization –** The process of using service-specific evaluation criteria to determine which individuals are most urgently in need of homeless services or housing interventions.
- **Progressive Engagement –** refers to a strategy of providing a small amount of assistance to everybody who enters your homelessness system, then waiting to see if that works. If it does not, you provide more assistance and wait to see if that works. If not, you apply even more, until eventually; you provide your most intensive interventions to the few people who are left.

- **Rapid Re-housing –** An approach that focuses on moving homeless individuals and families into appropriate housing as quickly as possible by providing the type, amount and duration of housing assistance needed to stabilize the household. Clients do not need to be considered "Housing Ready".
- **Referral –** linking a client to a particular program for possible assistance.
- **Screening –** For the purpose of this document, the process by which eligibility for housing and services is determined at the initial point of contact through coordinated entry. Once screening determines eligibility, the intake and referral process follows.
- **Systems Change –** For the purpose of this document, the process by which our CoC has altered the way homeless and at-risk households engage with the homeless and housing providers within our communities. The purpose of system change is to implement practices that have shown to decrease the incidence and length of time in homelessness, with a long-term goal of reducing and ending homelessness.
- **Tailored Programs and Services –** An approach to case management services that matches the services to the particular individual's or family's needs rather than using a one-size-fits-all approach.
- **Targeting –** Process of determining the population to whom assistance will be directed. That is, the target population. The targeting process can occur at both the system and the program levels.
- **Verification –** The gathering and review of information to substantiate the applicant's /client's situation and support program eligibility and priority determination.
- **Veteran (HUD) / Veteran Grant Per Diem (GPD)/ Veteran Self Sufficiency Veteran Families (SSVF)** - Any individual that has served one day of active duty.
- **Veteran (VASH) & Healthcare for Homeless Veterans (HCHV)** – any individual that has served 24 months of active duty or is eligible for VAMC Healthcare and has a discharge or release from service under conditions other than dishonorable discharge.

ENTRY SYSTEM

Applicants and Clients:

- Clients who are in need of homeless prevention or housing services can access information and eligibility criteria through the HRC, which serves as the Central Point of Access. Participants seeking assistance must be screened at the HRC by a Navigator or by the Homeless Outreach Teams during off-site outreach. Participants not eligible for services will be referred to other appropriate community resources.
- Eligibility: Individuals and families that are **"Literally Homeless"** (meeting HUD's Category 1 definition of homelessness).
- Eligibility for Youth: could include "**Category 2"** at risk of homelessness

- Participation Requirement: All households (with the exception of households in domestic violence situations) must be screened prior to program entry.
- Eligible Clients can expect :
  - To be treated with respect and dignity
  - Their initial phone call for assistance to be answered live or returned within two business days & navigated to appropriate resources.
  - For intake and assessment to be scheduled for eligible clients within seven to fourteen business days as capacity allows
  - To be matched to an appropriate program based upon their unique needs, and referred based on their priority status to opening in a program
  - To wait until the system has the capacity to assist them, and to get help through diversion or other resources available to them
- Responsibilities

  Client must:
  - Answer all questions truthfully and to the best of their ability
  - Bring all required documentation
  - Keep their contact information current in order to be notified of available openings, and referred in a timely manner

Providers:

- Participation Requirement
  - All providers receiving funding through HEARTH or a HUD funded program are required to participate in the coordinated intake and assessment process.
  - Providers must be live on the HMIS system and must maintain data which is inputted no later than within 24 hours of a service or outcome being achieved or rendered.
  - Providers must have an appeal process for those applicants who have been denied service or entry into a program.

HRC Partners:

- It is the HRC Partner's responsibilities to:
  - Regularly update and make current all program eligibility guidelines and program contact information so that Navigators can make the best referrals possible.
  - Ensure that when a placement referral is made, to confirm within two business days whether the referral is accepted, declined by provider, declined by client, or pending, or the provider is unable to contact the client.
  - Bring problems and suggestions to the monthly Standard Policies & Procedures Committee meeting.
  - Oversee provision of homeless diversion and housing services for eligible clients.

- Ensure utilization of the same screening and assessment tool, data collection forms, policies on eligibility verification and referral/information-sharing systems.

See Coordinated Entry Flow Charts for homeless services delivery system overview (Appendix B).

NOTE: *This system acknowledges that the needs of a household fleeing or attempting to flee, domestic violence, dating violence, sexual assault or stalking, may be different than the needs of non-victims. Navigators will be trained on sensitivity in regards to victim's assistance, and referrals will only be made to domestic violence providers.*

ASSESSMENT TOOLS & PROTOCOLS

The Coordinated Entry System focuses on providing a continuum of care including prevention, diversion, rapid re-housing, and permanent supportive housing approaches. For housing programs, the acuity list is utilized to ensure that those with the highest level of vulnerability and longest time homeless are prioritized for enrollment into housing services.

A Navigator assesses each household's eligibility for services. Prevention services target households at imminent risk of homelessness and may be referred to available homeless prevention programs. Diversion services will target participants as they are applying for entry into shelter. For housing programs, rapid re-housing services target literally homeless participants and the VI-SPDAT score indicates this type of housing. Housing first and permanent supportive housing targets chronically homeless participants and the VI-SPDAT score identifies this housing type.

Applicants and Clients:

- Each applicant is evaluated on a variety of criterion, including rental history, criminal history, domestic violence, mental health challenges, disabling conditions, language barriers, educational attainment, employment status, and length of homelessness. Services are then assigned based on the VI-SPDAT score.
- The Assessment tool provides a procedure for determining which applicants are eligible and appropriate for the variety of housing and support services available in the community.

Providers:

- Each participant who is referred for housing or services will have been evaluated through an assessment based on their current barriers to obtaining and successfully maintaining permanent housing.
- The Assessment will be used as a guide, with the understanding that each applicant has a unique set of circumstances.

HRC Partners and CoC Partners:

- The Vulnerability Service Prioritization Decision Assistance Tool (VI-SPDAT) is the assessment tool utilized for this system.
- The VI-SPDAT will utilize 4 domains for individuals and 5 for families to determine an acuity score that will help inform Navigators and Providers about the following:
  - People who will benefit most from Permanent Supportive Housing
  - People who will benefit most from Rapid Re-Housing
  - People who are most likely to end their own homelessness with little to no intervention on your part
  - Which areas of the person's life that can be the initial focus of attention in the case management relationship to improve housing stability.
  - How individuals and families are changing over time as result of case management process.
- The VI-SPDAT will be integrated into the HMIS System and each agency will ensure data is being maintained and monitored.
- The HRC Partners will provide a system of care that allows clients to give feedback on suggestions and improvements of the Intake and Assessment Process.
- The HRC Partners will ensure that the VI-SPDAT is not used to:
  - Provide a diagnosis
  - Assess current risk or be a predictive index for future risk
  - Take the place of other valid and reliable instruments used in clinical research and care

CoC Partners that receive federal CoC and ESG funds and any local funds required by the funder must participate in the Coordinated Assessment process and track data in the Homeless Management Information System (HMIS). Only Domestic Violence providers are exempt from the HMIS requirement as per Florida Statute and Federal regulations. CoC partners receiving federal CoC and ESG funds or any other local funds dedicated to homeless services must fill vacant beds based on acuity from highest to lowest as per CPD-16-11.

ACUITY DETERMINATION

Palm Beach County's Acuity list is formulated through the utilization of an index comprised of multiple indicators of vulnerability, as well as associated criteria for program and/or sub-population eligibility. Each indicator is weighted. The values of each indicator are calculated to identify a final score. This score determines ranking on the acuity list. The list is ordered from highest to lowest score. The highest scoring client receives priority for service/housing enrollment.

Individual Acuity Criteria: (This criteria pertains to Veterans and Individuals Fleeing DV)

The following indicators and associated scores are used to calculate an individual's final score:

- Length of time for current episode of Homelessness (see chart)
- TAY VI-SPDAT Score (see chart)
- LGBTQ+: Clients who identify as LGBTQ+ are given 1 point.
- Person of Color: Clients who identify as a person of color are given 1 point.
- Chronic Mental/Health/Physical Illness: 1 point is given to any client who lives with a chronic mental/health/physical illness and is not currently engaged in care.
- Current Exposure to Violence Home/Community: 1 point.
- Experience Human Trafficking: 1 point
- Veteran: 1 point
- FUSE: 1 point

In addition to the above indicators, chronically homeless individuals who are document ready under HUD guidelines will be assigned an additional 35 points (equal to sum of vulnerability indicators).

The Acuity Score is calculated using the following formula: (**LoH Acuity(*3)) + (VI-SPDAT Acuity(*2))** + **SP = Acuity Score**

The acuity list is ranked in order from highest score to lowest. The highest score is given priority for housing intervention.

Days of homelessness will be used as a tie breaker for clients with the same score.

Individuals will become inactive on the acuity list for the following reasons: permanently housed, have relocated out of state, Outreach and Navigation have been unable to make contact in last 90 days, or if person is deceased. Individuals can be active again following resuming contact with Navigation or Outreach.

Single Adults (Ages 25+)
Shelter/RRH/PSH Acuity Scoring Legend

LoH (Current Episode)

Min	Max	Acuity
-	365 days	0
366 days	3 years	1
4 years	7 years	2
8 years	11 years	3
12 years	15 years	4
16 years +	-	5

VI - SPDAT

Min	Max	Acuity
0	4	0
5	-	1
6	8	2
9	10	3
11	13	4
14	17	5

Special Population (SP)

Description	Acuity
Identify as LGBTQ+, Gender Identity or Sexual Orientation	1
Person of Color	1
Experience Human Trafficking	1
Chronic Mental/Health/Physical Issue - Not Engaged in Care	1
Current Exposure to Violence Home/Community	1
Veteran	1
FUSE	1

Weighted Criteria	
Length of Homelessness (Current Episode)	3
VI-SPDAT	2
Special Population	1

(LoH Acuity(*3)) + (VI-SPDAT Acuity(*2)) + SP = Acuity Score

Youth Prioritization Acuity Scoring: (This criteria pertains to Individual Youth ages 18-24, Parenting Youth are scored using Family Criteria)

The following indicators and associated scores are used to calculate an individual's final score:

- Length of time for current episode of Homelessness (see chart)
- TAY VI-SPDAT Score (see chart)
- LGBTQ+: Clients who identify as LGBTQ+ are given 1 point.
- Person of Color: Clients who identify as a person of color are given 1 point.
- Chronic Mental/Health/Physical Illness: 1 point is given to any client who lives with a chronic mental/health/physical illness and is not currently engaged in care.
- Current Exposure to Violence Home/Community: 1 point.
- Experience Human Trafficking: 1 point
- Veteran: 1 point
- FUSE: 1 point

The Acuity Score is calculated using the following formula: (**LoH Acuity(*3)) + (VI-SPDAT Acuity(*2))** + **SP = Acuity Score**

The youth acuity list is ranked in order from highest score to lowest. The highest score will have priority for housing intervention.

Days of homelessness will be used as a tiebreaker for clients with the same score.

Individuals will become inactive on the acuity list for the following reasons: Permanently housed, Relocated out of the State, Outreach and Navigation have been unable to make contact in last 90 days, or if person is deceased. Youth can be active again following resuming contact with Navigation or Outreach.

Youth PSH:

For PSH, youth will be scored using the same criteria as RRH as long as they meet the following three requirements:

1. TAY-VI-SPDAT Score 8+
2. Disabling Condition
3. Chronically Homeless
    i. If there are no youth that meet the Chronic Definition, youth with most days homeless will be prioritized.

Single Youth (Ages 18-24) Shelter/RRH/PSH Acuity Scoring Legend	
LoH (Current Episode)	**Special Population (SP)**

Min	Max	Acuity
0 days	3 days	0
4 days	14 days	1
15 days	30 days	2
31 days	45 days	3
46 days	60 days	4
60 days +	-	5

Description	Acuity
Identify as LGBTQ+, Gender Identity or Sexual Orientation	1
Person of Color	1
Experience Human Trafficking	1
Chronic Mental/Health/Physical Issue - Not Engaged in Care	1
Current Exposure to Violence Home/Community	1
Veteran	1
FUSE	1

TAY - VI - SPDAT		
Min	**Max**	**Acuity**
0	3	0
4	-	1
5	6	2
7	8	3
9	12	4
13	17	5

Weighted Criteria	
Length of Homelessness (Current Episode)	3
VI-SPDAT	2
Special Population	1

(LoH Acuity(*3)) + (VI-SPDAT Acuity(*2)) + SP = Acuity Score

Family Prioritization Acuity Scoring: (This criteria pertains to Veterans, Parenting Youth, and Individuals with children Fleeing DV)

The **Family Acuity List** includes all families screened by the Lewis Center and meet the Category 1 Homeless (HUD) definition. These families are screened using the VI-F-SPDAT and Referral for services is given based on Score. Those who score a 4+ are scheduled for a Clearance & Assessment that includes bringing in documents to verify client's homeless status, PBC residency, custody of children, and income. This intake appointment also includes a short assessment to help gather any additional information regarding barriers to obtain permanent housing.

Clients are included in the **Shelter Prioritization List** after intake appointment and prioritized for shelter based on the Acuity Score made up of the following factors: Length of Homelessness, VI-F-SPDAT Score, and Special Population. Clients are scored on a scale of 0-5 in the first two (2) categories and are awarded one (1) extra point if they are part of a special population. The scores are weighted (using key below) and then added together creating an Acuity Score. Clients will be prioritized based on this sum. Clients categorized as chronically homeless receive priority. Additional considerations are made for those who are about to give

birth or just given birth, have chronic health issues, or have a reunification plan through DCF that requires them to be sheltered.

Families with minor children
Shelter/RRH Acuity Scoring Legend

LoH (Current Episode)		
Min	**Max**	**Acuity**
0 days	30 days	0
1 month	3 months	1
3 months	6 months	2
6 months	9 months	3
9 months	12 months	4
12 months +	-	5

Special Population (SP)	
Description	**Acuity**
Identify as LGBTQ+, Gender Identity or Sexual Orientation	1
Person of Color	1
Experience Human Trafficking	1
Chronic Mental/Health/Physical Issue - Not Engaged in Care	1
Current Exposure to Violence Home/Community	1
Veteran	1
FUSE	1

VI - F - SPDAT		
Min	**Max**	**Acuity**
0	3	0
4	-	1
5	6	2
7	8	3
9	12	4
13	22	5

Weighted Criteria	
Length of Homelessness (Current Episode)	3
VI-SPDAT	2
Special Population	1

(LoH Acuity(*3)) + (VI-SPDAT Acuity(*2)) + SP = Acuity Score

Clients are included in the **Rapid Rehousing (RRH) Prioritization List** after intake appointment and prioritized based on the Acuity Score below. Clients categorized as chronically homeless receive higher priority. Clients are referred to RRH are based on acuity level, see chart below. **The chart describes the recommendations for the RRH Levels as approved in the PBC RRH Standards.** Clients are referred in cyclical order: level 4, level 3, level 2, level 1. Level 5 RRH will only be included in cyclical order when targeted funding is available. If there are no clients within an acuity range, referrals move to next level in the cycle. Referrals are subject to funding availability and case manager capacity. Clients are closed if two (2) viable units are declined or if they choose to seek permanent housing on their own (i.e. diversion, HA voucher). Clients

waiting for a unit in PSH can be housed through RRH and will remain on the list until a PSH unit is available or it is determined the client is managing successfully in this housing option. If RRH programming is deemed most appropriate, the client is moved to inactive on the PSH list at case closure.

Family RRH Levels			
Level	**Case Length**	**Services**	**Acuity Level**
Level 5		30% Adjusted Gross Income (AGI)	18-25
Level 4	12 mos	Subsidy & Case Management	12-18
Level 3	9 mos	Subsidy & Case Management	10-12
Level 2	6 mos	Subsidy & Case Management	5-10
Level 1	3 mos	Subsidy & Case Management	4

A client scoring a 9 or more on the VI-F-SPDAT and who reports a disability, is scheduled for the F-SPDAT. Clients are added to the **Family Permanent Supportive Housing (PSH) Prioritization List** when they present with a disability and their F-SPDAT score is above a 54. Prioritization for PSH is based on a combined weighted PSH Acuity Score, see chart below. Clients categorized as chronically homeless receive higher priority. Clients remain active on the list for one year and then must be re-assessed to remain on the list.

Family PSH Acuity Scoring Legend

LoH (Current Episode)		
Min	**Max**	**Acuity**
0 days	30 days	0
1 month	3 months	1
3 months	6 months	2
6 months	9 months	3
9 months	-	4

Special Population (SP)	
0	N/A
3	- Domestic Violence (last 3 months) - Veteran - Youth

*client can only score in one Special Population (SP) category

F - SPDAT		
Min	**Max**	**Acuity**
54	60	1
61	67	2
68	75	3
76	80	4

Weighted Criteria	
LOH	3
F-SPDAT	2
SP	1

(LoH Acuity(*3)) + (F-SPDAT Acuity(*2)) + SP = PSH Acuity Score

Clients will become inactive on the acuity list for the following reasons: permanently housed, relocated out of county/state, unable to contact within last 30 days, unable to complete program documentation, children taken out of custody, or if person is deceased.

Documentation of Priority and Chronic Homelessness

As chronic homeless beds become available, CoC Partners will follow the priority guidelines defined in **Appendix A** (page 26) which are in compliance with CPD-16-11. The CoC Partners must include in all case records an email from the HRC certifying the individual/family is the next on the list with the highest acuity and identify which priority category they meet. Since all CoC beds are funded for Chronic Homeless, the individual or family must meet the definition of Chronic Homelessness (Appendix B) and this must be documented according to Appendix C and included in the each case record. For families only, the placement can initially be completed without the documentation, but it must be obtained within 45 days of admittance. Should the CoC Partner and/or family not be able to document chronic homelessness, the CoC Partner Agency is still in compliance with CPD-16-11 since the CoC has adopted the policy of filling all beds with an individual or family with the highest acuity. If self-certification is required, a Self Certification of Homelessness and Chronic Homelessness is required (**Appendix A**).

PREVENTION / DIVERSION (Category 2 Homeless Definition)

According to the National Alliance to End Homelessness, many people seeking homeless assistance still have an opportunity to remain in their current housing situation, whether it is their own housing or the housing of a friend, relative, acquaintance or coworker. In light of this, prevention and shelter diversion are key interventions in the fight to end homelessness. Immediate screening for these possibilities at entry is an important tactic, and can preserve emergency beds for individuals/households that truly have nowhere else to go. Access to rental subsidies and case management at entry is often enough to ensure the household successfully remains housed.

While prevention and diversion are two separate concepts, they are utilized almost interchangeably in this strategy, as they both focus on preventing homelessness. Prevention targets people at imminent risk of homelessness, diversion targets people as they are applying for entry into shelter, and rapid re-housing targets people who are already homeless.

Coordinated Entry for Housing Stability (Formerly Homeless Prevention)

PBC's CoC is expanding the Coordinated Entry system to include services offered through Housing Stability offices formerly referred to as Prevention. Historically, when individuals

and/or families at-risk of homelessness were experiencing a crisis, they sought services on their own. The process included calling a list of service providers in the community oftentimes receiving the same message (ie. no appointments available, no more funds, please call back at a specified time). The CoC determined that this was not a client-centered approach and thus decided to expand the Coordinated Entry process to include at-risk of homelessness individuals and families.

The CoC will begin the expansion as a pilot adding additional navigators to the Coordinated Entry system access point at the Senator Philip D Lewis Center (LC). The pilot will begin with directing the calls and walk-ups from one of the busiest Housing Stability offices. The purpose of launching with one office is to assess the call volume, call flow and to determine if the staff-to-call ratio meets the needs of the community.

Calls made to the office will be directed to Navigation at the LC. Calls received at the LC will follow the same process for homeless calls separated by individuals and families. Navigators are considered Subject Matter Experts and will follow a script when speaking with callers. Navigators will be well versed in diversion strategies. Navigators will also be well versed in the existing resources in the community to meet the needs of the callers. When a navigator has determined the individual or family qualifies for services an appointment will be scheduled at the appropriate office.

The goal of the CoC is to add additional Housing Stability/Prevention offices and other service providers in a manner that does not congest the system, rather ensures an efficient and effective process. The Coordinated Entry system focusing on the Housing Stability will use the County's OSCARRS electronic appointment system for scheduling. Regular reporting will occur to ensure quality service delivery.

Once an individual/household enters into the system, they should be assessed to determine what housing needs they have. To determine which individuals/households are appropriate for prevention/diversion, Navigators can ask applicants a series of questions during the assessment, such as those delineated below:

Diversion

<u>Client:</u>

Clients who are being referred for housing stabilization will be asked:

- Where did you sleep last night? *If they slept somewhere safe where they could potentially stay again, this might mean they are good candidates for diversion*

- What other options do you have for the next few days or week? *Even if there is an option outside of shelter that is only available for a very short time, it worth exploring if this housing resource can be used.*
- (If staying in someone else's housing) What issues exist with you remaining in your current housing situation? Can those issues be resolved with financial assistance, case management, etc? *If the issues can be solved with case management, mediation, or financial assistance (or all of the above), diversion is a good option.*
- (If coming from their own unit) Is it possible/safe to stay in your current housing unit? What resources would you need to do that (financial assistance, case management, mediation, transportation, etc.)? *If the individual or family could stay in their current housing with some assistance, providers should focus on a quick prevention-oriented solution that will keep the individual or family in their unit.*

Providers:

Referrals to prevention/diversion providers must be at imminent risk of homelessness AND meet the following threshold.

- No appropriate subsequent housing options have been identified;
- The household lacks the financial resources to obtain immediate housing or remain in its existing housing; and
- The household lacks support networks needed to obtain immediate housing or remain in its existing housing

HRC Partner Agency:

The following list includes some, but not all risk factors that may be considered when determining imminent risk of homelessness. VI-SPDAT will be utilized to determine acuity of the risk factors (scores 0-3 for families and 0-3 for individuals):

- Eviction within two weeks from a private dwelling (including housing provided by family or friends)
- Residency in housing that has been condemned by housing officials and is no longer meant for human habitation
- Sudden and significant loss of income
- Sudden and significant increase in utility cost
- Mental health and/or substance abuse issues
- Physical disabilities and other chronic health issues including HIV/AIDS
- Severe housing cost burden (greater than 50% of income for housing costs);
- Homeless in last 12 months
- Young head of household (under 25 with children or pregnant)
- Current or past involvement with child welfare, including foster care

- Pending foreclosure of rental housing
- Extremely low income (less than 30% of AMI);
- High overcrowding (the number of person exceeds health and/or safety standards for housing unit size)
- Past institutional care (prison, treatment facility, hospital)
- Recent traumatic life event, such as death of a spouse or primary care provider, or recent health crisis that prevented the household from meeting its financial responsibilities.
- Credit problems that preclude obtaining of housing or
- Significant amount of medical debt.

Some participants may not be good candidates for diversion programs due to a lack of safe and appropriate housing alternative and require immediate admittance to shelter, e.g. client fleeing domestic violence. A client's safety should always be the top consideration when developing an individual /household referral to a program.

RAPID REHOUSING

Generally, rapid re-housing is intended to assist eligible participants to quickly obtain and sustain stable, permanent housing. Effective rapid re-housing requires case management and financial assistance, as well as housing search and locations services. Support and duration of service are tailored to meet the needs of each household and each household has a lease in their name and is connected to mainstream resources in the community in which they reside.

Clients:

Eligible households must:

- Be literally homeless as defined by HUD
- Be prepared to establish a reasonable plan that shows how they are going to maintain housing once housing assistance has ended, develop a budget, a financial worksheet and or a narrative description of changes in household circumstances that caused them to become homeless.
- Entry is based on VI-SPDAT Acuity score (highest to lowest) and length of time homeless

Providers:

Providers who are funded for rapid re-housing:

- Will utilize the **"Progressive Engagement"** methodology; that is, providers will determine the amount of rent and utility assistance and/or supportive services that a

household will receive using the progressive engagement approach. Household will be asked to identify the minimum amount and duration of assistance needed to achieve housing stability. If it becomes clear that a rapid re-housing intervention is insufficient and or inappropriate for a particular household, the provider will work with the Navigator and/or other housing provider to find a more suitable program.

- Households should be attempted to be housed within 30 days of acceptance into the program.
- Providers are expected to remain engaged with the household from first contact to program exit as per the CoC approved Rapid Re-Housing Standards.

CoC Partners:

The following process will be used to refer clients to any Rapid Re-Housing program. Providers will receive referrals from any of the following sources; provided they have been assessed by the Navigator and all eligibility and vacancy information is up to date in HMIS.

- Coordinated Access Point and/or Outreach Workers
- Shelters
- Transitional Housing Programs

All households being referred for Rapid Re-Housing must be assessed by a Navigator. While they may be identified through other resources, i.e., shelter or transitional housing providers, McKinney-Vento Liaisons in school districts, or other service providers, they will require screening and assessment through the HRC Coordinated Intake and Assessment System. School Liaisons can conduct the VI-SPDAT and provide this information to the Navigator to be included on Rapid Re-Housing Placement Priority List.

- Navigators are responsible for gathering documentation for verification of homeless status.
- All Rapid Re-Housing clients must be entered into HMIS by the Navigator once the provider has confirmed entry into the program. Information should include all HUD required data elements.

HOUSING AND/OR PROGRAM REFERRAL

Participants unable to be served by prevention, diversion or rapid re-housing programs will most likely need more intensive housing and service interventions, such as transitional housing or permanent supportive housing. Those fleeing domestic violence that are not eligible or appropriate for prevention and rapid re-housing services may fall into this category of needing

more intensive service intervention, and should be referred to a domestic violence provider prior to intake and/or HMIS data entry.

Table 1 below delineates the characteristics of Permanent Support Housing and Transitional Housing Programs.

Characteristics of Transitional Housing & Permanent Supportive Housing Programs

Programs & Characteristics	Transitional Housing	Permanent Supportive Housing	Other Permanent Housing
Length of Stay	Maximum stay 24 months	No time limit	No time limit
Occupancy Agreement or Lease	Participants are clients, not tenants and sign an occupancy or program agreement instead of a lease	Participants have a lease	Participants have an Occupancy Agreement or Lease
Service Requirements	Services are required	Services are optional	Services are optional
Eligibility	Applicant must meet HUD's definition of homeless	Applicant must meet HUD's definition of homeless and member of the household must have a disabling condition	Applicant must meet HUD's and/or other federal definition of homeless

Provider:

Transitional Housing: programs that provide housing to individuals and/or families, usually for a period of four to twenty-four months, along with supportive services to help them become self-sufficient. In addition to providing a place to live, transitional housing providers should help participants to increase their life management skills and resolve the problems that have contributed to their homelessness. Individuals/Households who are homeless and have two or more of the following barriers are appropriate for referral to Transitional Housing:

- Domestic Violence victims fleeing a domestic violent situation
- youth (18-24)
- No income
- Poor rental history (i.e. current eviction, rent/utility arrears)
- Sporadic employment history
- No high school diploma or GED
- History of homelessness

Permanent Supportive Housing: Permanent Supportive Housing targets individuals/households who need services in order to maintain housing. Prioritization is given to chronic homeless and/or those with the highest level of vulnerability as per HUD. As a minimum, candidates for Permanent Supportive Housing must meet the following basic requirements:

- Literally homeless

- chronic homelessness
- Lacks the resources to obtain housing
- Has a member of the household with a severe or significant disabling condition
- Qualifies as a high need based on the SPDAT

CoC Partner Agencies:

The navigator or other appropriate staff such as Outreach Workers or Diversion Specialist can provide: needed housing navigation services, frequent communication with the client and serves as the primary liaison between the client and the housing provider. The CoC Partner Agency is responsible for overseeing and ensuring that:

- Advocacy and services to collect required housing documentation are provided
- A climate of trust is created and maintained between clients and navigators.
- A current housing inventory is maintained within HMIS
- Clients are housed based upon a prioritization determination; that is, those who score according to the identified criteria as the most vulnerable will be prioritized for housing depending on the availability of housing and services. Legacy programs with beds not dedicated to Chronic Homeless must prioritize the beds for Chronic Homeless Individuals and Families as beds become available.

If the Partner Agency evaluates a client for their bed and questions whether their program fits the needs of the client, they must staff the case with the existing Housing First Providers and a consensus reached that the placement not accepted must be considered in another program. If this occurs, then the Housing First Program with the bed will accept the next person on the priority list and the first individual will be placed in the next available bed in Housing First Program deemed most appropriate.

UNACCOMPANIED YOUTH AND TRANSITION AGE YOUTH

Unaccompanied youth is a fast growing and underserved sub- population, in our community.

Clients:

Unaccompanied Youth (ages 13-17) and Transition Age Youth (ages 18-24) are defined as youth and transition age youth who are unaccompanied by a parent or guardian and are without shelter where appropriate care and supervision are available, whose parent or guardian is unable or unwilling to provide shelter and care, or who lack a fixed, regular and adequate nighttime residence. Undocumented unaccompanied youth and transition age youth may also be served under these provisions except where exclusions are noted. Unaccompanied youth may be encountered during outreach but would not enter the Homeless Resource Center due to their age. City provisions prevent anyone under 18 from entering the program unless they

had legally been as an emancipated as an adult. Those under 18 would be connected to the appropriate program based on their age and circumstances.

Providers:

Providers of services for unaccompanied youth and transition age youth should be able to provide safe and high quality housing and supportive services (scattered-site independent apartments, host homes, and shared housing) to youth and transition age youth experiencing homelessness that involve integrated affordable housing, intensive strength-based case management, self-sufficiency services, trauma informed care, and positive youth development approaches.

HRC Agency:

All housing referrals for unaccompanied youth and transition age youth must be screened and assessed. The HRC Agency is responsible for overseeing and ensuring that:

- Transition Age Youth willingly engage with coordinated intake for a screening and when appropriate, a TAY-SPDAT.
- Low barriers of entry for this highly vulnerable population are necessary.
- Navigators consult with expert providers of this population when conducting intake to properly match clients and providers, and reduce the risk of flight for this highly vulnerable population.

PROGRAM EVALUATION

Coordinated Intake and Assessment is one of many projects within our community that addresses the needs of individuals and families that are at risk or experiencing homelessness within our communities. The HRC Partner Agencies will evaluate the effectiveness as well as required HEARTH Act outcomes by utilizing data from HMIS. As recommended by the National Alliance to End Homelessness, the HRC Partner Agencies will track progress in the following areas to evaluate the Coordinated Intake and Assessment process:

- Length of stay, particularly in shelter: If participants are referred to the right interventions and those interventions have the necessary capacity, fewer individuals and families should be staying in shelter waiting to be moved elsewhere. Also if clients are referred immediately to the right provider, over time, clients will likely spend less time jumping from program to program looking for help, which could reduce their overall length and/or repeated episodes of homelessness.
- New entries into homelessness: if every individual and family seeking assistance come through the front door and the front door has prevention and diversion resources

available, more people should be able to access these resources and avoid entering a program unnecessarily.

- Repeat episodes of homelessness: If clients are sent to the intervention that is the best suited to meet their needs on the first time, families are more likely to remain stably housed.

To track the outcomes summarized above, the CoC Lead Agency will analyze the following Performance Measures annually.

1) PBC CoC will reduce the number of person experiencing homelessness.
    a. Reduction in the total number of persons experiencing homelessness
    b. Reduction in the total number of persons experiencing first time homelessness.
2) PBC CoC will reduce the length of homelessness episodes
    a. Reduction in the mean length of homelessness episode for individuals
    b. Reduction in the mean length of homelessness episode for families with children
    c. Reduction in the mean length of homelessness episode for youth
3) PBC CoC will reduce the number of persons returning to homelessness.
    a. Reduction in return to homelessness within one year following exit
    b. Increase in exits to permanent housing
    c. Increase in income at exit

Measuring the success of this system and transparency with the community and providers will be a key to the success of coordinated assessment process. The CoC Lead Agency will summarize the data annually. The performance measures are utilized for all CoC programs regardless of funding source. For CoC funded and ESG funded programs, these criteria will be utilized for consideration for renewal or new projects based on the program type.

Moving forward, the CoC Lead Agency will expand the evaluation of outcomes by establishing mechanisms to monitor the quality of service through system-wide monitoring. For example, once a client enters shelter an assessment is to be completed within 72 hours. Procedures will be built into the monitoring system to determine how often this goal is met. This will allow for ongoing monitoring of the quality of services and how the program and Providers are able to follow through with this goal.

As part of the evaluation process, as recommended by the National Alliance to End Homelessness, the CoC Lead Agency will set a goal to establish an integrated feedback loop that involves using information gained from these assessments to make any necessary program/process adjustments to the system. Additionally, the CoC Lead Agency will continue working to develop data tools to ensure overall system efficiency and effectiveness.

Updated & Ratified by Homeless & Housing Alliance Executive Committee – March 25, 2021
Reviewed & Updated by Standards Policies & Procedures Committee – July 9, 2019
Adopted by Homeless and Housing Alliance Membership – May 26, 2018
Adopted by Homeless and Housing Alliance Membership – August 24, 2017
Reviewed & Updated by Homeless & Housing Alliance Membership – March 23, 2016
Ratified by Homeless & Housing Alliance Executive Committee -February 23, 2015
Adopted by Homeless & Housing Alliance Membership - February 26, 2015

Appendix A

Palm Beach County Continuum of Care Chronic Homelessness Prioritization
(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 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 or 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.

There are no chronically homeless households that meet the criteria for dedicated PSH beds in Order of Priority1.

(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.

There are no chronically homeless households that meet the criteria for dedicated PSH beds in Order of Priority1 or 2.

(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.

There are no chronically homeless households that meet the criteria for dedicated PSH beds in Order of Priority 1, 2 or 3.

CoC Program-funded PSH must follow the order of priority above, as adopted by the CoC, while also considering the goals and any identified target populations served by the project. For example, non-dedicated or non-prioritized CoC Program-funded PSH that is permitted to target youth experiencing homelessness should follow the order of priority as adopted by the CoC, to the extent in which youth meet the stated criteria.
CoC Grantees must exercise due diligence when conducting outreach and assessment to ensure that persons are prioritized for assistance based on their length of time homeless and the severity of their needs following the order of priority described in this Notice, and as adopted by the CoC. HUD recognizes that some persons–particularly those living on the streets or in places not meant for human habitation–might require significant engagement and contacts prior to their entering housing and recipients are not required to keep units vacant indefinitely while waiting for an identified eligible individual or family to accept an offer of PSH (see FAQ 1895). CoC Program-funded PSH must follow a Housing First approach to the maximum extent practicable. Street outreach providers should continue to make attempts to engage those persons that have been resistant to accepting an offer of PSH and where the CoC has adopted these orders of priority into their written standards, these individuals and families must continue to be prioritized until they are housed.

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

An individual who:

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

Page 2

- Can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability.

An individual who:

- Has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days;
- Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions in the last 3 years; and
- Can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability.

A family with an adult head of household (or if there is no adult in the family, a minor head of household) including a family whose composition has fluctuated while the head of household has been homeless who:

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

- Can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability.

Severity of Service Needs

Individual or Family for whom at least one of the following is true:

- History of high utilization of crisis services, which include but are not limited to, emergency rooms, jails, and psychiatric facilities; or
- Significant health or behavioral health challenges or functional impairments which require a significant level of support in order to maintain permanent housing.

Severe service needs should be identified and verified through data-driven methods through the use of a standardized assessment tool that can identify the severity of needs such as the Vulnerability Index (VI), the Service Prioritization Decision Assistance Tool (SPDAT)

Documentation of Disability:

Evidence of diagnosis with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability.

Evidence of this criterion must include one of the following:
1) Written verification of the condition from a professional licensed by the state to diagnose and treat the condition;
2) Written verification from the Social Security Administration;
3) Copies of a disability check (e.g., Social Security Disability Insurance check or Veterans Disability Compensation);
4) Intake staff (or referral staff) observation that is confirmed by written verification of the condition from a professional licensed by the state to diagnose and treat the condition that is confirmed within 45 days of the application for assistance and accompanied with one of the types of evidence above; or
5) HUD Verification of Disability Form from a MD, DO, LCPC, LCSW, APRN-BC, or NP.

Documentation of Chronic Homelessness

Chronic Homelessness: An individual or household must have had either one occasion that lasted continuously without a break for 12 months or over a period of at least four occasions, each separated by a break where cumulative length of time homeless totals at least 12 months.

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

Page 4

D**uration of homelessness:**
Evidence that the homeless occasion was continuous, for at least one year: documentation that the homeless occasion was continuous, for a year period, without a break in living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter.

- A break is considered at least seven or more consecutive nights not residing in a place not meant for human habitation, in shelter, or in a safe haven.

- A single encounter with a homeless service provider on a single day within 1 month that is documented through third-party documentation is sufficient to consider an individual or family as homeless for the entire month unless there is any evidence that the household has had a break in homeless status during that month.

Evidence that the household experienced at least four separate homeless occasions over 3 years: evidence that the head of household or an individual experienced at least four, separate, occasions of homelessness in the past 3 years.

- Documentation preference is for at least three occasions to be documented by either: (1) HMIS data, (2) a written referral, or (3) a written observation. Any other occasion may be documented by a self-certification with no other supporting documentation.
- HUD will permit a certification from the individual or head of household seeking assistance in place of third-party documentation for the three occasions that must be documented by either: (1) HMIS data, (2) a written referral, or (3) a written observation. Where third-party evidence could not be obtained, the intake worker must obtain a certification from the individual or head of household seeking assistance, and must document efforts made to obtain third-party evidence, and document of the severity of the situation in which the individual has been living.

Is there a minimum number of days in which a person must be homeless in order for that period to count as an occasion? No**.** In order to provide the maximum extent of flexibility to communities, HUD has not required that a single occasion of homelessness must total a certain number of days. Instead, HUD would consider an occasion to be any period of homelessness where the household resided in a place not meant for human habitation, an emergency shelter, or a safe haven where that period was demarcated by a break, defined as at least 7 or more consecutive nights not residing in a place not meant for human habitation, in shelter, or in a safe haven.