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# COORDINATED ENTRY POLICIES AND PROCEDURES

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Balance of State & Mountainlands Continua of Care



NOVEMBER 1, 2018  
Coordinated Entry Leads  
Local Homeless Coordinating Councils



# Coordinated Entry Policies and Procedures

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## UTAH MOUNTAINLANDS & UTAH BALANCE OF STATE CONTINUA OF CARE

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\*References LHCC specific items, also listed in the Implementation section.

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VERSION UPDATES		
Date	Date Approved	Changes Made
January 2015		Original Draft
July 2017	October 2018	Updates to include new HUD regulations & Diversion
November 2018		Annual Review / Update

## Scope

The Coordinated Entry (CE) process is an approach to coordination and management of a crisis response system's resources that allows users to make consistent decisions from available information to efficiently and effectively connect people to interventions that will rapidly end their homelessness.

The Mountainlands (MTL) and Balance of State (BoS) Continua of Care coordinators developed this document jointly. It includes specific input from several local coordinated entry leads, general community partners, the Utah Domestic Violence Coalition, and Domestic Violence (DV) service providers.

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## Policy Statement

An effective system is designed to:

- Be person-centered, prioritizing those with the greatest need
- Be without precondition
- Include all subpopulations
- Incorporate the foundational concept that wherever individuals seeking services, they will be able to participate in the same assessment and linkage process where providers use a uniform decision-making approach

As communities have begun implementation efforts, we have learned that CE is not only a best practice for serving consumers; and a way to more efficiently use available resources; but also is an excellent tool to shift thinking to holistic service provisions and overall community need.

In an effort to accommodate the diversity of geographic areas, availability of services, and participating service providers within the MTL and BoS CoCs, adaption outlined in this document, it's recognized that \*Local Homeless Coordinating Committees (LHCCs)/local coordinated assessment groups will define specific assignments and communication patterns to facilitate implementation in their unique geographical areas. \*Each LHCC will create a local addendum to specify how these guidelines are implemented in their community.

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## Reason for Policy

MTL-BOS CE system has adopted HUD CE System regulations, updated 2018, required to be met by agencies receiving CoC and/or Emergency Solutions Grant (ESG) funding, and implemented by January 2018.

Upon approval, this document will serve as the Policies and Procedures manual for CE in the MTL and BoS CoCs, with the understanding the System will include:

- A. Ongoing planning with stakeholder consultation – Stakeholders annually evaluate and update the CE system, to include regularly gathered feedback from consumers.

- B. CE sub-committees – In addition to the Balance of State and Mountainland subcommittees, \*Each LHCC shall have at least one body that acts as a CE sub-committee. The makeup of this body, frequency and content of meetings, and procedures for calling additional staffing should be outlined in the local addendum.
- C. Inform local planning – Information gathered through CE will guide community decision-making around homeless assistance planning.
- D. \*Leverage local attributes and capacity – Implementation with fidelity by local stakeholders that reflect community attributes and overall context, services and providers, will assist and define items each LHCC is asked to develop as an addendum in addition to these policies and procedures.

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## Client Identification and Inclusion

- 1. Prioritization – The people with the greatest needs receive priority for any type of housing and homeless assistance available. The VI-SPDAT pre-screen and SPDAT assess acuity, following the premise that individuals with the highest acuity should be prioritized for available housing and homeless assistance of all types.
- 2. Low Barrier – The process does not screen people out of the CE process because of perceived barriers to housing or services, including but not limited to: income or employment, active or a history of drug or alcohol use, domestic violence history, a criminal record, a client’s previous area of habitation, the type or extent of a disability-related services or supports that are needed, history of evictions or poor credit, lease violations or history of not being a leaseholder, or resistance to treatment or intervention, etc.
- 3. Housing First Orientation – People are housed quickly, without preconditions of service participation requirements.
  - 3.1. The process cannot require disclosure of specific disabilities or diagnosis.
  - 3.2. Specific diagnosis or disability information may only be obtained for purposes of determining program eligibility to make appropriate referrals.
  - 3.3. Programs may require clients to provide certain pieces of information to determine program eligibility only when the applicable program regulation requires the information to establish or document eligibility.
- 4. Client-Centered – The process incorporates client choice in regard to housing and service options, and information the client is asked to provide.
  - 4.1. Client Autonomy: Clients are freely allowed to decide what information they provide, including specific disability or diagnosis, during the assessment process, to refuse to answer assessment questions and to refuse housing and service options without retribution or limiting their access to other forms of assistance. Clients can maintain their place in the CE process when they reject options, if applicable.
  - 4.2. Client Communication: In order for clients in CE process to maintain their place for housing, the agency, and/or client, must maintain contact and receive regular communication regarding placement progress, unless SPDAT score changes.

- 4.3. Client Inactivation: A client may be inactivated for placement if there is no contact, after several continued, documented efforts to locate and communicate with a client, with no response after 60 days. The client may re-enter the CE process in the future, without preconditions or retribution.
- 4.4. Client Grievance: Clients must be informed of the ability to file a nondiscrimination complaint. If the Client is dissatisfied with a service, decision, action or situation involving the CE process, or the client wishes to file a complaint against a perceived unfair treatment, the following procedures can be followed:
  - 4.4.1. \*The client can make a verbal complaint to the Agency, or if the client does not feel comfortable making the complaint to the Agency, they may contact CE Lead within the LHCC.
  - 4.4.2. If the contact with the Agency or CE Lead does not resolve the problem, or if the client does not feel comfortable making the complaint to the CE Lead, they may contact a CoC Board Member, or the CoC Collaborative Applicant.
  - 4.4.3. Complaints regarding the scoring of a particular client with the VI-SPDAT, SPDAT, and/or program acceptance or denial will be reviewed closely, within 30 days, on a case by case basis. The process may require the individual issuing the complaint to meet and discuss the need of reconsideration.
  - 4.4.4. Within 7 business days after review, the respondent will inform the client of the resolution of the complaint, all measures taken to resolve complaint and the final decision.
5. General Outreach/Marketing/Access Plan – Written material designed for persons who are literally homeless or at high risk of homelessness that lists the quick assessment agencies in the area and provides associated contact information, including a phone number for phone assessment. Written material should be easily accessible on the web, at homeless and low-income service provider agencies in the area, at major public centers (e.g. library or community center), and at resource referral centers such as 211, Transient Services Offices, CAP agencies, local mental health and substance use authorities, and/or United Ways that serve in this capacity.
6. Fair and Equal Access – Ensures all people in different populations and subpopulations in the participating CoC’s geographic area; including people experiencing chronic homelessness, veterans, families with children, youth, and survivors of domestic violence; have fair and equal access to the same assessment approach; including standardized decision-making at all access points; while ensuring participants are not be denied access to the CE process on the basis that the participant is or has been a victim of domestic violence, dating violence, sexual assault or stalking.
7. Affirmative Marketing of Housing and Supportive Services – Outreach to people on the street, other service sites and public locations, regardless of race, color, national origin, religion, sex, age, familial status, handicap, disability, actual or perceived sexual orientation, gender identification, or marital status or who are least likely to apply in the absence of special outreach.
8. Unique/Special Needs Populations – CoCs will prioritize unique population vulnerabilities, providing focused resources available for:

- 8.1. Chronically Homeless: Many Utah communities are still on track to effectively end chronic homelessness. In order to do so, chronically homeless persons need to be prioritized for quick assessments and available services.
  - 8.2. LGBTQ: In accordance with Federal regulation and recent Federal guidance, individuals shall not be discriminated against due to sex, gender or sexual orientation. Providers will offer services in safe and culturally competent ways.
  - 8.3. Veterans: In accordance with the federal plan to end veteran homelessness, the state of Utah prioritizes Veterans/veteran families for homeless resources. Therefore, homeless persons/families identifying as ‘Veterans’ should be referred to Veteran housing resources to determine Veteran status and available resources, including VA, VASH, SSVF, GPD. Where Veterans are not eligible for any VA funded housing resource, Veterans should be assessed for available units using the coordinated entry system and prioritized first in case of a tie. \*Communication and coordination between agencies providing CE services and the Veteran resources will be defined in the LHCC addendum to ensure accurate representation of Veterans served is reflected in this process.
  - 8.4. Unaccompanied Youth: Unaccompanied homeless youth are defined as between the age of 18-25 without an older adult in the household. This population requires specialized service provisions, and agencies should maintain an awareness of current best practice for this sub-population on an ongoing basis. Where unaccompanied youth tie for service prioritization, they should be served first.
  - 8.5. Domestic Violence: People fleeing, or attempting to flee DV; and victims of trafficking; will have safe and confidential access to the CE process and victim services. This includes access to the comparable process used by victim service providers, as applicable, and immediate access to emergency services such as DV hotlines and shelter. Safety planning and lethality risk need to be accounted for in the case of survivors of DV. Where appropriate, DV service providers may wish to include the scoring of the Campbell Lethality Assessment in the prioritization process to indicate the need for project-based placement. A unique pre-screen data entry mechanism has been created for DV providers to enter this sub-population into UHMIS (see Appendix). All providers need to remember that survivors of DV are not required to have identifying information entered into UHMIS in order to receive services, and providers must express this option to potential program participants. Providers may wish to consult with a DV advocate to better understand the potential risks. A template for obtaining consent of DV clients to participate in CE utilizing the VI-SPDAT and SPDAT is in the Appendix of this manual.
  - 8.6. HIV+: An additional resource, Housing Opportunities for Persons with AIDS (HOPWA), is available for persons who are HIV+. This resource is contracted through the State DWS HCD Office and providers are encouraged to contact this office directly if they are not aware of who provides HOPWA within their LHCC.
  - 8.7. 55+: Persons age 55+ and/or 60+ may have access to additional housing resources in your area. Aging services divisions may be willing to offer support and advocacy and many communities have affordable housing units set aside specifically for persons in these categories.
9. Effective Communication – Steps are taken to ensure effective communication with individuals with disabilities by providing auxiliary aids and services necessary to ensure effective communication (e.g. Braille, audio, large type, assistive listening devices, and sign

language interpreters). Effort is made to provide translation to Limited English Proficiency (LEP) clients.

10. Access Points – These are places; either virtual or physical, where an individual or family in need of assistance, accesses the CE process. Ensure access points, if physical locations, are accessible to individuals with disabilities, including accessible physical locations for individuals who use wheelchairs, as well as people in the CoC who are least likely to access homeless assistance. If access points are virtual, they offer entry where individuals and families experiencing a housing crisis may present for initial assessment screening. These can include:
- a central location or locations within a geographic area where individuals and families present to receive homeless housing and services
  - a 211 or other hotline system that screens and directly connects callers to appropriate homeless housing and service providers in the area
  - a “no wrong door” approach in which a homeless family or individual can present at any homeless housing and service provider in the geographic area but is assessed using the Vi-SPDAT, SPDAT or family or youth versions of these, so that referrals are consistently administered across the CoC
  - a specialized team of case workers that provides assessment services at provider locations within the CoC
  - a regional approach in which “hubs” are created within smaller geographic areas.

*Note - Victim service providers funded by CoC and ESG program funds are not required to use the CoC’s CE process, but CoC- and ESG-funded victim service providers are allowed to do so. Or, victim service providers may use an alternative CE process for victims of DV, dating violence, sexual assault, and stalking, and the DV agency will provide case management coordination between non-DV and DV agencies.*

11. Emergency Services – Access to emergency services are not delayed by the process and may be accessed at all hours regardless of the hours assessments are conducted. An immediate crisis response will be activated for clients presenting at an Emergency Shelter for the Unique and Special Needs populations, as defined in this manual, or families presenting with children. These clients could receive assessment(s) and, if applicable, placement in the CE process outside standard timelines.
12. Inclusive – All subpopulations of persons experiencing homelessness are included. Current status can be determined by asking where an individual or household slept last night. If the location was an emergency shelter program, safe haven, or place not meant for human habitation, the person(s) would be considered literally homeless.

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## System Procedures

1. Homeless Prevention – By design, and in-line with best practice models nationally, a CE system will include a homeless and shelter diversion component, as identified below. Additional assessment tools will be explored for consistent homeless prevention service prioritization in future phases of implementation.



2. Diversion Assessment & Referral – The diversion assessment & referral helps a provider to identify whether or not a person is literally homeless. Regardless of homeless status, the quick assessment is intended to safely divert individuals and households from homelessness where possible and/or identify and refer individuals to emergency services and further assessments as needed.
  - 2.1. Who conducts the diversion assessment: \*Every LHCC will have designated diversion assessment agencies. These may include any agency with trained staff, where individuals entering the homeless system tend to first present. The diversion assessment represents a front line, person-centered response to homelessness at the primary entryway into the homeless services system.
  - 2.2. Timeline for implementation: Diversion training was conducted statewide in spring 2016 and spring 2017. Each community should have access to the personnel designated as Diversion Specialists through this training, and is encouraged to implement diversion assessments as an entry point to services. Several agencies throughout the state were funded in fall 2016 to facilitate implementation. By end of 2017, each community should have specified those designated agencies and will begin actively entering diversion assessment data in UHMIS. With proper implementation, communities will be able to review diversion data as a part of the monthly CE report, and written preferred practices for conducting diversion assessments will be drafted in conjunction with the diversion learning collaborative. This process will be part the annual evaluation of CE systems.
  - 2.3. Who receives a diversion assessment & referral: Agencies will conduct a diversion assessment for any individual or household that presents as literally homeless or at high risk of homelessness (seeking emergency shelter). The agency will then refer the individual to the appropriate emergency or diversion services, assuring households are connected to community resources for follow-up and additional assessments as needed. Each community's\* localized addendum will include a plan for after-hours and delayed diversion assessments, as well as available local resource to aid in diversion activities.
  - 2.4. Access to subsequent assessments: Literally homeless individuals/households who refuse the emergency service referral should be offered information on where to go should they change their mind about emergency services and how they can receive subsequent assessments regardless of choice of participation in offered services (i.e. persons are not required to be admitted to emergency shelter in order to receive a pre-screen assessment).
3. Referral to Projects – Referrals to homeless programs, homeless housing and/or services will uniformly use the CE to fill vacancies in housing programs funded by CoC or ESG, using the housing prioritization list.
  - 3.1. Clear referral expectations:
    - 3.1.1. Housing - Clients have the information and support needed to understand: the program they are being referred to; what the program expects of them; what they can expect of the program; and evidence of the program's rate of success.
    - 3.1.2. Services - Clients will be referred to other mainstream benefits, such as SS, DWS, Health Care, food banks, or any other local community resource. This can include virtual referral, such as 211 hotline, who may identify other local resources.
  - 3.2. Referrals from CoC and agencies participating in the CE will comply with the equal access and non-discrimination provisions of Federal Civil Rights laws as defined by this manual's Client Identification and Inclusion section, items 6-8.

- 3.3. Commitment to referral success – Clients are supported throughout the process once a referral decision has been made. In the rare instance of an eligible client being rejected by a participating project, that agency must document in ClientTrack the reason for not accepting that referral, and the client will maintain their prioritization on the housing list and be offered the next suitable housing opportunity (see also 9.3 in this section) as long as the client or family is in need of housing. If the highest prioritized client does not have a ClientTrack client file because the client was referred from a DV service provider, the agency must provide a written explanation to the CE Lead.
4. Outreach – The CE is linked to street outreach efforts so that people sleeping on the streets are prioritized for assistance in the same manner as any other person assessed through CE.  
\*Each LHCC will have a unique outreach plan that addresses need, including sub-populations, in the specific geographic area.  
At minimum the community outreach plan should include:
  - 4.1. Marketing/Access: CoC’s will take reasonable steps to offer CE process materials and program instruction to potential clients; including effective communication with individuals with disabilities; by providing appropriate auxiliary aids and services necessary; and also in multiple languages to meet the needs of minority, ethnic, and groups with Limited English Proficiency (LEP).
  - 4.2. Street Outreach: Street outreach efforts funded under ESG or the CoC program are linked to the CE system. Written policies and procedures describe the process by which all participating street outreach staff, regardless of funding source, ensure that persons encountered by street outreach workers are offered the same standardized process as persons who access CE through site-based access points. An early morning, systematic and comprehensive street outreach effort during the annual point-in-time count. Ideally, communities will engage in at least two comprehensive street outreach events each year and constantly reassess the need for ongoing outreach.
  - 4.3. An early-morning, systematic and comprehensive street outreach effort during the annual point-in-time count.
5. Safety planning – Protocols are in place to address the needs of individuals and families who are fleeing, or attempting to flee, DV, dating violence, sexual assault, or stalking, but who are seeking shelter or services from non-victim service providers. At a minimum, people fleeing or attempting to flee domestic violence and victims of trafficking have safe and confidential access to CE and victim services, including access to the comparable process used by victim service providers, as applicable, and immediate access to, and coordination with, emergency services such as domestic violence hotlines and shelter, in adherence with the Violence Against Women Act (VAWA), regardless where they present.
6. Full coverage – The entire geographic area of the CoC is covered through CE in sum or through localized parts. Communities with limited emergency services (e.g. w/o an emergency shelter) will need to work with neighboring communities who provide such services to homeless persons in their area. Housing lists have been established by LHCCs, the LHCC and county dropdown options in UHMIS allow persons anywhere within the MTL-BoS CoCs to be referred to a housing intervention within or outside their home community. This is considered a strength of the unified system, which has the ability to bring great benefit to clients. CoC leadership will work with the Salt Lake CoC to identify modes of integration that fit with its coordinated entry model.

7. Standardized Access and Assessment – The No Wrong Door approach encourages all locations and methods of contact to offer the same assessment approach and referrals using a uniform decision-making process. A person presenting at a particular coordinated entry location is not steered towards any particular program or provider simply because they presented at that location; or because of race, color, national origin, religion, sex, disability, or the presence of children.
8. Assessment – Consistent assessment practices can accurately gauge immediate need of any persons presenting for services, as well as eligibility for services. Therefore, the Housing Community and Development Division of the State of Utah DWS provides official training of *OrgCode*'s VI-SPDAT and SPDAT administration, including Family and Youth versions.
  - 8.1. The VI-SPDAT, Y-VI-SPDAT and F-VI-SPDAT Pre-screen: Are triage tools intended to quickly identify persons who should be continually engaged for a full assessment (SPDAT) and additional services. Pre-screen assessment times last only 8 minutes, and is not intended to be a comprehensive assessment. Much like the way triage would work in a hospital emergency room setting, the VI-SDPAT pre-screen is a brief, self-report assessment to help identify the presence of an issue based on that person's own perspective and prioritize persons for the more comprehensive assessment. The SPDAT on the other hand, helps identify the severity of that issue and acuity.
    - 8.1.1. Per the VI-SPDAT Manual (*OrgCode*): "The VI-SPDAT is entirely a self-report instrument. If an assessor questions the information being provided, then it is recommended that you complete a full SPDAT, which also brings in such information as observation, documentation, and (with consent) what other professionals have to contribute."
    - 8.1.2. Who conducts versions of VI-SPDAT pre-screen: Any agency that works with unsheltered homeless persons or offers emergency shelter services (whether at a congregate site or via motel voucher) should have staff trained to conduct pre-screens. CoC's access points include virtual entry systems, like a 211 or other hotline, where individuals and families experiencing a housing crisis may present for initial pre-screen that directly connects callers to appropriate crisis housing and service providers in the area.
    - 8.1.3. Who receives a VI-SPDAT pre-screen: A pre-screen will be completed for each first-time literally homeless individual, youth, or household that has resided in an emergency shelter for 14 days or longer; or, based upon discretion of staff, could be completed right away for each individual, youth, or household that has been identified as unsheltered (living in a place not meant for human habitation), or is a long-term shelter stayer; or after 7 days minimal service for each individual or household that is returning to emergency shelter for a subsequent episode that is not considered a long-term stayer, or administered anytime over the phone, or during a PIT or Street Outreach activities. Individuals should receive the VI-SPDAT, or Y-VI-SPDAT pre-screen, while families should receive the F-VI-SPDAT pre-screen.
    - 8.1.4. To identify whether a walk-in should receive a VI-SPDAT pre-screen assessment, staff should identify if a client record exists in UHMIS, viewing VI-SPDAT history, or ask where the individual or household slept the preceding night. If the location indicated is an emergency shelter program or place not meant for human habitation, staff can complete the VI-SPDAT Pre-screen, or use sound judgment to determine if the pre-screen should be administered.

- 8.2. SPDAT, Y-SPDAT, & F-SPDAT – These Assessments are a more comprehensive administration that assesses the severity of acuity, and ultimately prioritizes individuals and households for services and housing intervention.
- 8.2.1. SPDAT Administration: The SPDAT, Y-SPDAT, & F-SPDAT should be conducted by agencies who either typically place persons onto housing lists or by agencies who outreach to homeless housing program clients. Homeless housing programs may include any housing program dedicated to homeless persons, including those funded by CoC, ESG, PAHTF, or CNH. This may include transitional housing, rapid rehousing, permanent supportive housing and other permanent housing programs.
- 8.2.2. Crisis Consideration: If a client is in crisis at the time of a SPDAT measurement, it may misrepresent overall acuity. To provide greater accuracy in the overall measurement, it is recommended that an additional SPDAT evaluation be taken once the crisis is resolved. Regardless of the scoring and priority sequencing system outlined above, circumstances may require additional information be considered in establishing the priority of clients to be served. This decision rests with the LHCC coordinated entry team leader within the community. It is incumbent upon these decision makers to justify exceptions in service delivery, acknowledging that there can be many reasons for an exception based upon local circumstances and with sufficient justification. \* Local CE Leads can develop their own rules pertaining to priorities from scoring, system navigation, integration with the UHMIS and the use of the notwithstanding clause. Individual organizations and communities may not adjust the scoring, ranking or descriptions of any of the 20 SPDAT components.
- 8.2.3. Who receives the SPDAT: This assessment variations should be given to the individuals/households who score highest on the pre-screen, by order of highest to lowest score. Persons who scored less than 5 on the pre-screen are not eligible for housing intervention and therefore should not receive a full assessment. In unique cases where the provider feels the VI-SPDAT Pre-screen is not an accurate reflection of the situation, and the individual or household is willing to participate in a SPDAT assessment, the provider may use SPDAT questions to inform an updated VI-SPDAT score or simply progress to administering the SPDAT assessment, even if 1<sup>st</sup> time presenting as homeless.
- 8.3. Assessor Training
- 8.3.1. VI-SPDAT and F-VI-SPDAT Pre-screen training consists of two parts. The first part is available in a 30-minute webinar online at <https://vimeo.com/86520820> for VI-SPDATS and <https://vimeo.com/86867825> for F-VI-SPDATS. Once the webinar training has been completed, staff should schedule a pre-screen training with UHMIS staff to learn how to accurately enter and use pre-screen data in the system, including use of tools to identify who receives a pre-screen, who has completed a pre-screen, and whether a subsequent SPDAT assessment has been or should be completed.
- 8.3.2. SPDAT & F-SPDAT training: The use of these tools requires specialized, full day training offered by *OrgCode* or by a certified trainer identified through Utah DWS, Homeless Programs section. Once the full day training has been completed, a second part training regarding UHMIS access and tool utilization will need to be completed by UHMIS staff.

*Note: Entry of client assessment information into UHMIS for VI-SPDAT/SPDAT for clients who are not literally homeless, and not being served by CE procedures, agencies providing services and programs funded by CoC or ESG grants, may skew agency reporting. Youth VI-SPDAT and Youth SPDAT are currently not in UHMIS.*

- 8.3.3. CoCs ensure training opportunities are provided at least once annually to organizations and/or staff persons at organizations that serve as access points or administer assessments. Materials clearly describe the methods by which assessments are to be conducted with fidelity to the CE Policies and Procedures. Updates are distributed at least annually. Training curricula includes the following topics for staff conducting assessments:
  - Review of CoC’s written Coordinated Entry Policies and Procedures, including any adopted variations/addendums
  - Requirements for use of assessment information to determine prioritization
  - Criteria for uniform decision-making and referrals
- 8.3.4. All staff administering assessments use culturally and linguistically competent practices, including:
  - Required annual training protocols incorporate cultural and linguistic competency training for participating projects and staff members
  - LHCC administration of assessments use culturally and linguistically competent questions for all persons that reduce cultural or linguistic barriers to housing and services for special populations
- 8.4. Subsequent Assessments
  - 8.4.1. Subsequent assessments may be conducted when:
    - There is a major life change or other circumstance that would warrant an updated assessment. Some examples include: pregnancy, health concern/diagnosis, new episode of homelessness, new housing situation, DV situation.
    - It has been 6 months since the prior assessment (assessments expire after a 6 month period)
    - If the client requests a new assessment be completed.
9. Housing Placement Prioritization – All available resources should be prioritized and offered to clients at the top of the SPDAT-assessed list, limited only by funding requirements. Agencies obtaining placement prioritization lists through UHMIS have already agreed to Agency Partner Agreement for UHMIS (see Appendix) which details data security regarding client information sharing.

*Note. Prioritization is used for housing placement and not crisis services.*

- 9.1. This prioritization list should be continually worked from throughout the community. Lead case managers should be assigned to each of the highest acuity persons; to attempt diversion exercises, identify needed mainstream resources, and find creative solutions to transition out of homelessness; regardless of which resources are available.
- 9.2. When a housing resource becomes available, the hosting agency should identify the first eligible person from the top of the list and assess them for program eligibility and intake. If the client’s VI-SPDAT and SPDAT assessments have already been completed, the agency should only ask additional questions that are required to determine compliance with program requirements.

- 9.2.1. Individuals scoring 40+ on the SPDAT or 54+ on the F-SPDAT are eligible for permanent supportive housing. They are also eligible for any less intensive housing intervention types which include transitional housing or rapid rehousing. A person does not lose their place on the prioritization list if they choose not to accept the offered resource. Rather, that person would continue to be engaged and offered any subsequently available resources.
  - 9.2.2. Individuals/households scoring between 20-39 on the SPDAT or 27-53 on the F-SPDAT are eligible for transitional housing or rapid rehousing, but not any of the more intensive housing intervention types. \*LHCC Addendum will document guidance for the percentage or amount of rent each program participant must pay while receiving rapid rehousing assistance.
  - 9.2.3. Individuals/households who score less than 20 on the SPDAT or 27 on the F-SPDAT are not eligible for housing intervention. It is crucial that service providers engage with this population to identify current barriers to housing and seek solutions. If they remain homeless for a substantial period after the assessment, or if they have a significant change of circumstance, a new assessment should be completed.
  - 9.3. If the person next on the list does not meet program eligibility criteria, this information should be shared with the coordinated assessment workgroup and other possible resources identified. The ineligible client shall remain on the prioritization list until a suitable program can be found (see 3.3 of this section).
10. Release of Information, Consent, and Information Sharing - CoC does not use data collected from the assessment process to discriminate or prioritize households for housing and services on a protected basis, such as race, color, religion, national origin, sex age, familial status, disability, actual or perceived sexual orientation, gender identify or marital status. CoC's written policies and procedures for CE document how determining eligibility is a different process than prioritization.

*\*Note – In certain circumstances some projects may use disability status or other protected class information to limit enrollment, but only if Federal or State statute explicitly allows the limitation (e.g. HOPWA-funded projects may only serve participants who are HIV+/AIDS).*

- 10.1. Each non-DV agency that serves as an entry point will have a community-level release of information form for client to sign prior to assessment and referral.
- 10.2. DV providers cannot have a general consent to release information for a list of agencies, rather, it must be completed on a single agency basis. The release must include an expiration date and purpose. \*The LHCC may wish to develop a system whereby DV clients are asked for permission to release information to the coordinated entry lead to facilitate more efficient coordination of resources and minimize confidentiality breaches. A template for DV client consent is provided in this manual's Appendix.
- 10.3. When communicating about persons on the prioritization list, great care should be taken to maintain appropriate confidentiality. Agencies and staff who have not completed the UHMIS security training and signed end-user agreement cannot be involved in staffing discussions. Whenever possible, Client IDs should be used. Personal information should never be sent via email. General security training offered by UHMIS staff should be adhered to in all cases. Confidentiality for DV survivors should comply with VOCA/VAWA guidelines.

- 10.4. UHMIS Consent Form: Clients should consent to have their information entered into UHMIS in accordance with the UHMIS Standard Operating Procedures for the UHMIS Privacy and Data Sharing Policy. This document also outlines what data can and cannot be shared within the system. If the client declines to sign a consent form, their information may not be viewed by other agencies, but should still be entered into UHMIS. Contact the UHMIS Lead Agency for client-record lock-down. See 10.6 of this section.
- 10.5. Consent for Assessment: Per the *OrgCode* VI-SPDAT Manual, “An individual must provide informed consent prior to the VI-SPDAT (or SPDAT) being completed. You cannot complete an [assessment] with a client without that person’s knowledge and explicit agreement. You also cannot complete [an assessment] solely through observation or using known information within your organization. This applies to all participants in the coordinated entry system, including survivors of domestic violence.” Consent for assessment is separate and in addition to consent to have information entered into UHMIS.
- 10.6. In the case that a client consents to take the assessment, but will not consent to their data being placed in UHMIS, the case worker may, with client consent, bring a paper copy of the assessment to community meetings and facilitate any further coordination for resources.
11. Using UHMIS for Coordinated Entry – UHMIS or another data system may be used for documenting assessments and referrals. MTL-BoS has opted to use UHMIS as the data management, communication and performance tracking platform for CE. The housing placement prioritization list/SPDAT assessed list can be accessed in UHMIS in real time through “My ClientTrack” and selecting “VI-SPDAT/SPDAT Housing List.” Steps are outlined in this manual’s Appendix.
12. Reporting Requirements – Scoring, status or placement reporting in UHMIS should be completed within 5 working days of the assessment, status change, geography change, or placement date. \*Some communities have set goals to report client status updates in a much shorter timeframe in UHMIS in order to keep UHMIS data and reporting factors more current. Timeframes regarding actual status change dates and the day the change was entered into the UHMIS is calculated and reported regularly in the Coordinated Assessment Summary Report.
- Note – Recording Placements in UHMIS is just as important as any other Data Point, and reiteration of this practice should happen as often as possible in order for Reporting to be accurate. Remember that Reporting will be used for funding opportunities.*
13. Tracking Progress – Process evaluation, performance and helpful information for decision-making requires data be reported regularly and be readily available and coordinated assessment tools can be an excellent resource for doing so. The following focus areas are recommended for tracking progress:
- 13.1. Community Level: Coordinated Assessment Summary Reports, System Performance Measures, Data Quality Reports
- 13.2. Program Level: Program Housing Assessment Summary Reports are forthcoming. In the meantime, agencies can view their own placements through the prioritization list screen.

13.3. Client Level: SPDAT/F-SPDAT as a case management tool – Clients’ SPDAT history is shown on UHMIS client workspace, if entered into the UHMIS following the procedures to associate SPDAT scores with client records

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## Implementation

1. LHCC Addendums – Will be developed to be utilized as written policies and procedures in conjunction with this manual. As the LHCC addendums are completed by November 2017, and approved, they will be added as appendixes to this manual. Some items reflected in this manual that should be addressed to meet the needs of local communities are:
  - Each LHCC shall have at least one body that acts as a CE sub-committee
  - Identify and leverage local attributes and capacity
  - CE Lead contact info within the LHCC will be updated regularly and accessible publicly for grievance non-discrimination purposes
  - Communication and coordination between agencies providing CE services and the VA resources will be defined in the LHCC addendum to ensure accurate representation of Veterans served in this process
  - Every LHCC will have designated diversion assessment agencies and defined a plan for after-hours and delayed diversion assessments, as well as available local resource to aid in diversion activities
  - A unique plan that addresses local need, including sub-populations, in the specific geographic area, that address outreach and prioritization
  - Local project’s identification and application of percentage or amount of rent each project participant must pay while receiving rapid rehousing assistance
  - Each community’s identified Diversion Assessment agencies or staff, including delayed diversion administered when clients show up after normal operating hours
  - The LHCC may wish to develop a system whereby DV clients are asked for permission to release information to the coordinated entry lead
  - LHCCs to set the benchmarks for the reporting measures on the LHCC Coordinated Assessment Summary Report, System Performance Reports, Data Quality Reports
  - Annual training plan defined and scheduled for LHCCs, identifying entry point agencies and staff
  - Some communities have set goals to report status changes in UHMIS in a much shorter timeframe that what is identified in this document, in order to keep UHMIS data and reporting factors more current
  - Plan on how LHCCs will regularly evaluate its effectiveness.
2. Agency Training – \*Annual training for agencies and staff will be defined and scheduled by LHCCs. CoC and/or Collaborative Applicant staff may be asked to participate in scheduled trainings, along with LHCC CE Leads.
3. Evaluation – Once the CE is implemented, \*CoCs and LHCCs will regularly evaluate its effectiveness. Lessons should be derived from these evaluations to further improve CE system success. Factors for program implementation evaluation need to include data driven results. The CoCs will evaluate its CE primarily by LHCC data reporting, but will also consider aggregate data.



3.1. Potential questions to be used for evaluation purposes to evaluate the functioning and success of the CE:

3.1.1 Questions for LHCCs:

- How does the “No Wrong Door” function in your area?
- Do all access points provide uniform assessment practices?
- How many agencies in your LHCC do not participate in CE?
- What significant differences are there between what was planned and what has been implemented?
- What have been the challenges in implementing CE, and how can the CoC help address them?
- Have agencies noted trends or concerns as a result of CE?
- Are there additional screening measures your agencies are utilizing?
- How is the CE advertised in your LHCC?
- How accessible is it?
- What does outreach and advertising activities look like

3.1.2. Questions for Clients:

- Thinking about the most recent time you became homeless, what could have PREVENTED you from becoming homeless? – Check all that apply:
  - Rental Assistance
  - Other Financial Assistance
  - Help Finding a Job
  - Substance Use Treatment
  - Health Care
  - Help Finding an Apartment
  - Mental Health Treatment
  - Help with Budgeting
  - Case Management
  - Other
- To which agency did you first go to get help when you became homeless? – List name of agency
- How did you find out about this agency?
- Choose from range between ‘Strongly Agree’ and ‘Strongly Disagree’
  - It was easy for me to find services to help me when I became homeless
  - I felt that the services I received while homeless were focused on helping me get into permanent housing as quickly as possible
- If you are currently in housing – How many homeless assistance organizations or programs did you have to work with before you got into permanent housing?
- Yes/No - If you worked with multiple agencies, did the referral process go smoothly?
  - If answered no, please explain what we can do to make it easier for people in need of services to access the help they need?

3.2. Types of data that may be gathered to be used for evaluation purposes to evaluate the functioning and success of the CE:

3.2.1. System Performance Measures: Help CoCs understand how their system works, and if they are moving in the right direction to end homelessness. As CE is a key component to getting households quickly out of homelessness and

matching those households with the right housing intervention, it is logical to use System Performance Measures to evaluate how CE is working. The following System Performance Measures will be included in reporting:

- Measure 1. Length of time persons remain homeless
  - Measure 2. The extent to which persons who exit homelessness to permanent housing destinations return to homelessness
  - Measure 3. Number of homeless persons
  - Measure 5. Number of persons who become homeless for the first time
  - Measure 7. Successful housing placement
- 3.2.2. Coordinated Assessment Summary Reports: Quarterly release of monthly data gathered from UHMIS Master Assessment fields, reflected for up to a year, that provide an overview of LHCC-level data points:
- Number of VI-SPDAT administered in a month
  - Number of Full SPDAT administered in a month
  - Lists average number of days between pre-screen assessed and data entry into UHMIS
  - Lists average number of days between pre-screen assessed and full assessment
  - Lists days from pre-screen to placement
  - Lists days from placement to status change in UHMIS
- 3.2.3. Data Quality: Reflects accuracy, timeliness, and quality of data being entered in UHMIS at client intake by agency staff.
4. Technical Assistance – CoCs and Collaborative Applicants will coordinate efforts to provide guidance and assistance to agencies and LHCCs to implement with fidelity the pieces outlined in this manual.

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## Definitions

**Access** - The engagement point for persons experiencing a housing crisis. Also refers to how a person is identified for service.

**Assessment** - Progressive gathering of information at various phases in the coordinated entry process, for different purposes, by one or more staff.

**Agency** – An organization within a CoC’s geographic boundaries, by whom homeless services or programs are provided or administered.

**Chronically Homeless** - An individual who:

- (i) Is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
- (ii) Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions totaling 12 months or more in the last 3 years; and
- (iii) Can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000 (42 U.S.C. 15002)),

- post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability;
- An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition [as described in Section I.D.2.(a) of this Notice], before entering that facility;
  - A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) of this definition [as described in Section I.D.2(a) of this Notice, including a family whose composition has fluctuated while the head of household has been homeless. (24 CFR 578.3)

**Comparable Database** - A comparable database allows the recipient and the CoC to obtain the needed aggregate data while respecting the sensitive nature of client-level information. The comparable database must collect client-level data over time and generate unduplicated aggregate reports based on those data. The comparable database may not be a database that records only aggregate information. Comparable databases must comply with all HMIS data, technical, and security standards as established in rule or notice.

**Contact** - Agencies must record contacts they have with each person served. A contact is defined as an interaction between a worker and a client designed to engage the client. Contacts may include activities such as a conversation between the shelter worker and the client about the client's well-being or needs, an office visit to discuss their housing plan, or a referral to another community service. A contact must be recorded anytime a client is met, including when an engagement date or project entry date is recorded on the same day.

**Continuum of Care (CoC)** - The CoC Program consolidated 3 separate McKinney Vento Homeless assistance programs of: Supportive Housing, Shelter Plus Care, and Section 8 Moderate Rehabilitation SRO program into a single grant. It is designed to assist individuals (including unaccompanied youth) and families experiencing homelessness and to provide the services needed to help such individuals move into transitional and permanent housing, with the goal of long-term stability. More broadly, the program is designed to promote community-wide planning and strategic use of resources to address homelessness; improve coordination and integration with mainstream resources and other programs targeted to people experiencing homelessness; improve data collection and performance measurement; and allow each community to tailor its program to the particular strengths and challenges within that community.

**Coordinated Entry (CE)** - An approach to coordination and management of a crisis response system's resources that allows users to make consistent decisions from available information to efficiently and effectively connect people to interventions that will rapidly end their homelessness.

**Coordinated Entry Lead** - The person chosen by the LHCC to serve as the point of contact for the Coordinated Entry system, ensures agencies participating in the CE.

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

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

Department of Veterans Affairs (VA) - The VA was elevated to a cabinet-level executive department by President Ronald Reagan in October 1988. The change took effect March 15, 1989, and administrative changes occurred at all levels. President George H. W. Bush hailed the creation of the new Department, saying, "There is only one place for the Veterans of America, in the Cabinet Room, at the table with the President of the United States of America."

Disability – the statutory definition requires that the individual or family has a head of household with a diagnosable disability that (a) is expected to be of long-continued and indefinite duration, (b) substantially impedes an individual's ability to live independently, and (c) is of such a nature that the individual's ability could be improved by more suitable housing conditions. Disabilities can include a diagnosable substance use disorder, serious mental illness, developmental disability, posttraumatic stress disorder, and cognitive impairments resulting from a brain injury, chronic physical illness or disability, the disease of AIDS or any conditions arising from the etiological agency for AIDS.

Disappear/Disappeared - Persons who leave/disappear and no longer considered to be participating in the project, an agency will exit enrollment because an agency worker has been unable to locate the client for an extended period of time and there are no recorded contacts, or without completing an exit interview, and has not been housed or placed by the program.

Diversion - Diversion is empowering persons facing imminent homelessness to identify safe and appropriate housing options other than the street/car/shelter and assisting them in avoiding shelter and returning immediately to housing. This could be temporary or permanent. Applies a conflict resolution practices to assist clients at risk of homelessness use a strength-based approach to identify and mine strengths, successes and resources they've used in the past to regain control over their situation and lives.

Data Driven - Homeless Management Information Systems (HMIS) and the PIT count data are used to evaluate and improve the performance of their homeless programs and service delivery systems, as well as to inform funding and resource allocation decisions. In addition, communities used PIT count data to track their progress, determine if corrections were needed, and to improve the identification and rapid connection to housing of people experiencing chronic homelessness. The State of Utah uses PIT count data, and increasingly HMIS data, in order to set annual goals for PSH creation, measure system performance, and make decisions regarding funding. As of the 2012 PIT, Utah experienced a 72 percent reduction compared with the 2005 PIT for chronic homelessness.

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

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

HEARTH Act – the first significant reauthorization of the McKinney-Vento Homeless Assistance programs in nearly 20 years, it allocates funds to homelessness prevention, rapidly rehousing and providing permanent supportive housing for homeless people with disabilities. It also modernized and streamlined housing and services to more efficiently meet the needs of

people seeking assistance. The bill reauthorized the HUD’s McKinney-Vento Homeless Assistance programs, which represent the largest federal investment in preventing and ending homelessness.

Engagement – Agencies are required to record engagements. Per the HMIS Data Standards and by agreement across all federal partners, an engagement date is the date when an interactive client relationship results in a deliberate client assessment or beginning of a case plan. The date of engagement should be entered into HMIS at the point when the client has been engaged by the shelter worker. This date may be on or after the project entry date and must be prior to project exit. If the client exits without becoming engaged the engagement date should be left blank. If the client was contacted on the date of engagement, a contact must also be entered for that date.

Homelessness Prevention – Is stabilizing households at imminent risk of homelessness. For clients that are being served in programs targeted for persons “at-risk of homelessness” such as homelessness prevention then the client would be residing in a housing situation and unless they were residing in that situation for a very short time (less than 7 nights) and immediately prior to that were homeless. See Imminently at Risk of Homelessness.

Homeless System - All of the services and housing available to persons who are literally homeless.

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

Housing Interventions - Housing programs and subsidies; these include transitional housing, rapid re-housing, and permanent supportive housing programs, as well as permanent housing subsidy programs (e.g. Section 8 Vouchers).

Imminently at Risk of Homelessness (HUD Homeless definition Category 2) - An individual or family who will imminently lose their primary nighttime residence, provided that:

- (i) The primary nighttime residence will be lost within 14 days of the date of application for homeless assistance;
- (ii) (ii) No subsequent residence has been identified; and
- (iii) (iii) The individual or family lacks the resources or support networks, e.g., family, friends, faith-based or other social networks needed to obtain other permanent housing (24 CFR 578.3)

Inactive - Data quality includes maintaining accuracy in the number of active records in a system. For projects where clients often leave or disappear without an exit (street outreach and night-by-night shelters), the records often remain open and hamper the project and community’s ability to generate accurate performance measurement. The HMIS Standard Reporting Glossary 2017’s Inactive Records section sets a 90-day limit on inactive records and reports how many records within the report range are inactive (i.e. should have been exited but were not) based on contact with the client for outreach or bed nights for shelter. Some projects have less formal project start and exit dates, for example a shelter which houses persons on a night by-night basis or a medical services-only project. These projects often enter clients upon first service, but may not exit clients from the project or exit them (manually or automatically) after a period of inactivity.

Lead Agency or UHMIS Lead Agency - The entity designated by the Continuum of Care to operate the Continuum's HMIS on its behalf.

Literally Homeless (HUD Homeless Definition Category 1) - An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:

- (i) An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;
- (ii) An individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low income individuals); or
- (iii) An individual who is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution (24 CFR 578.3)

Local Homeless Coordinating Council (LHCC) - A geographic area represented by one or more local homeless coalitions that implements Homeless Services and the CoC coordinated entry system.

No Wrong Door - An approach to Coordinated Entry that ensures people experiencing homelessness can access services regardless of how they enter the Coordinated Entry System.

Permanent Supportive Housing - A housing intervention that combines housing assistance with voluntary support services to address the needs of chronically homeless people.

Placed or Placement – The client status change reference(s) that indicates the client has been matched and is eligible; and next on the Housing Prioritization list; for resources that will provide homeless housing opportunities.

Prevention Services - Financial assistance and supportive services designed to prevent homelessness for an otherwise housed household.

Prioritization - Ensures that those persons with the greatest need and vulnerability receive the supports they need to resolve their housing crisis.

Point-In-Time (PIT) – A snapshot of the homeless population taken on a given day. Since 2005, HUD requires all CoC s to complete this count annually in the last week of January. This process includes a count of clients both in the streets and in emergency shelter and transitional beds, to produce an Unduplicated Count of homeless persons.

Project - Housing or supportive services, intended to help a program participant to rapidly exit homelessness.

Provider or System Provider - Organizations that serve program participants in projects funded by CoC Program or ESG Program grants. This includes recipients and sub-recipients.

Rapid Re-Housing - A housing intervention designed to help individuals and families quickly exit homelessness and return to permanent housing.

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

SPDAT/F-SPDAT – Service Prioritization Decision Assistance Tool and Family Service Prioritization Decision Assistance Tool, an evidence-informed assessment used to gauge a client or household acuity related to housing stability.

Transitional Housing - A time-limited housing intervention that combines housing assistance with support services to address the needs of people experiencing homelessness.

Utah Homeless Management Information Systems (UHMIS) – The information system designated by the CoC to process Protected Personal Information (PPI) and other data in order to create an unduplicated accounting of homelessness within the CoC. A HMIS may provide other functions beyond unduplicated accounting.

VI-SPDAT, F-VI-SPDAT, Y-VI-SPDAT - Vulnerability Index-Service Prioritization Decision Assistance Tool; Vulnerability Index-Service Prioritization Decision Assistance Tool for Families; and Transition-Age Youth Vulnerability Index-Service Prioritization Decision Assistance Tool are the standardized assessment tools used in the Coordinated Entry System. The VI-SPDAT series is a set of triage tools that are designed to be used by all providers within the Coordinated Entry System to quickly assess the health and social needs of people experiencing homelessness and match them with the most appropriate support and housing interventions that are available.

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## Contacts

<i>Contact</i>	<i>Phone</i>	<i>Email</i>
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Sarah Moore	801-468-0045	<a href="mailto:smmoore@utah.gov">smmoore@utah.gov</a>
Heather Hogue	801-318-0739	<a href="mailto:heatherhogue@unitedwayuc.org">heatherhogue@unitedwayuc.org</a>

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## Related Information

Continuum of Care – Mountainlands Board – Lynell Smith, Chair  
Local Homeless Coordinating Committee:  
Mountainlands (Utah, Summit, Wasatch Counties)  
MTL Collaborative Applicant – United Way – Heather Hogue

Continuum of Care – Balance of State Board – Herm Olsen, Norma Olsen, Chair (BRAG)

Local Homeless Coordinating Committees:

Bear River – Jill Anderson  
Uintah Basin – Kim Dieter  
Tooele County- DeAnn Christiansen  
Wasington County – Mike Barben  
Iron County – Peggy Green  
Davis County – Kim Michaud  
Carbon/Emery Counties – Christopher Gravett  
Weber County- James Ebert  
Six County – Debbie Mayo  
SouthEastern Utah Region – Renee Raso  
Grand County – Mary McGann  
San Juan County – Vacant

BoS Collaborative Applicant – Utah DWS, Homelessness Programs – Jennifer Domenici

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## History

Effective: Coordinated Entry was first implemented in Utah’s CoCs in 2015. This current document is version 2, and replaces all previously approved procedures. This document will be incorporated into CoC Governance Charter, and CE processes will be reviewed annually. Any changes to the Appendixes shall not impact the use and approval of the body of this document. Last Updated: August 2017, November 2017 (Appendices)

Responsible Office:

*BoS and Mountainland Collaborative Applicant*

Responsible Administrators:

*Coordinated Entry Lead Team*

Policy Contact:

*Utah DWS Housing and Community Development, Homelessness Programs office*

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## Key HUD Documents

- HUD Prioritization Notice CPD-14-012 - Notice on Prioritizing Persons Experiencing Chronic Homelessness in Permanent Supportive Housing and Recordkeeping Requirements for Documenting Chronic Homeless Status (2014)
- Coordinated Entry Policy Brief (2015)
- HUD Prioritization Notice CPD-16-11 – Notice on Prioritizing People Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing (July 2016)



- HUD Coordinated Entry Notice CPD-17-01 – Notice Establishing Additional Requirements for a Continuum of Care Centralized or Coordinated Entry System (January 2017)
- HUD Equal Access Rule 24 CFR 5.105(a) (2) and 5.106(b)
- HUD Coordinated Entry Core Elements
- Coordinated Entry – Management & Data Guide (October 2018)

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## Governance

### 1. CoC Program Interim Rule

24 CFR 578.7 (a) (8) In consultation with recipients of Emergency Solutions Grants program funds within the geographic area, establish and operate either a centralized or coordinated assessment system that provides an initial, comprehensive assessment of the needs of individuals and families for housing and services. The Continuum must develop a specific policy to guide the operation of the centralized or coordinated assessment system on how its system will address the needs of individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking, but who are seeking shelter or services from non-victim service providers. This system must comply with any requirements established by HUD by Notice.

### 2. ESG Program Interim Rule

24 CFR 576.400 (d) Centralized or coordinated assessment. Once the Continuum of Care has developed a centralized assessment system or a coordinated assessment system in accordance with requirements to be established by HUD, each ESG-funded program or project within the Continuum of Care’s area must use that assessment system. The recipient and sub recipients must work with the Continuum of Care to ensure the screening, assessment and referral of program participants are consistent with the written standards required by paragraph (e) of this section. A victim service provider may choose not to use the Continuum of Care’s centralized or coordinated assessment system.

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## Appendix

- A: UHMIS Entry of VI-SPDAT and SPDAT
- B: UHMIS Entry of VI-SPDAT and SPDAT for DV
- C: Diversion Services Template and UHMIS Service Entry
- D: Client Consent for DV CE process template
- E: UHMIS Client Consent
- F: UHMIS Privacy Posting
- G: UHMIS Agency Partner Agreement
- H: Template DV internal storage document (YCC)
- I: Local Homeless Coordinating Committees’ Addendums
- J: Entry Points
- K: Templates for assessment data tracking tools (*OrgCode*):

1. Family SPDAT Worksheet
2. SPDAT Assessment Worksheet
3. VI-SPDAT Client Data

## Appendix A

### *VI-SPDAT & SPDAT Entry in UHMIS*

#### *Adding a Prescreen (VI-SPDAT) to a client already in ClientTrack*

Workgroup: UHMIS: HMIS Programs

Workspace: **Client**

1. Look up the client to be assessed:
  - Use first 2 letters of first name and last name
  - If not found, try birthday or partial SSN
  - If they don't have a record, go to Option 2, below
  - If Client is found, open the client record, and in the client workspace, use the left-hand navigation bar:
    - Click on SPDAT Assessment folder
    - Choose VI-SPDAT folder
    - Choose "Add New VI-SPDAT Assessment" button
    - Choose "VI-SPDAT Individual" or VI-SPDAT Family"
    - Fill out the VI-SPDAT Assessment
    - Click "Save"
2. Complete "Master Assessment" part of the workflow
  - Field = Status Change Date- enter the date the VI-SPDAT assessment was administered
  - Field = Program- This is the program the person who is editing the master assessment associates their time with
  - Field = Entered/Edited by- prepopulated with user who entering the assessment in UHMIS
  - Field = Local Homeless Coordinating Committee (LHCC)- Choose from drop-down
  - Field = County- Choose from drop-down
  - Field = Status- Choose "Pre-screen Assessed"
  - Click "Save"
  - Click "Finish"

#### *Adding a Prescreen (VI/SPDAT) with a quick client record entry for those NOT in ClientTrack*

Workgroup: UHMIS Programs

Workspace: **Client**

1. Click on "SPDAT Assessment" folder
  - Choose "Add New Client with VI Assessment"
  - Search Existing Clients to ensure that a duplicate record is not created, following steps in #1 above.

If a client record is not found:

  - Click "Next"
  - Fill out Basic Client Information

- Fill out any Family Member Information, if applicable
  - Choose “VI-SPDAT Individual” or VI-SPDAT Family”
  - Fill out the VI-SPDAT Assessment
  - Click “Save”
3. Complete “Master Assessment” part of the workflow
- Status Change Date- enter the date the VI-SPDAT assessment was administered
  - Program- This is the program the person who is editing the master assessment associates their time with
  - Entered/Edited by- prepopulated with user who entering the assessment in UHMIS
  - Local Homeless Coordinating Committee (LHCC)- Choose from drop-down
  - County- Choose from drop-down
  - Status- Choose “Pre-screen Assessed”
  - Click “Save”
  - Click “Finish”

**Entering Full SPDAT in ClientTrack to prioritize clients for Coordinated Entry**

Workspace: **Home**

1. Choose “VI-SPDAT/SPDAT Housing List” from left-hand navigation menu  
Look up the client to be assessed:
  - Use first 2 letters of first name and last name
  - If not found, try birthday or partial SSN
  - Click “Complete SPDAT” by clicking the green arrow icon next to the Client ID
  - Select either SPDAT or F-SPDAT
  - Complete the SPDAT assessment
  - Click “Save”
2. Complete “Master Assessment” part of the workflow
  - Update the Status to “Full SPDAT Assessed”
  - Follow the outline below “Editing the Master Assessment to Change Status or Geography”

**Entering Full SPDAT in ClientTrack for case-management**

Workspace: **Client**

- Look up the client to be assessed:
- Use first 2 letters of first name and last name
  - If not found, try birthday or partial SSN
- Select Client
- Choose “SPDAT Assessment” folder from left-hand navigation menu
  - Choose “SPDAT” folder from left-hand navigation menu
  - Click “Add New SPDAT” or “Add New F-SPDAT”
- Complete the SPDAT
- Click “Save”

**Editing the Master Assessment to Change Status or Geography**

Changes to status or geographic assignment should be made as the client progresses through the coordinated assessment system. The client for whom the change should be made can be located one of two ways:

Workspace: **Client**

1. Look up the client to be assessed/updated:
  - Use first 2 letters of first name and last name
  - If not found, try birthday or partial SSN
2. Select Client
  - Choose “SPDAT Assessment” folder from left-hand navigation menu
  - Click the Blue Arrow next to the Assessment that needs the status or Geography updated
  - Choose “Edit Assessment”
  - Follow the steps below for Updating Master Assessment

Workspace: **Home**

1. In “My ClientTrack” on the left-hand navigation, choose ‘VI-SPDAT/SPDAT Housing List’ Folder:
  - Search for the client that needs to be changed
  - Click the pencil icon for ‘Update Status’ next to their name

If you encounter a client with more than one VI-SPDAT master assessment, you must decide which VI-SPDAT assessment is currently the most accurate. Select the Master Assessment of the incorrect VI-SPDAT. You will then change this status to “Inactive Assessment”. Clients can have multiple SPDAT assessments.

2. Updating Master Assessment screen:
  - Update the fields in the edit screen to reflect the date of status change (i.e. date of assessment, change in geography or placement), current status, and who is editing it.
  - If the change in status is due to housing placement, indicate the type of placement from the drop down menu.
  - Enter a change note in the open comments field at the bottom of the screen. The change note should be made by entering the following:
    - The date (mm/dd/yy) that the master assessment was changed
    - The first word of what the status or geography was prior to your edit
    - The first initial and last name of the person making the change. Please train your case managers to use middle initials if needed to create a unique identifier.
    - Example: 08/19/14-Prescreen-M.Smith-SAC
    - The initials of the organization the staff works for, who is making the change. This should be entered the same way each time.

*Note: Do not change the assessment date, program or assessor fields. These indicate when and who entered the original assessment into ClientTrack.*

  - Click the ‘SAVE’ Button

### **Pulling a Community Housing List**

This search screen allows you to pull a list of persons who have been assessed and entered into ClientTrack. This search can be filtered by all of the data elements that you see on the screen. If the data element is left blank or has “-- SELECT --”, then that variable will not be filtered; in other words; it will bring up all possible answers.

Workspace: **Home**

In “My ClientTrack” on the left-hand navigation, choose ‘VI-SPDAT/SPDAT Housing List’ Folder:

- To identify which client should receive a full SPDAT, select “Pre-Screen Assessed” as the status, select your LHCC and sort the list from highest to lowest according to “VI-SPDAT Score Total”.
- To pull the housing prioritization list for your community select “Full SPDAT Assessed” as the status and select your LHCC. Once these filters have been applied, sort the list according to “Total” from highest to lowest.

## Appendix B

### *Using Housing Prioritization List for Domestic Violence Survivors*

*This adaption of coordinated assessment is to ensure appropriate housing interventions are equally accessible to survivors in the community. It is expected that coordinated assessment as a whole will better serve these individuals and their dependents while facilitating efficient access for advocates representing those survivors who do not present directly to DV provider services.*

#### DV Pre-screen entry for Housing Prioritization Process

- Using the proper informed consent, agencies will complete VI-SPDAT Pre-screen for survivors they encounter who may be either unsheltered, or who have resided in emergency shelter for 14 or more days. Individuals should first be asked if they have already completed the VI-SPDAT during their current homeless episode; to avoid be re-assessed.
- The DV provider will complete the following steps to record the completed pre-screen into the coordinated assessment database (HMIS). All staff that access HMIS are first required to attend the mandatory HMIS training, complete training assignments and sign confidentiality agreement forms.

Workgroup: UHMIS: DV Coordinated Assessment

Workspace: **Client**

- From left-hand navigation, choose “Add New Client with VI Assessment”
- Search Existing Clients to ensure that a duplicate record is not created
- Enter the first few letters of the client’s name to see if they have an existing assessment on the housing prioritization list.
- If the client already has an assessment, determine with the client whether the prior assessment is accurate or needs to be updated.
- If the assessment is accurate, see if the client is willing to sign a release of information for the previous assessing agency to coordinate with on behalf of the client. If the assessment needs to be updated, mark the current assessment(s) that show on the housing list as “inactive assessment” and continue to subsequent steps.

If a client record is not found:

- Enter the first few letters of your agency name into the ‘Last Name’ search field and hit the “next” button at the bottom right corner of the screen.
- A list of all aliases inputted by your agency will come up. Click the triangle next to “first name” and select “sort descending.” The top listed number should be the highest unique identifier already assigned by your agency

- You will use the next sequential number to create a unique alias through the following Alias Naming Convention:
- First Name: last two digits of the year hyphen and a unique four-digit number without spaces (e.g. 17-0001, 17-0002, 17-0000, etc.); Last Name: provider agency name (e.g. CAPSA) – This must be entered in the same way by every user.
- Assure the alias First Name and Last Name is accurate. In the “Name Quality” field select “Partial, street name, or code name reported” and note the system may try to revert back to “full name recorded.”
- Leave the Social Security Number field blank.
- Enter “data not collected” for “SSN Quality”
- Leave the date of birth field blank.
- Data not collected for “Date of Birth Quality”
- Enter “Data not collected” for Gender, disabling condition and veteran status (Please note: If the survivor is a veteran, you will want to contact your local veteran services provider to identify if this is a good fit for housing services).
- Click the “Finish” button, then on the Family and Family Members screen. Click the “Save” button.
- Choose the VI-SDPAT (for individuals) or F-VI-SPDAT (for a family/household with children). The Vulnerability Index Assessment date will auto-enter. Leave all other fields blank and select “Save.”
- The master assessment screen should automatically come up.
- Update all of the fields in the edit screen to reflect the date of status change (i.e. in this case, the date of assessment), your name as the person editing the record, the LHCC you are in, the county, and “Pre-screen Assessed” as the status.
- Click the “Save” Button.
- Click ‘FINISH’ button to complete the workflow.
- Record the alias on the paper pre-screen and enter it, the pre-screen score, and the associated client ID from your internal database or the person’s name into a password protected master document to allow you to match the unique numerical identifier to the client when necessary – this master list will be maintained by the DV service provider only (see template). In the future you may want to first reference this list or add an indicator in your internal database to see if a client has already been assessed.
- Once these steps are completed, the client will show up under their alias on the coordinated assessment list with the date the VI-SPDAT was conducted and a score of 0. This allows a community to see how many VI-SDPATs the DV provider has conducted and no other information.

#### DV SPDAT entry for Housing Prioritization Process

- Provider agencies will complete SPDAT assessments beginning at the highest scoring VI-SDPAT Pre-screen at any given time (down through those who score 5 if possible). DV providers will need to determine this from their internal password protected list. Some agencies may choose to immediately complete a SPDAT assessment for all persons who score 10 or higher on the VI-SPDAT Pre-screen.
- The DV provider will complete the following steps to enter record of the completed SPDAT or F-SPDAT into the coordinated assessment database (HMIS). All staff that access HMIS are first required to attend the mandatory HMIS training, complete training assignments and sign confidentiality agreement forms.

Workgroup: UHMIS: DV Coordinated Assessment

Workspace: **Home**

- Select “VI-SPDAT/SPDAT Housing List” folder from the left-hand navigation menu.
- Change all search menu status fields to “select” and search for the alias of the client that needs to be changed in the first and last name fields.
- Click ‘complete SPDAT’ by hovering over the green arrow icon next to their Client ID
- Select either SPDAT or F-SPDAT
- Complete the SPDAT assessment (note: there are comment options to the right of each component section, these should remain blank for survivors being entered under an alias. All SPDAT assessors are responsible to gather verifying information; however, any notes will need to be securely stored in accordance with VAWA regulation).
- Click the “Save” button.
- The master assessment screen should automatically come up.
- Update the fields in the edit screen to reflect the date of status change (i.e. in this case, the date of assessment), the program you are personally affiliated with, your name as the person editing the record, the LHCC you are in, the county, and “SPDAT Assessed” as the status.
- Click the “SAVE” Button
- DV providers gain direct access to community prioritization lists to identify where current clients fall on the prioritization list, assist with list maintenance for these clients, and place high-acuity, qualifying households from the list in available DV housing stock.
- Once SPDATs are entered into the database the alias will be pulled and prioritized along with the community’s named, single housing list. A representative of the DV provider should attend housing meetings regularly to assure survivors have equal opportunity to access housing as they are prioritized. The representative should also watch for duplicates and assist to maintain the community list.

To pull a housing list in HMIS, follow these steps:

Workgroup: UHMIS: DV Coordinated Assessment

Workspace: **Home**

- Select “VI-SPDAT/SPDAT Housing List” folder from the left-hand navigation menu.
- This search screen allows you to pull a list of persons who have been assessed and entered into ClientTrack. This search can be filtered down by all of the data elements that you see on the screen. If the data element is left blank or has “--SELECT --”, then that variable will not be filtered (in other words, it will bring up all possible answers).
- To identify who needs to be prioritized to receive a full SPDAT, select “Pre-screen Assessed” as the status, select your LHCC and sort the list from highest to lowest according to “VI-SPDAT Score Total”.
- To pull the housing prioritization list for your community select “Full SPDAT Assessed” as the status and select your LHCC. Once these filters have been applied, sort the list according to “Total” from highest to lowest.

- Changing “status” or geography: Changes to status or geographic assignment (shifting to another community’s list) should be made as the client progresses through the coordinated assessment system. These changes are made in ClientTrack as follows:
  - “Home” Workspace, click on housing ‘VI-SPDAT/SPDAT Housing List’
  - Search for client whose status is to be changed by using the first 2 letters of the name and assuring all other fields are marked as “select.”
  - Click the ‘update status’ notepad icon next to the person’s name/alias.
  - Once you are on the master assessment screen:
    - Update all fields to reflect the date the status changed for that person, your user name and agency fields, and the status or geography change.
    - Enter a change note in the open comments field at the bottom of the screen. The change note should be made by entering the following:
      - The date (mm/dd/yy) that the master assessment was changed (typically today’s date)
      - The first word of what the status or geography was prior to your edit.
      - The first initial and last name of the staff making the change in HMIS. Please train your case managers (use middle initials if needed to create a unique identifier)
      - The initials of the organization the person making the change works for (this should be entered the same way each time)
      - If appropriate, a parenthetical may be added after the note with further explanation, such as to indicate refusal of an offered resource.
      - Example: 08/19/14-Pre-screen-M.Smith-SAC
      - ‘Save’ button.
    - DV provider-run housing should be included among the community resources where individuals are placed only through the community housing/services list. Ideally TH providers for survivors would work through the list of all individuals, starting with the highest scorers, who identify being victim to a violent act and seek additional information from other providers as needed to offer specialized services.
    - In order to ease communications, each participating coordinated assessment agency should specify their agency acronym and choose a point of contact within their agency to coordinate the offering of services to survivors. This directory will be linked to agency acronyms and made available to all UHMIS users. Updates to the point of contact should be made in advance of staffing changes whenever possible.
    - The SPDAT and F-SPDAT are also recommended as case management tools, to track progress and acuity over time for individuals who are placed into housing.
    - Establish an aggregate reporting system that allows DV provider work to show on monthly coordinated assessment reports.
    - With proper use of the database as outlined above, the only information missing from DV-providers is the number of persons who scored 5 or higher on the VI-SPDATs. This could potentially be collected in aggregate via google forms to produce community performance data.

Procedures for unique circumstances:

- Where entry for DV providers is new to the system, it is expected that several unique circumstances that are not already represented in this document shall arise. Appropriate procedures will be discussed and written standards updated in a timely fashion.



- If the individual or household has already been entered into HMIS with a VI-SPDAT pre-screen assessment score and qualifies to receive a SPDAT assessment, the individual and provider should determine which provider will complete the assessment based on where they expect to receive services in the meantime. If it is with the DV provider, the provider can note the existing VI-SPDAT score for their internal record, change the existing HMIS record to “inactive assessment” and begin the data entry process over again as outlined in this document, without reassessing.
- Returns to homelessness: If the client is returning to homelessness (i.e. they have been homeless before), the VI-SPDAT pre-screen should be completed within 7 days of entry into emergency shelter rather than 14. If the individual/household is unsheltered or a long-term shelter stayer, they should be assessed immediately. Assessments should not be repeated except in instances where there has been a significant change for the individual that may warrant a new assessment (including a new episode of homelessness).
- Second SPDAT: If a second SPDAT is required for housing/service prioritization (prior to housing placement), the assessor should contact HMIS staff in order to attach the updated assessment.

## Appendix C

### Template Diversion Initial Assessment

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Interviewer: \_\_\_\_\_ Location: \_\_\_\_\_

*This is a worksheet to help guide your conversation. Space is provided to take notes.  
 This is not an official form.*

### ***Step 1: Introduce yourself and the purpose of the appointment***

“Hi, my name is \_\_\_\_\_ and I work for \_\_\_\_\_ agency, which is a part of the \_\_\_\_\_ Coordinated Entry Network. The purpose of this meeting is to help you and your family find a safe place to stay. Typically shelters in this area are very full and the goal is that we brainstorm alternatives to staying in shelter. The hope is that we can find another safe place for you to stay, other than a shelter OR help you return to where you were staying previously.”

### ***Step 2: Active Listening***

**Physical Preparedness for Listening** If possible, sit next to the client, not behind desk. Have a toy for kids. No distractions.

**Paraphrase & ask open ended questions - Avoid “Why” questions, which sound judgmental**

**Allow the person to tell their story about their housing crisis**

**R** – *Relaxed*  
**O** – *Open*  
**L** – *Leaning towards the speaker*  
**E** – *Eye Contact*  
**S** – *Squared towards the speaker*

### Step 3: Strengths Exploration

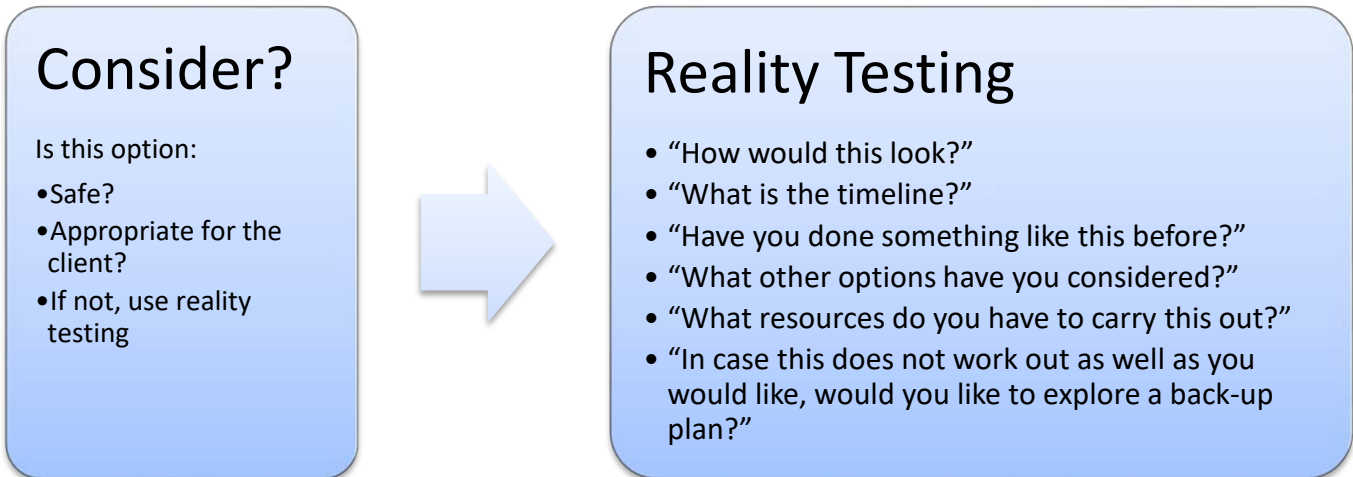
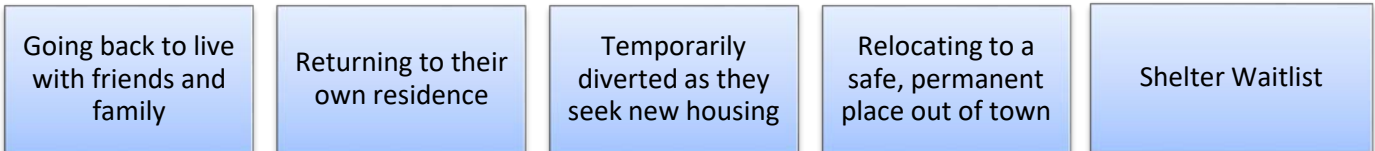
Over the past 6 months, what have you been able to do to avoid seeking emergency shelter?	Identify when you have been a support to others?	What were things like for you when things were going better?	Who are your friends, allies, and family members?
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### Step 4: Moving Forward

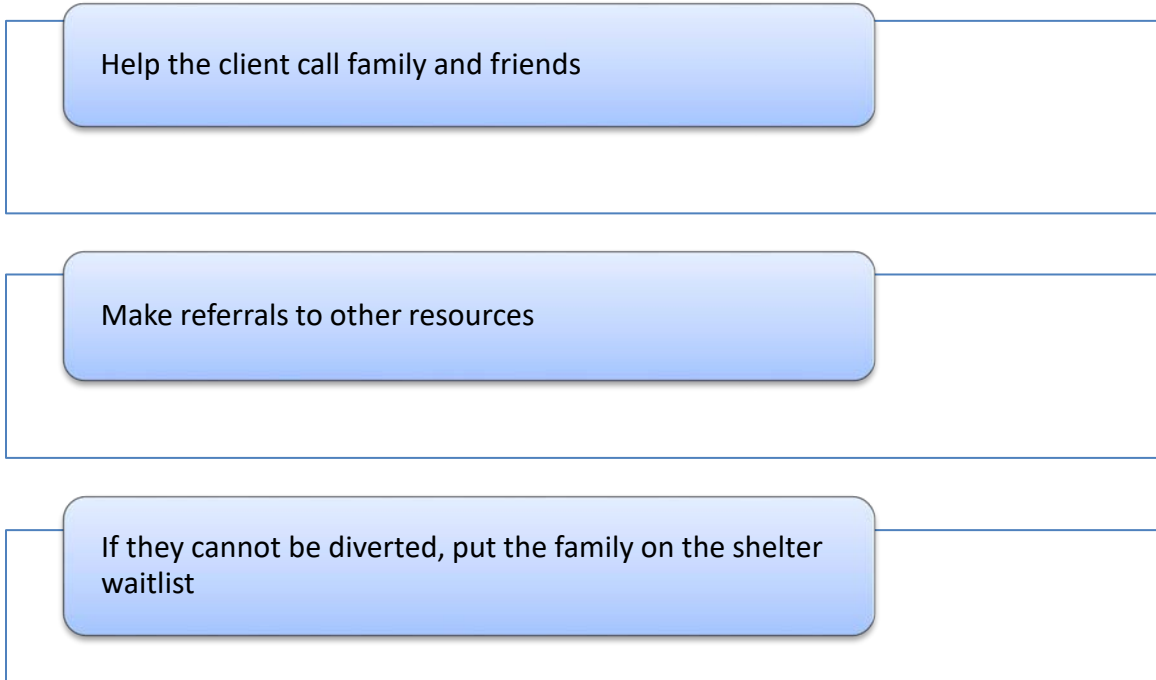
Help pick the best option:



*It's their choice!*



## ***Step 5: Getting Help***



## ***Step 6: Complete the paperwork***

Fill out what you can; you may have already obtained much of the required information by active listening.

- UHMIS Release
- Diversion Assessment (Preferably directly into UHMIS)
- VI-SPDAT - ONLY IF THE CLIENT IS LITERALLY HOMELESS (outdoors, in a car, uninhabitable location)
  - The client has been staying outside/uninhabitable location and will return to staying outside
  - Check UHMIS to see if they have an existing VI – SPDAT. Only do a new one if major life changes have occurred.

## **Appendix D**

Template consent document for DV VI-SPDAT

My name is [assessor’s name] and I work as a [position] for [agency]. We are here today to talk about your housing and service needs. If you give me permission, I will take about 10 minutes of your time to ask you some questions. These questions are about your health and housing. Answers should be only “yes”, “no”, or one word answers.

By participating in the interview you give permission to create a non-identifying alias to store your score into the Utah Homeless Management Information System (UHMIS), which is a secure database that collects information about homelessness. Identifying information will be kept confidential and will only be shared with outreach workers and case managers who will follow up with you for services. If you are accepted into a housing program, a new profile

unaffiliated with services received during your time with the domestic violence program will be created with your real information.

Some of the questions we ask during the interview might make you feel uncomfortable or be upsetting. If you feel uncomfortable or upset during the interview, you may ask the interviewer to take a break or to skip any of the questions. You can skip any questions you do not want to answer, end the interview at any point, or choose to not have your picture taken. If you do not understand any of the questions asked, please ask for clarification.

There are no “correct answers” to these questions. The more honest and accurate you can be in your responses, will allow us to help identify services that fit your unique needs.

Additional information about UHMIS, and a list of participating agencies, is available from your case manager or online at <http://UtahHMIS.org>.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Appendix E

### UTAH HOMELESS MANAGEMENT INFORMATION SYSTEM Client Consent

**PLEASE READ THE FOLLOWING STATEMENTS**

**MAKE SURE YOU HAVE HAD THE CHANCE TO HAVE YOUR QUESTIONS ANSWERED.**

\_\_\_\_\_ is part of the Utah Homeless Management Information System (UHMIS). (Agency Name)

UHMIS is a system that uses computers to collect information about homelessness. The reason for UHMIS is to track funding for homeless programs given by many funders. The goal is to simplify service delivery to people in need.

UHMIS operates over the internet and uses many security protections to keep your information safe. Many service providers across Utah use UHMIS, so your information may be shared with other service providers who provide similar services. Information collected is housed in a secure server, employees have access to this server and the data only for network support and maintenance purposes. UHMIS staff collect and use only information that is needed for general reports on homelessness to help inform policy decisions. Every person with access to the UHMIS must sign and comply with all required confidentiality agreements.

To provide services to you in the best way possible \_\_\_\_\_ (Agency Name) is asking your permission to share your information with other approved UHMIS participating agencies in Utah. This will include sharing the following information about you and any dependent minor children with you: **Name, gender, SSN, birth date**

By signing this form you are acknowledging how your information, and the information of your dependent children under the age of 18, will be stored and could be viewed by other UHMIS

participating agencies. This information will be accessible for seven years from the last date of service.

You may cancel this consent at any given time by written request to this agency. The cancellation will not be applied to records already collected from you. If you choose to not give consent, it **does not** affect your eligibility to receive services unless you are applying for programs funded by the Homeless Prevention and Rapid Re-housing grants.

### Your Rights

- You have the right to get services even if you choose **NOT** to participate in the UHMIS.
- You have the right to ask who has seen your information.
- You have the right to see your information and to change it if it's not correct. But you must show documentation.

A list of participating agencies is available from your case manager or online at <http://utahhmis.org> If you don't want your information shared with a specific agency, please let your case manager or intake worker know. He/she can then take the proper action to honor your request.

\_\_\_\_\_  
SIGNATURE OF CLIENT (AND/OR GUARDIAN)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINTED NAME OF CLIENT

\_\_\_\_\_  
SIGNATURE OF INTAKE WORKER/CASE MANAGER

## Appendix F

### UTAH HOMELESS MANAGEMENT INFORMATION SYSTEM

#### Privacy Posting

**\*\*PLEASE READ CAREFULLY\*\***

THIS NOTICE DESCRIBES HOW  
INFORMATION ABOUT YOU MAY BE USED

When we ask you for information about you and your family, we are entering it into a computer database called the Utah Homeless Management Information System (UHMIS). This system helps us keep track of your information. Some of the information is personal. This helps us improve services for people experiencing homelessness.

It is our duty to protect your personal information. We are required to follow the privacy practices in this Notice. You may request a copy of the notice from any UHMIS participating agency.

#### How We May Use and Disclose Your Information

We only collect information that is needed to provide you services. We do not use or reveal your information without your written consent, except in certain situations. The situations are when

required by our funders or by law, or for specific administrative or research purposes. These specific purposes are outlined in our policy found at <http://utahhmis.org>. We use this information for reports on homelessness and services. Information that could be used to identify you will never be included in these reports.

If you have any questions about the use of your personal information or are concerned about your privacy or safety, please share your questions or concerns with staff. You may also ask for a copy and/or an explanation of the privacy policy.

If we need to collect any more information, you will be given a UHMIS Consent form with more details. You must sign this form before we can use your information. You do not have to sign the form in order to receive services, with a few exceptions.

### **Clients' Rights**

- Clients have the right to get services even if they choose NOT to take part in the UHMIS.
- Clients have the right to ask who has seen their information.
- Clients have the right to see their information and to change it if it's not correct, by providing documentation.

## **Appendix G**

### **UTAH HOMELESS MANAGEMENT INFORMATION SYSTEM AGENCY PARTNER AGREEMENT**

#### **1) Purpose and Policy**

a) This Agency (here forth referred to as CHO (Contributing HMIS Organization)) shall uphold baseline standards, as issued by the U.S. Department of Housing and Urban Development (HUD) and the desire for any related procedure or practices to be consistent with HUD standards (see [Final Revised HMIS Data Standards August 2016](#) or [69 Federal Register 45888, July 2004](#) for additional information).

b) UHMIS operates in an “open with exception” manner to ensure that necessary and appropriate referrals and coordinated case planning takes place. All records are open for sharing, unless otherwise closed by the entering agency, to ensure that the designated purpose and need for sharing of UHMIS information is met.

c) The CHO agrees to uphold the expectations outlined in this form, *UHMIS Agency Partner Agreement*, in conjunction and coordination with other CHOs, for all clients providing information for the UHMIS database. The *Client Consent* form, once signed by the client, authorizes client data to be shared with CHOs.

d) The standard sharing for all participating agencies will be to share a client's Name, gender, partial SSN, birth date.

e) Client authorization to release information shall be established through the use of a written, signed *Client Consent* form, to be completed at the point-of-entry and retained on file at the CHO.

f) The CHO shall solicit consent from clients to share their information across the UHMIS database. The Agency agrees not to release any confidential information received from the UHMIS database to any organization or individual without proper client consent.

- g) The CHO can release information in the following exceptions:
- i) When required by law and to the extent that use or disclosure complies with, and is limited to, the requirements of the law
  - ii) When a CHO reasonably believes that a child or vulnerable adult is a victim of abuse and neglect and should be reported
  - iii) To create unduplicated data within the UHMIS system, where only users who have signed an end-user agreement to maintain client privacy and protections, are allowed to access disaggregated data
  - iv) To avert a serious threat to health or safety if:
    - (1) The service provider believes that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of an individual or the public
    - (2) The use or disclosure is made to a person reasonably able to prevent or lessen the threat, including the target of the threat
  - v) To a law enforcement official for a law enforcement purpose (if consistent with applicable law and standards for ethical conduct)
  - vi) In response to a lawful court order, court ordered warrant, subpoena or summons issued by a judicial officer or a grand jury subpoena, unless otherwise restricted by law
  - vii) If the service provider believes in good faith that the protected personal information constitutes evidence of criminal conduct that occurred on its premises
  - viii) When required for payment or reimbursement for services. Information disclosed is to be used only for payment or reimbursement for services, and remains protected by this policy
- h) Confidential information shall be defined as any and all information relating to past or present clients, any information required by law to be kept confidential, computer codes, passwords and access information for the UHMIS, and any information designated as confidential by the disclosing party.
- i) CHOs will ensure that the necessary users and personnel have the appropriate certifications to access the UHMIS software.
  - j) CHOs shall ensure that all staff, volunteers and other persons issued a User ID and password for the UHMIS receives annual certification training provided by the UHMIS team.
  - k) All CHOs are bound by all restrictions placed upon the data by the client of any CHO. CHOs shall diligently record all restrictions requested. CHOs shall not knowingly enter false or misleading data into the live site under any circumstances.
  - l) If this agreement is terminated, the UHMIS lead agency and remaining CHOs shall maintain their right to the use of all client data previously entered by the terminating CHO; this use is subject to any restrictions requested by the client.
  - m) Clients who choose not to authorize sharing of information cannot be denied services for which they would otherwise be eligible.
  - n) The CHO shall keep signed copies of the *Client Consent* form, and other client documentation for the UHMIS for a period of seven years.

## **2) Data Entry and Use**

- a) CHOs will only use lawful and fair means by which to collect client Personal Protected Information (PPI) with the knowledge or consent of the client. The CHO will operate full respect to each individual's right to privacy, confidentiality, and safety.
- b) The CHO shall utilize the UHMIS database for business purposes only.

- c) Clients will be made aware that personal information is being collected and recorded. PPI will only be collected for the purposes listed above.
- d) All CHOs will post the *UHMIS Privacy Posting* in locations where PPI is collected. A copy of this written notice can be found in Appendix G of this *UHMIS SOP Manual*. This posting will be explained in cases where the client is unable to read and/or understand it.
- e) Client PPI will never be turned over into a national database. It's important that the client's rights to their information is honored by all participating CHOs.
- f) PPI that is gathered needs to be accurate, complete, and relevant; and entered into the system in a timely manner.
- g) The UHMIS team will provide initial end-user training and certification (including confidentiality training) and periodic updates to CHO staff on the use of UHMIS software.
- h) The CHO shall consistently enter data in "real-time" when possible, or enter within 24 hours, or in extreme circumstances, within 5 business days of initial intake, contact, or provided service. This is to ensure that accurate and timely data is being reported to Local, State, and Federal government entities.
- i) All PPI collected will be relevant to the purposes for which it is to be used. Data will be entered in a consistent manner by authorized users.
- j) Identifiers will be removed from data that is not in current use after 7 years (from date of creation or last edit) unless other requirements mandate longer retention.
- k) Measures will be developed to monitor data for accuracy, completeness and for the correction of errors.
- l) Data quality is subject to routine audit by UHMIS system administrators who have administrative responsibilities for the database.
- m) CHO staff will attend all pertinent meetings with the UHMIS team and the Utah State HCD as required.
- n) The CHO's program managers or security officers should hold regular UHMIS user meetings and report all pertinent information (i.e. software issues, trouble with entering or placing client, etc.) to the UHMIS Help desk.
- o) The UHMIS team will provide general technical assistance via a Help Desk and periodic site visits as deemed appropriate for the purpose of troubleshooting and report generation.
- p) The transmission of any material in violation of any federal or state regulations is prohibited. This includes, but is not limited to, copyright material, material legally judged to be threatening or obscene, client PPI, and material considered protected by trade secret.
- q) The CHO shall not use the UHMIS database with intent to defraud federal, state or local governments, individuals or entities, or to conduct any illegal activity.
- r) The CHO staff should fully inform clients about the limits of confidentiality in a given situation, the purposes for which the information was obtained, and how it may be used, per appropriate State and Federal guidelines.
- s) When providing a client with access to his/her UHMIS records, the CHO staff should provide either a screen visual without allowing direct access to input devices, or a hard copy printout. Appropriate measures must be taken to protect the confidentiality of all other records.



t) The CHO staff should afford clients reasonable access to any UHMIS records concerning them, in accordance with internal policies and procedures.

### **3) Reports**

a) The CHO shall retain ownership of identifying and statistical data on the clients it serves.

b) The CHO's access to data on clients not directly served shall be limited.

c) The CHO may make aggregate data available to other entities for funding or planning purposes pertaining to providing services to homeless person or persons at risk of homelessness, in accordance with the UHMIS procedures on data use and release. However, such aggregate data shall not directly identify individual clients.

d) The Utah State HCD will use only aggregate UHMIS data for homelessness related policy and planning decisions, in preparing federal, state or local applications for homelessness and housing funding, to demonstrate the need for and effectiveness of programs, and to obtain a system-wide view of program utilization in the state.

e) The UHMIS staff may need to view data on occasion for quality assurance purposes. The UHMIS staff will follow all guidelines and restrictions on data.

### **4) Proprietary Rights of UHMIS**

a) The CHO shall follow, comply with and enforce the *UHMIS End-User Agreement* and the *UHMIS Standard Operating Procedures* expectations. Modification to these forms shall be made by the UHMIS Staff with input from the UHMIS Steering Committee. Revisions will be done as needed for the purpose of the smooth and efficient operation of the UHMIS system. The UHMIS lead agency will announce approved modifications in a timely manner.

b) The CHO shall not give, or share, user logins and/or passwords to the UHMIS database with any other agency, business, or individual.

c) The CHO shall not intentionally cause, in any manner or way, corruption of the UHMIS database.

### **5) Hold Harmless**

a) The Utah State HCD and the UHMIS lead agency makes no warranties; expressed or implied. The CHO, at all times, will indemnify and hold the Utah State HCD harmless from any damages, liabilities, claims, and expenses that may be claimed against the CHO; or for injuries or damages to the CHO or another party arising from participation in UHMIS; or arising from any acts, omissions, neglect, or fault of the CHO or its agents, employees, licensees, or clients; or arising from the CHO's failure to comply with laws, statutes, ordinances, or regulations applicable to it or the conduct of its business.

b) The CHO will also hold the Utah State HCD harmless for negative repercussions resulting in the loss of data due to delays, non-deliveries, miss-deliveries, or service interruption caused by the CHO's or another CHO's negligence, errors or omissions, as well as natural disasters, technological difficulties, and/or other events out of its control. The Utah State HCD shall not be liable to the CHO for damages, losses, or injuries to the CHO or another party other than if such is the result of the gross negligence or willful misconduct.

c) Utah State HCD shall not be liable to CHO for any cessation, delay, or interruption of any UHMIS services, nor for any malfunction of UHMIS hardware, software, or equipment.

**6) Terms & Conditions**

a) The CHO recognizes the UHMIS Steering Committee to be the discussion and decision center regarding UHMIS, including UHMIS processes, updates, policy and practice guidelines, data analysis, and software/hardware upgrades. The CHO may designate an assigned UHMIS user within their agency to attend, and/or become a member of, the UHMIS Steering Committee meetings, and understands that the Committee will continue to be responsible for coordinating the UHMIS activities.

b) The CHO understands that periodic updates and/or changes to data requirements may occur based on HUD mandate, State mandate, or by the Continua of Care. UHMIS staff are tasked with coordination and implementation of revisions and will provide due notification before such changes take effect.

c) Neither the Utah State HCD nor the CHO shall transfer or assign any rights or obligations without the written consent of the other party.

\_\_\_\_\_  
Agency/CHO

\_\_\_\_\_  
Agency/CHO Executive Director

\_\_\_\_\_  
Date

\_\_\_\_\_  
UHMIS Lead Agency

## Appendix H

Template DV Internal Storage and Tracking

## Appendix I

*Bear River LHCC  
Coordinated Entry Policy & Procedure  
Local Addendum*

**CE Sub-committee**

Representatives from BRAG, CAPSA, & New Hope Crisis Center make up the CE sub-committee. Stefanie Jones is the CE Lead. Any changes to the lead will be reported to the collaborative applicant for updates on public website.

**Training**

BRAG, CAPSA & New Hope Crisis Center staff have received diversion, VI-SPDAT and SPDAT training. Yearly HMIS trainings will be provided by UHMIS. SPDAT training will be

offered yearly by Stefanie Jones an org.code designated trainer. CE members will receive training upon request.

### **Basic underlying assumptions**

- When a housing unit is available, all agencies will pull from the top of the housing prioritization list for placement.
- Survivors who present at a DV shelter will be assessed for diversion. BRAG and the Crisis Response team will conduct diversion for those who present unsheltered but are not DV.
- Households with children should receive the family versions of the VI-SDPAT Pre-Screen and SPDAT.
- Coordinated assessment follows a housing first philosophy, meaning provider actions and program policies, in as much as is possible, should facilitate barrier-free housing placement.
- Discussion around using the ClientTrack database for all community prioritization records is in process and will likely influence updates to this procedure.

### **Community Procedures**

#### 1) VI-SDPAT

- a. When an individual or household presents as unsheltered (living on the streets, in a car, shed or other place not meant for human habitation), staff will conduct the VI-SPDAT.
- b. When someone presents for shelter,
  - i. a diversion assessment will be conducted on HMIS by BRAG, CAPSA, or New Hope Crisis
  - ii. After hours and delayed diversion assessments will be organized in conjunction with Utah State University and Crisis Response subcommittee. Formal written process will be adopted by Jan 2018.
  - iii. After 14 days of emergency shelter with general housing assistance, clients should be offered the VI-SPDAT Pre-Screen Assessment.

Note: If a client scores less than 5 on the VI-SPDAT Pre-Screen and remains homeless or in shelter for an additional 14 days, the client should be reassessed with the VI-SDPAT Pre-Screen.

#### 2) SPDAT

- a. The highest scoring clients on the VI-SPDAT Pre-Screen will receive a full SPDAT assessment first until all clients scoring 5 or higher on the VI-SDPAT Pre-Screen receive a SPDAT assessment.

#### 3) Community List

- a. List is pulled at 10:00 a.m. every other Tuesday for the CE meeting at 11:00 a.m.
- b. The coordinated assessment lead will extract the scores from ClientTrack and compile all data as a single community list that will be presented at the CE

- meeting. Agencies outside of BRAG, CAPSA, NHCC who are interested in participating must sign a confidentiality agreement.
- c. This list will allow all agencies to identify highest-acuity clients and work together to end their homelessness and connect them to adequate supportive services. It will also be used to compile a monthly assessment-placement summary report to track community data and progress.
- 4) Housing Placement (note: dialog around highest-acuity clients should not be reserved for times of available housing. This list should spur an ongoing dialog about how to engage partners to serve those with the highest acuity in the community)
- a. When a program has a placement available, they will contact the highest scoring/acuity individual/household from the list or contact the agency associated with that alias to identify if the individual is interested in participating in the open program. If there are other programs available, the client should have the option to identify which placement would best meet their needs and interests.
  - b. Standard eligibility for the program should be conducted and documentation compiled with help and communication from the agency staff member that conducted the full SPDAT with the client.
  - c. Upon the date of move-in the new case manager will conduct another full SPDAT assessment followed by interval re-assessments and use the information to formulate a case plan and share progress with the client.
  - d. Once the client is placed, the placement should be reported to the coordinated assessment lead who will change their status on the community prioritization list, so they no longer show up as needing housing.
- 5) Other changes in client status
- a. Other changes in a client's status on the coordinated assessment list may be made as needed. Again, these will be reported to the coordinated assessment lead to update the status on the master list. The date of status change and date of reporting the change should both be included in this reporting.
    - i. Change in geography
      1. TBD
    - ii. Status change
      - Full SPDAT Assessed – persons with this status constitute the community prioritization list that should be drawn from both for housing placement and provider coordination/dialog.
      - Pre-Screen Assessed – this status shows those who should receive a full SPDAT assessment.
      - Placement in Process – For those who have been issued a voucher or been assigned to a program, but have not leased or found a placement just yet.
      - Placed – indicate the type of housing placement; friends and family, permanent supportive housing, rapid rehousing, self-housed, transitional housing, veteran housing, self-housed or other.

- Death – for clients who should be removed from the prioritization list due to death.
- Not Recommended for Housing
- Unknown/Disappeared – for clients who have been out of contact for 90 days or more and providers have tried all available avenues to contact them prior to giving this status.

### **Veterans**

VA representative will call in to scheduled CE meetings and attend LHCC meetings.

### **Rapid Re-housing**

Rapid Re-housing rent is paid at 100% for move-in and first three months. A graduated downscale of rent will follow 75% for months 3-6, 50% for months 6-9, and 25% for months 9-12. Max per family is \$9000 and max per individual is \$5000.

### **Evaluation**

Client Surveys- Clients will be provided survey materials to evaluate the CE process in the Bear River Area.

### **Data Driven Decisions**

System Performance Measures will be evaluated at each LHCC meeting and presented by the CE Lead.

## *Carbon/Emery LHCC Coordinated Entry Policy & Procedure Local Addendum*

### **LHCC Membership**

Carbon/ Emery County LHCC are a group of individuals and representatives of local organizations who are intentional in the coordinated effort to eliminate homelessness. The Carbon County LHCC Summary Report is reviewed annually and updated as members are added or changed.

### **Sub-Committee**

The Carbon County LHCC has created a sub-committee to serve as the Coordinated Entry committee. The LHCC Coordinated Entry Lead is Renee Raso from Southeastern Utah Association of Local Governments. The other members of this committee are: Julie Rosier (Southeastern Utah Association of Local Governments) Christopher Gravette (Chrysilas)

### **Leverage Local Attributes and Capacity**

Leveraging grants: PAHTF RRH,CM, TANF RRH

### **Centralized Access**

The Carbon/Emery County LHCC covers a wide geographic area much of which is rural but there are access points throughout this area and available 24 hours to individuals and families in

need of housing and/or services. Those access points are the Carbon County Sheriff's Department, Emery County Sheriff's Department, Colleen Quigley Women's Shelter. Each of these access points have posters and advertisement and are in communication with COC and RRH recipients able to utilize a comprehensive and standardized assessment tool. Access points are also advertised on Southeastern Utah Association of local Governments website under Unified Funding, flyers placed in public areas throughout the counties.

### **Communication/Coordination between agencies SSVF-HVF and VA**

Veterans seeking assistance with services and/ or housing can be connected to Shauna Horrocks (SEUALG) or Jimmie Jones(DWS).

### **Assessment Process**

Carbon/Emery County LHCC uses the VI-SPADAT and SPADAT (vulnerability index-service prioritization decision assistance tool) to facilitate our assessment process in achieving fair, equitable, and equal access to services within the community. This tool is consistent with COC and ESG written standards. Those staff persons and organizations using this tool are trained and required to attend regular trainings to continue to be proficient with the tool and stay updated with changes to the system.

### **Housing Placement Prioritization**

Carbon/Emery County LHCC Coordinated Entry follows the Housing First model in an effort to effectively serve the most vulnerable in our area through the coordinated entry process. This process determines and prioritizes which individuals and families will receive housing, rental assistance, rental deposit and utilities. During the assistance period, the Carbon County PAHTF RRH grant recipients calculate the client's portion of rent according to their income and ability to pay. Attention to future self-sustainability is always paramount and training the client to budget accordingly includes paying an increasing portion of their rent not to exceed 30% of their adjusted gross income.

### **Marketing**

The Carbon/Emery County LHCC recipients of COC, PAHTF RRH grants funds affirmatively market housing and supportive service to eligible person regardless of race, color, national origin, religion, sex, age, family status, handicap, chronically homeless, youth, survivors of domestic violence or those unable to physically present to the access points. The CE Lead is able to drive to outlying areas, domestic violence shelters, hospitals and homes for assessment and subsequent services. This provides fair and equal access to the coordinated entry process.

### **Diversion Assessment Agency & After Hours Diversion Assessments**

Carbon/Emery County Colleen Quigley women's shelter are designated as diversion agencies. These agencies have individuals trained in diversion assessment and are available at any hour of the day. The Carbon/Emery County CE lead is also available to outlying areas for assessment.

### **Safety Planning**

Carbon/Emery County LHCC has a DV shelter and a hotline available 24/7 for individuals or families in a domestic violence situation. Coordinated entry is available at any time and there is in place written policy and procedures that address the immediate issues and the long term stability support. Coordinated assessment with the crisis organization and other resources within the LHCC are treated with the utmost confidentiality. Those individuals and families experiencing domestic violence have safe and confidential access to the coordinated entry

process. Names are not used, only client numbers when posted to the housing list. Coordination with other LHCC resources is only through signed release forms (ROI) specific to the clients need.

### **Street Outreach**

Carbon/Emery County LHCC participates in the annual Point in Time count as required and also reaches out on a regular basis to those living in areas not meant for human habitation. Outreach includes supplying those individuals and families with basic necessities but also an opportunity to be housed through the same standardized process as persons who access coordinated entry through site-based access points.

### **Benchmarks**

For monthly reports, System Performance Reports, Data Quality Reports, Prescreen, full assessment and placement in process are within the reasonable range on the HMIS Housing Prioritization list as a result of close communication with the case manager of Carbon/Emery county Southeastern Utah Association of Local Governments.

### **Status changes in UHMIS**

The LHCC has agreed that the time period for clients to remain on the housing list will be as follows:

- Disappeared/unknown: 60 days from date of assessment. Diligent attempts will be made to contact the client during that period of time.
- Placement in process: as needed. These clients have secured funding for housing and are in the process of locating and moving into the home.
- Inactive: Incarceration, Client self-housed, assessment date exceeds 90 days or a change in the family composition.

### **LHCC evaluations**

The Carbon/Emery County LHCC reviews the LHCC Summary Report quarterly and makes adjustments as needed. This report is also a tool for adding members and enlarging the pool of resources. Sub Committees are created as projects are initiated. The Carbon/ Emery County LHCC CE Committee will meet annually to review the CE Policies and Procedures and the local addendum

***Davis County LHCC  
Coordinated Entry Policy & Procedure  
Local Addendum***

### **Sub-Committee**

Davis County's Local Homeless Coordinating Committee (LHCC) has identified a body which serves as its Coordinated Entry (CE) Sub-Committee. This body shall be comprised, at minimum, of representatives from any agency which utilizes the community-wide housing prioritization list. These agencies include Davis Community Housing Authority (DCHA), Davis Behavioral Health (DBH), Safe Harbor Family Crisis Center (SHCC), Homeless Veterans Fellowship of Ogden (HVF), and Open Doors. Other agencies which serve low-income and/or homeless individuals or families will regularly be invited to attend. Meetings for this committee shall occur no less than monthly, with ongoing communication between caseworkers and agencies.

## **Leverage Local Attributes and Capacity**

PAHTF-RRH, TANF H2H Diversion, CSBG, Private Contributions

### **CE Lead Contact Information**

The current CE Lead for Davis County is Julia Morales, Housing Coordinator at Open Doors. She may be reached at 801-771-4642 ext. 106. This contact information is available to any person accessing the Coordinated Entry System

### **Communication and Coordination between CE and Agencies Serving Veterans**

HVF shall serve as the main contact for individuals who identify themselves as veterans. A representative from HVF will attend CE on a regular basis. Agencies assessing individuals who identify as veterans should, at minimum, provide a referral to HVF so that eligibility for veteran-specific housing opportunities may be determined. Whenever possible, referral shall be a “warm hand-off” to help ensure that the participant is assessed appropriately and in a timely manner.

### **Diversion**

Davis LHCC has designated Open Doors as its main diversion agency. Open Doors’ diversion services are available to all those seeking emergency shelter in an attempt to identify safe, appropriate alternatives. Open Doors and Safe Harbor Family Crisis Center also have the capacity to conduct diversion assessments and input these assessments into UHMIS without reporting confidential, identifying information. This is done by utilizing the UHMIS DV Workgroup.

Open Doors’ Diversion Specialist has flexible hours and the capacity to conduct delayed diversion assessments at shelters, motels, and other locations that are accessible to the participating family or individual.

### **Outreach**

Outreach to those experiencing homelessness in Davis County is done through several methods as listed below:

- Annual Point in Time Count
  - All agencies that participate in CE also participate in the annual January PIT Count. Discussions have been had about conducting a second PIT Count during the summer months but have not yet been scheduled.
- Street Outreach
  - Agencies participating in CE all have individualized outreach plans. Some participating agencies have outreach plans tailored to meet the needs of specific sub-populations including, but not limited to, veterans, families with children, and survivors of domestic violence. Outreach activities may include canvassing the geographic area covered by the LHCC, bringing food/clothing/hygiene supplies to those known to be experiencing homelessness, or traveling to camps as referred by individuals or other agencies. Those experiencing homelessness who are contacted via outreach are offered connection to the CE process and, whenever possible, are assessed using the VI-SPDAT or F-VI-SPDAT.
- Agency Outreach



- Davis County does not currently have an emergency shelter to serve non-DV participants, so agencies participating in CE regularly reach out to those located outside the county.
- Community Education
  - Given the current lack of emergency shelter within the Davis LHCC geographic area, an emphasis is put on education community members about other available community resources. This is done through coordination among LHCC-participating agencies as well as non-participating agencies and distribution of information to community members and organizations/businesses such as libraries, hospitals, gas stations, and 24-hour restaurants.

**Percentage/Amount of Rent Paid**

Percentage of rent paid by participants of RRH Programs is determined on a case by case basis and is in compliance with HUD Guidelines.

**DV Permissions**

Those who are simultaneously accessing DV services and Davis LHCC’s CE system may choose to sign a release of information strictly between Safe Harbor and the CE Lead. The release, written with explicit intent to only communicate information necessary to increase the efficacy of the CE process must include an expiration date. Any participant who chooses to sign this release will be provided with a complete explanation of how the information will be used and with whom it will be shared.

**Training**

Any agency placing people on Davis LHCC’s Housing Prioritization List must have at least one person trained in VI and Full SPDAT administration, UHMIS data entry and confidentiality guidelines, and CE Policies and Procedures. Information regarding these trainings are distributed, as available, to LHCC and CE members. Diversion training is also recommended for case workers who serve individuals and families experiencing homelessness and participate in Davis CE. Davis is also in the process of establishing quarterly training to address issues such as sub-populations, cultural awareness and sensitivity, CE Policies and Procedures, outreach, etc. Collaborative Applicant staff will be asked, as necessary, for input, participation, and available training materials.

Current access points in Davis LHCC’s geographic area include the following:

- Safe Harbor Crisis Center
- Davis Behavioral Health
- Davis Community Housing Authority
- Open Doors

Most agencies have the capacity to travel to participants in order to provide access to CE.

**Evaluation of Effectiveness**

CE/LHCC reports distributed by the UHMIS team are to be reviewed monthly, or as available, as part of evaluating the effectiveness of the CE process.

*Iron County  
Coordinated Entry Policy & Procedure  
Local Addendum*

**LHCC Membership**

Iron County LHCC is an impressive group of individuals and representatives of local organizations who are active and intentional in the coordinated effort to eliminate homelessness. The Iron County LHCC Summary Report is reviewed annually and updated as members are added or changed.

**Sub-Committee**

The Iron County LHCC has created a sub-committee to serve as the Coordinated Entry committee. The LHCC Coordinated Entry Lead is Lee Larson from Iron County Care & Share. The other members of this committee are: Cindy Rose (Five County Association of Governments) and Robyn Lewis (Canyon Creek Women's Crisis Center).

**Leverage Local Attributes and Capacity**

Leveraging grants: TANF-RRH, ESG-RRH, PAHTF, Private and Community sources.

**Centralized Access**

The Iron County LHCC covers a wide geographic area, much of which is rural but there are access points throughout this area and available 24 hours to individuals and families in need of housing and/or services. Those access points are the Iron County Sheriff's Department, Beaver County Sheriff's Department, Iron County Care & Share Shelter, Canyon Creek Women's Crisis Center and IHC Hospitals in Cedar City and Beaver. Each of these access points have posters and advertisement and are in communication with CoC and ESG recipients able to utilize a comprehensive and standardized assessment tool. Access points are also advertised on the LHCC website, SUU campus, Five County Association of Governments, Southwest Behavioral Health Center, Cedar City Police Department, Iron County Sheriff's Department, Beaver and Millard County Sheriff's Department and by flyers placed in public areas throughout the County. The general public can drop-in or call the Iron County Care & Share or the Women's Crisis Center (in cases of domestic violence) for assessment or shelter.

**Communication/Coordination between agencies SSVF-HVF and VA**

Veterans seeking assistance with services and/or housing can be connected to Social Services for Veterans and their Families (SSVF), Homeless Veterans Fellowship (HVF) through the Iron County Care & Share who will then introduce them to the representatives for those organizations. Brad Evans, representing HUD-VASH/Veterans Justice Outreach is available at Iron County Care & Share on a bi-weekly basis. Brad is also a member of the Iron County LHCC.

**Assessment Process**

Iron County LHCC uses the VI-SPDAT and SPDAT (vulnerability index-service prioritization decision assistance tool) to facilitate our assessment process in achieving fair, equitable, and equal access to services within the community. This tool is consistent with CoC and ESG written standards. Those staff persons and organizations using this tool are trained and required to attend regular trainings to continue to be proficient with the tool and stay updated with changes to the system.

### **Housing Placement Prioritization**

Iron County LHCC Coordinated Entry follows the Housing First model in an effort to effectively serve the most vulnerable in our area through the coordinated entry process. This process determines and prioritizes which individuals and families will receive rapid-rehousing, homeless prevention rental assistance, permanent supportive housing assistance or light touch assistance (ie: deposit assistance only). During the assistance period, the Iron County's ESG and TANF RR grant recipients calculate the client's portion of rent according to their income and ability to pay. Attention to future self-sustainability is always paramount and training the client to budget accordingly includes paying an increasing portion of their rent not to exceed 30% of their adjusted gross income.

Unfortunately, Iron County's rental availability is inadequate for the present population due to an increase of SUU students. Students occupy most of the studio and one-bedroom rentals which are the more affordable for the most vulnerable individuals and families. This trend is not likely to change in the immediate future but the Iron County LHCC has among its membership developers, real estate agents, property managers and local city council members who are actively involved in developing future affordable housing.

### **Marketing**

The Iron County LHCC recipients of CoC, ESG and TANF grant funds affirmatively market housing and supportive services to eligible persons regardless of race, color, national origin, religion, sex, age, familial status, handicap, chronically homeless, youth, survivors of domestic violence or those unable to physically present to the access points. The CE Lead is able to drive to outlying areas, domestic violence shelters, hospitals and homes for assessment and subsequent services. This provides fair and equal access to the coordinated entry process.

### **Diversion Assessment Agency & After Hours Diversion Assessments**

Iron County Care & Share is a 24/7 shelter as is Canyon Creek Women's Crisis Center and are designated as diversion agencies. Both of these agencies have individuals trained in diversion assessment and are available at any hour and day. The Iron County CE lead is also available to outlying areas for assessment.

### **Safety Planning**

Iron County LHCC has a crisis shelter and a hotline available 24/7 for individuals or families in a domestic violence situation. Coordinated entry is available at any time and there is in place written policy and procedures that address the immediate issues and the long term stability support. Coordinated assessment with the crisis organization and other resources within the LHCC are treated with the utmost confidentiality. Those individuals and families experiencing domestic violence have safe and confidential access to the coordinated entry process. Names are not used, only client numbers when posted to the housing list. Coordination with other LHCC resources is only through signed release forms (ROI) specific to the client's need.

### **Street Outreach**

Iron County LHCC participates in the annual Point in Time count as required and also reaches out on a regular basis to those living in areas not meant for human habitation. Outreach includes supplying those individuals and families with basic necessities but also an opportunity to be housed through the same standardized process as persons who access coordinated entry through site-based access points. Iron County Care & Share also performs "well-check" for camps to be sure that people are safe.

## **Benchmarks**

For monthly reports, System Performance Reports, Data Quality Reports Prescreen, full assessment and placement in process are within the reasonable range on the HMIS Housing Prioritization List as a result of close communication with the case managers of Iron County Care & Share, Canyon Creek Women’s Crisis Center and Five County Association of Governments who meet regularly and discuss client need.

## **Status changes in UHMIS**

The LHCC has agreed that the time period for clients to remain on the housing list will be as follows:

- Disappeared/Unknown: 60 days from date of assessment. Diligent attempts will be made to contact the client during that period of time.
- Placement in Process: as needed. These clients have secured funding for housing and are in the process of locating and moving into the home.
- Inactive: Incarceration, Client self-housed, assessment date exceeds 90 days or a change in the family composition.

## **LHCC Evaluations**

The Iron County LHCC reviews the “LHCC Summary Report” quarterly and makes adjustments as needed. This report is also a tool for adding members and enlarging the pool of resources. Sub-committees are created as projects are initiated. The Iron County LHCC CE Committee will meet annually to review the CE Policies and Procedures and the local addendum.

## ***Mountainland LHCC Coordinated Entry Policy & Procedure Local Addendum***

### **Local Addendum**

The Mountainland Continuum of Care coordinated entry system (CES) follows the characteristics outlined by HUD’S Opening Doors strategy and the recent publication on HUD’S Core Requirements for Coordinated Entry Systems. The following addendum outlines the specific ways the Mountainland Continuum of Care, as its own LHCC, implements these requirements.

### **CES Subcommittee**

The CoC has operated a Coordinated Support Services Committee that has met on a biweekly basis since the summer of 2015, and will act as the CES committee for our LHCC. This committee maintains and case manages the by-name list with the CoC’s CEA lead. Each direct-service agency within a county area provides one representative to meet with this group. These representatives typically include lead case managers from public housing authorities, non-profits that lead street outreach (this team surveys the area several times a week), veterans, and family services. An MOU discussing confidentiality and purposes of the committee was agreed to and signed by executives of each agency. This group is established in Utah County and another began for Wasatch/Summit counties in the winter of 2016. These groups make comments about the coordinated entry and assessment process and inform their organizations on policies and best practices.

### **Leverage Local Attributes and Capacity**

Other leveraging funds for our CES include TANF-RRH, PAHTF (diversion funds and emergency shelter), SSVF, and a private fund called the Utah County Housing First Fund (focuses on direct housing costs, diversion, and veterans' emergency shelter).

### **CE Lead Contact/Grievance Process**

Our CoC will allow clients to contact our Continuum of Care Program Coordinator via email if they need to report a grievance with any CoC agency, particularly for reasons of discrimination. This information will be provided to clients at service provider agencies, with the 2-1-1 call center, and on the Continuum website.

The MCoC established a CoC-wide grievance process in 2017 that will be applied for general grievances in the coordinated entry and assessment process: "The CoC must act if a service provider is reported for denial of services to a client based on sexual orientation or gender identity. First, if an act of discrimination is reported to CoC staff, the Executive Director will be sent a notice of discrimination within three business days of the report. The organization will then be given ten business days to create a report on how they either 1) made restitution with the client, or 2) found defensible evidence for denial of services. If the CoC staff find that the denial of services to the client was wholly or in part due to sexual orientation or gender identity, and that no effort for restitution had been made to the client, they will be reported to Utah's Fair Housing Antidiscrimination and Labor Division. If restitution is not made, organizations will be noted in monitoring findings and subject to discontinuance of future funding." This grievance process will be followed for any discrimination in the CEA process on the basis of age, sex, race, ethnicity, religion, creed, disability, sexual orientation, familial status, or natural origin in accordance with all state and federal regulations.

### **Communication/coordination between agencies for SSVF/HFV and VA**

The CoC has maintained ongoing relations with Homeless Veterans Fellowship, the CoC's SSVF/HFV provider, and the VA since Fall 2015. They have attended committee meetings and have been present for outreach in the CoC area biweekly or monthly. Representatives from each agency will continue to serve on the Utah County CSS committee and is committed to do outreach with the Wasatch/Summit CSS committee monthly. They are both enrolled and engaged in HMIS.

### **Housing Placement Prioritization**

The MCoC LHCC is committed to a housing first approach, where ideally the most vulnerable clients are prioritized for housing resources first. As many other areas in the state, Utah, Wasatch, and Summit counties have insufficient units that qualify for housing voucher requirements, and the housing search for voucher holders can extend as long as 90 days. However, our committee, which is composed of both service providers and public housing agencies, are committed to ensure that those who score highest on standardized assessments receive special case conferencing and any available units (particularly LIHTC set-asides) are reserved for these clients first.

The assessment timeline for the MCoC is typically oriented around the first appointment made by the client. Once an appointment with an agency has been made (except for in cases of street outreach, where they attempt assessments during first contact), and live VI-SPDAT is completed with the case worker. Input for the assessment should be done at the time of the appointment

with the client or within the same day of street contact. If the client scores a 9+ on the VISPDAT or 12+ on the FSPDAT, our case workers are expected to complete a SPDAT or FSPDAT within 14 days with the client. If clients continue in services beyond 60 days, a new assessment should be given by their assigned case worker.

The by-name list is reviewed in order of the following groups: 1) SPDAT 40+/FSPDAT 53+ (chronic are highlighted and discussed first, as well those with the greatest length of time homeless and youth), veterans, and if there is any additional time, VI-SPDAT 9+/FSPDAT 12+ and SPDAT 20-39/FSPDAT 40-53. Each client is reviewed in terms of street outreach, their progress in the voucher application process, funding opportunities, and any available units that may be available in the area. The full by-name list is updated every six months.

### **Diversion Assessment**

The designated agency in the MCoC LHCC of diversion is Community Action Services and Food Bank, who operate a diversion program funded by the Pamela Atkinson Housing Trust Fund. This agency operates in all three counties within the LHCC, however the only program that can truly operate diversion is in Provo, Utah. This is because the emergency shelter vouchers provided by private donors are only arranged with motels in Provo. As for other shelters, the Center for Women and Children in Crisis has participated in diversion training and implements diversion principles with clients to divert them to places of safety, and the Food and Care Coalition is currently working with our LHCC to implement diversion with our veteran clients.

### **Outreach/24-7 Access Plan**

Our CoC has created several resources to improve the opportunities for equal access to coordinated entry and assessment in our LHCC geographic area.

*Outreach resource cards.* In 2015, our COC created 2-1-1 housing resource cards that were distributed to all public safety departments, businesses, city buildings, and individuals to offer to panhandlers or persons who claimed to be homeless. On each card included the basic resources, office hours, address, and contact information for agencies that offered emergency services. These were made for both the Utah County and Wasatch/Summit areas. The cards also included the contact information for the 2-1-1 line and CoC website, where clients could find more information about further housing services (and all the available contact points for CE).

*No wrong door approach.* Starting in 2018, clients who wish to engage in CE will be offered a quick assessment at any agency, even if they do not qualify for services. This information will be entered in HMIS and referral will be given to other agencies where the clients may qualify. At this juncture, the clients will be given the VI-SPDAT.

*“After-hours” access.* Clients who wish to engage in CE after-hours may go to the Mountainland Continuum of Care website ([mountainlandcoc.org/gethelp](http://mountainlandcoc.org/gethelp)) to engage in a CE assessment online (virtual VI-SPDAT). This information will be sent to the CoC’s Program Coordinator, who will report on the new names in the following CSS Subcommittee meeting. This resource will be advertised by agencies and will be directed through our local 2-1-1 services by any clients who may call. For those who need help with internet access, a laptop will be available at the Provo City Dispatch Office 24/7.

### **Amount of Rent**

The rapid rehousing programs in our LHCC are primarily operated by Community Action Services and Food Bank, which operates in all three counties of our jurisdiction. TANF RRH typically covers deposit help and up to four months of prorated rental help. Their RRH Program for Homeless Persons, which extends particularly to Summit County for Peace House, a domestic violence shelter, typically covers a deposit and several months of rent. The RRH Youth program, which is co-operated with the Department of Child and Family Services and the youth shelter Vantage Point (Wasatch Mental Health), typically offer clients up to 6 months of assistance. Homeless Veterans Fellowship, how operates the SSVF vouchers for our area, also occasionally offers rapid rehousing assistance for up to nine months to veteran clients who qualify.

### **DV and Coordinated Entry System**

Our LHCC includes two domestic violence shelters, the Center for Women and Children in Crisis Utah County and Peace House in Summit County. The Center for Women and Children in crisis operate in HMIS with a special ID number system that allows them to case conference clients in the by-name list without offering personally identifiable information. Peace House maintains all hard copy coordinated entry assessments in house, but Community Action has access to these files for purpose of housing resource qualification. For those who qualify for housing resources, Community Action inputs these individuals into HMIS without disclosing their affiliation with Peace House. Peace House clients all sign a UHMIS consent form to allow this data sharing to occur for VI-SPDATs.

### **System Performance Reports/ Data Quality Reports**

Our CoC reviews system performance measures quarterly in CoC meetings, and agency-level measures are reviewed and implemented into monitoring visit discussions. DWS HMIS Staff reports are also reviewed monthly in COC meetings in order to ensure that agencies are engaging in timely assessment entry. Proportional placements of the most vulnerable clients are also reviewed within this report.

### **Training plans for case managers**

Our LHCC offers an annual training for all case managers with coordinated entry and assessment policies and standards. This training covers all CE policies and procedures, Fair Housing rules, local resources, and program eligibility requirements. All case managers- new and experienced- are required to attend this training for all CoC-funded programs. All other agencies are invited and encouraged to attend.

### **MCoC CES Evaluation timeline**

The CSS/CE committee will evaluate the efficiency and quality of the CES system every six months in special meeting with the CE lead.

## *Tooele County LHCC Coordinated Entry System Local Addendum*

### **LHCC Membership**

Tooele County Local Homeless Coordinating Council is made up of individuals and representatives from local organizations who are committed and active in the coordinated effort

to eliminate homelessness. The Tooele County LHCC reviews and updates members as they are added and/or removed from the council.

### **Sub-Committee**

Tooele County LHCC has created a sub-committee to serve as the Coordinated Entry Committee. Tooele County's Coordinated Entry Lead is Ivette Trujillo with Valley Behavioral Health / Tooele Resource Center. Other members of this committee consist of: Tooele County Domestic Violence Coalition, Tooele County Housing Authority, Salt Lake Community Action, Valley Behavioral Health and Department of Workforce Services.

### **Leverage Local Attributes and Capacity**

Leveraging grants: TANF-RRH, ESG-RRH, PAHTF, Shelter Plus Care, VOCA, VAWA and private and community sources.

### **Centralized Access**

The Tooele County LHCC covers a wide geographic area, much of which is rural. Tooele County Sheriff's Office and Mountain West Medical Center are both 24 hour access points available to individuals and families in need of housing and/or services.

Valley Behavioral Health Resource Center is the centralized access point for Tooele County. Community partners who refer here include Tooele County Housing Authority, Department of Workforce Services, DCFS, Utah Community Action Program, Skull Valley Band of Federated Tribe of Goshute, Tooele County Dispatch, Mountain West Medical Center, LDS Transient Bishop Team, Tooele County Sheriff, Grantsville Police, Tooele City Police, Stockton City Police, East Wendover Police, Tooele School District, Valley Behavioral Health, Pathways Domestic violence Shelter and Victim Advocate program, Adult Probation and Parole.

### **Communication / Coordination between agencies SSVF-HVF and VA**

Veterans seeking assistance with services and/or housing can be connected to Social Services for Veterans and their Families (SSVF), Homeless Veterans Fellowship (HVF) through the Tooele Resource Center who will then introduce them to the representatives for those organizations. Department of Workforce Services Veteran's Representative/ACE Specialist will also be available by phone or appointment to assist local Veterans.

### **Assessment Process**

Tooele County LHCC utilizes the SPDAT and VI-SPDAT (vulnerability index-service prioritization decision assistance tool) to facilitate our assessment process in achieving fair, equitable and equal access to services within the community. This tool is consistent with CoC and ESG written standards. Staff members and organizations using this tool are trained and required to attend regular trainings to continue to be proficient with the tool and stay updated with changes to the system.

### **Housing Placement Prioritization**

Tooele County LHCC Coordinated Entry follows the Housing First model in an effort to effectively serve the most vulnerable in our area through the coordinated entry process. This process determines and prioritizes which individuals and families will receive rapid-rehousing, homeless prevention rental assistance, permanent supportive housing assistance or light touch assistance (i.e. deposit assistance only). During the assistance period, the Tooele County's ESG and TANF Rapid Rehousing grant recipients calculate the client's portion of rent according to



their income and ability to pay. Attention to future self-sustainability is always paramount and training the client to budget.

Rentals in Tooele County are very high in demand at this time. There are not enough units to fill the need in our area.

### **Marketing**

Tooele County LHCC recipients of CoC, ESG and TANF grant funds affirmatively market housing and supporting services to eligible person regardless of race, color, national origin, religion, sex, age, familial status, handicap, chronically homeless, youth, survivors of domestic violence or those unable to physically present to the access points. Tooele County covers a large geographical area to which the Coordinated Entry Lead is able to drive to these outlying areas to provide fair and equal access to the coordinated entry process.

### **Diversion Assessment Agency & After Hours Diversion Assessments**

Valley Behavioral Health's Resource Center and Women's Shelter are on-call 24/7 and are designated as diversion agencies. Both of these agencies have individuals trained in diversion assessment are available at any time.

A Case manager will implement diversion technique to any individual or family that presents a need of homelessness during the interaction.

If the case manager is able to divert the individual or family to stay with a friend, family, etc. then no other assessment will be conducted.

If the case manager is not able to divert them to an individual or family member for shelter, then the case manager will continue to do VI-SPDAT.

Diversion partners are LDS Transient Bishop Team, Division of Workforce Services, Utah Community Action Program, Valley Behavioral Health Resource Center, Valley Behavioral Health Mental Health, Valley Behavioral Health Pathways Domestic Violence Shelter and the Utah Domestic Violence Coalition.

### **Safety Planning**

Tooele County Valley Behavioral Health has a crisis shelter and a hotline available 24/7 for individuals or families in a domestic violence situation. These individuals are then referred to the coordinated entry lead. Coordinated assessment with the crisis organization and other resources within the LHCC are treated with the utmost confidentiality. Those individuals and families experiencing domestic violence have safe and confidential access to the coordinated entry process. Names are not used, only client numbers when posted on the housing list.

Coordination with other LHCC resources is only through signed release forms (ROI) specific to the client's needs.

### **Street Outreach**

Tooele County LHCC participates in the annual Point in Time count as required and also reaches out on a regular basis to those living in areas not meant for human habitation. Outreach includes supplying those individuals and families with basic necessities but also an opportunity to be housed through the same standardized process as persons who access coordinated entry through site-based access points.

### **Benchmarks for monthly reports, System Performance Reports, Data Quality Reports**

Prescreen, full assessment and placement in process are within the reasonable range on the HMIS Housing Prioritization List as a result of close communication with the case managers of

Tooele County Housing Authority, Pathways Domestic Violence Shelter and Department of Workforce Services who meet regularly and discuss client need.

### **Status Changes in UHMIS**

Tooele County LHCC has agreed to the time period listed below for clients to remain on the housing list.

- Disappeared/Unknown – 60 days from date of assessment. Diligent attempts will be made to contact the client during this period of time.
- Placement in Process – As needed. These clients have secured funding for housing and are in the process of locating and moving into a home.
- Inactive – Incarceration, client self-housed, assessment date exceeds 90 days or a change in the family composition.

### **LHCC Evaluation**

The Tooele County LHCC reviews the “LHCC Summary Report” quarterly and makes adjustments as needed. This report is also a tool for adding members and enlarging the pool of resources. Sub-committees are created as projects are initiated. The Tooele County LHCC CE Committee will meet annually to review the CE Policies and Procedures and the local addendum.

## *Uintah Basin LHCC Coordinated Entry System Local Addendum*

### **Sub-committee**

The Uintah Basin LHCC has created a sub-committee to serve as the Coordinated Entry Committee. Representatives from UBAOG, Northeastern Counseling, Roosevelt City Housing, and Women’s Crisis Center make up the CE sub-committee. Fran Harding is the CE Lead. Any changes to the lead will be reported to the collaborative applicant for updates on public website.

### **Leverage Local Attributes and Capacity**

- **Leveraging grants: PAHTF RRH, COC RRH, TANF RRH, CSBG, Private Sources**

### **Training**

UBAOG CSBG staff have received Diversion, VI-SPDAT and SPDAT training. Yearly HMIS trainings will be provided by UHMIS. SPDAT training will be offered yearly by Julie Sloan an org.code designated trainer. CE members will receive training upon request.

### **Basic underlying assumptions**

- When funds are available, UBAOG case managers will pull from the top of the housing prioritization list for placement.
- Survivors who present at a DV shelter will be referred to UBAOG for VI-SPDAT/Full SPDAT assessment.
- UBAOG will conduct VI SPDAT and FULL SPDAT for those who present unsheltered but are not DV.
- Households with children should receive the family versions of the VI-SDPAT Pre-Screen and SPDAT.

- Coordinated assessment follows a housing first philosophy, meaning provider actions and program policies, in as much as is possible, should facilitate barrier-free housing placement.

### **Community Procedures**

#### **VI-SDPAT**

- a. When an individual or household **presents as unsheltered** (living on the streets, in a car, shed, camp trailer with no heat or running water, tent or other place not meant for human habitation), staff will:
  - iii. Conduct VI-SPDAT or F-VI-SPDAT in the UHMIS database
  - iv. Make an appointment for the client(s) to return within 7 days
  - v. Conduct a FULL-SPDAT upon return, so as to add them to the Housing First List
- b. Note: If a client scores less than 5 on the VI-SPDAT Pre-Screen and remains homeless or in shelter for an additional 14 days, the client should be reassessed with the VI-SDPAT Pre-Screen.

#### **SPDAT**

- c. The highest scoring clients on the VI-SPDAT Pre-Screen will receive a full SPDAT assessment first until all clients scoring 5 or higher on the VI-SDPAT Pre-Screen receive a SPDAT assessment.

#### **Community List**

- d. List is pulled at 8:00 a.m. every other Monday for the CE meeting at 9:00 a.m.
- e. The senior UBOAG Case Manger will extract the scores from ClientTrack and compile all data as a single community list that will be presented at the CE meeting
- f. This list will allow all agencies to identify highest-acuity clients and work together to end their homelessness and connect them to adequate supportive services.

#### **Housing Placement**

- g. When a program has a placement available, they will contact the highest scoring/acuity individual/household from the list or contact the agency associated with that alias to identify if the individual is interested in participating in the open program. If there are other programs available, the client should have the option to identify which placement would best meet their needs and interests.
- h. Standard eligibility for the program should be conducted and documentation compiled with help and communication from the agency staff member that conducted the full SPDAT with the client.
- i. Upon the date of move-in the new case manager will conduct another full SPDAT assessment followed by interval re-assessments and use the information to formulate a case plan and share progress with the client.

- j. Once the client is placed, the placement should be reported to the Senior Case Manager who will change their status on the community prioritization list, so they no longer show up as needing housing.

### **Other changes in client status**

- k. Other changes in a client's status on the coordinated assessment list may be made as needed. Again, these will be reported to the Senior Case Manager to update the status on the master list. The date of status change and date of reporting the change should both be included in this reporting.

### **l. Status change**

1. Full SPDAT Assessed – persons with this status constitute the community prioritization list that should be drawn from both for housing placement and provider coordination/dialog.
2. Pre-Screen Assessed – this status shows those who should receive a full SPDAT assessment.
3. Placement in Process – For those who have been issued a voucher or been assigned to a program, but have not leased or found a placement just yet.
4. Placed – indicate the type of housing placement; friends and family, permanent supportive housing, rapid rehousing, self-housed, transitional housing, veteran housing, self-housed or other.
5. Death – for clients who should be removed from the prioritization list due to death.
6. Not Recommended for Housing-for clients that score 3 or less on the VI SPDAT
7. Unknown/Disappeared – for clients who have been out of contact for 60 days or more and providers have tried all available avenues to contact them prior to giving this status.

### **Veterans**

VA representative will call in to scheduled CE meetings and attend LHCC meetings.

### **Outreach**

Outreach to those experiencing homelessness in the Uintah Basin is done through several methods listed.

- **Annual Point in Time Count**

- UBAOG serves as the lead agency on the Annual Point in Time Count. We recruit volunteers from the community and other service agencies to canvas the large geographical areas that is Duchesne, Uintah, and Daggett Counties.

- **Street Outreach**

- Agencies in the Uintah Basin that are participating in CE all have individualized outreach plans. Some participating agencies have outreach plans tailored to meet

the needs of specific sub-populations including, but not limited to, veterans, families with children and survivors of domestic violence. Outreach activities may include canvassing the geographic area covered by the LHCC, bringing food/clothing/hygiene supplies to those known to be experiencing homelessness or traveling to camps as referred by individuals or other agencies. Those experiencing homelessness who are contacted via outreach are offered connection to the CE process and, whenever possible, are assessed using the VI-SPDAT or F-VI-SPDAT.

- **Agency Outreach**

- The Turning Point homeless shelter located in Vernal serves as the only non DV shelter in the Uintah basin. Representatives there have been trained in CE and are currently administering paper VI-SPDAT's on all homeless clients. A representative from UBAOG is assisting the shelter in entering the VI-SPDAT's and performing full SPDAT's into UHMIS on a weekly basis.
- Roosevelt City Housing Authority and Northeastern Counseling case managers in Roosevelt, UT have been trained in CE and ClientTrack, and are conducting VI-SPDAT's on their clients who present as literally homeless.
- Women's Crisis Center case managers in Vernal, UT have been trained in CE and ClientTrack. They can conduct VI-SPDAT's at their location or refer their clients to us and we schedule a time to meet with them to conduct the CE process.
- Vernal Housing Authority/Myton City Housing Authority are not currently participating in CE, but ongoing dialogue is happening to facilitate the CE process for their literally homeless clients.

- **Community Education**

- Given the large geographical area of the Uintah Basin and only having 1 small homeless shelter, emphasis is put on educating community members about other available community resources. This is done through coordination among LHCC-participating agencies as well as non-participating agencies and distribution of information to community members and organizations/businesses such as libraries, hospitals, food pantries, local governments and local housing authorities.

### **Rapid Re-housing**

Rapid Re-housing rent is paid at 100% for move-in. Any additional month's rental assistance will be determined on a case by case basis, but will never be more than 30% of the family/individuals NET monthly income. Max assistance per family/individual, depending on program used, is \$2000 - \$6000 or 4-6 months, whichever comes first.

### **Evaluation**

- Client Surveys- Clients are provided survey materials to evaluate the CE process in the Uintah Basin Area.

CE/LHCC reports distributed by the UHMIS team are to be reviewed monthly, or as available, as part of evaluating the effectiveness of the CE process

***Washington County  
Coordinated Entry Policy & Procedure  
Local Addendum***

**Sub-Committee**

The Washington County LHCC has created a sub-committee to serve at the Coordinated Entry committee. The LHCC Coordinated Entry Lead is Toni Tuipulotu, at Five County Association of Governments – Community Action Partnership. The other members of this committee are: Maren Fisher (Switchpoint Community Resource Center), Brenda Evans and Heather Tuttle (DOVE Center), Becky Workman (St. George Housing Authority), and Sheri Dominguez (WA County Attorney's Office-Justice Reinvestment Initiative).

**Leverage Local Attributes and Capacity**

Leveraging grants: CSBG, SSBG, TANF-RRH, Private sources, PAHTF, VOCA

**CE Lead contact info with in the LHCC**

Hang up posters that give the protocol to file non-discrimination complaint at all access points. 1 year goal of the Washington County Coordinated Entry Committee is to create a brochure that can be handed to a person who would like to file a grievance. Complaints will be given to Toni Tuipulotu, who will include Matt Loo and Jimi Hughes. Then onto DWS.

**Communication/Coordination between agencies SSVF-HVF and VA**

Social Services for Veterans and their Families (SSVF) and Brad Evans (HUD-VASH vouchers & Veterans Justice Outreach) currently attends the Human Services Case Manager's meeting at least every other month. Both of these agencies participate consistently and work well with our homeless veterans. SSVF and Brad Evans also communicate well between each other. Both agencies also go to Switchpoint Community Resource Center to find homeless veterans they're not working with, as well.

**Housing Placement Prioritization**

WA County Coordinated Entry follows the Housing First model in hopes to effectively serve those in the most need. Like most other areas in the nation, Washington County is severely deficient in affordable units, therefore, it takes a while to find affordable housing for those receiving funding. If an individual/family has a housing opportunity that falls within the RRH or PSH scores, they can then receive the funding to move in at that time AS LONG AS a discussion with the WA County Coordinated Entry group occurs prior to the individual/family being placed. This discussion can/may happen at the monthly Human Services Case Manager's meeting, when the HMIS Housing Prioritization List is reviewed and edited. Other funding sources need to be available to the households that are scoring higher than the individual/family being placed. Due to the lack of affordable housing and occupancy rates in Washington County, the Washington County Coordinated Entry group would like to free up a shelter bed and get someone housed that is towards to the top of the list as expeditiously as possible. Each participant will be referred to the service provider that will be providing the COC housing funding to them. Washington County has a referral ROI template that is used for the referral. If the general ROI template isn't used, best practice is to at least email or call the service provider client was referred to.

### **Diversion Assessment Agency & After Hours Diversion Assessments**

Switchpoint Community Resource Center (CRC) and DOVE Center are our designated diversion agencies. Switchpoint CRC may admit individual/family into shelter for the night, then the diversion assessment is completed in the morning. DOVE Center may admit an individual/family into shelter. A family advocate meets with them within 48 hours to complete diversion, if circumstances allow in consideration of trauma. If an individual/family reach out to Five County Association of Governments for housing, diversion may be completed at that time.

The WA County CE lead is also willing to drive to outlying areas in order for those experiencing homelessness to be assessed.

Currently, the Washington County resources for diversion activities are Salvation Army, private sources (for safety transfers), and UDVC also has some funding to relocate to rural areas. In rare cases, the LDS Transient Bishops/Elders may help with diversion activities, as well.

### **Outreach Plan**

Non-access points, in Washington County, who hear about unsheltered people may call Switchpoint Community Resource Center or Five County Association of Governments – Community Action to complete the coordinated entry assessments. St. George Housing Authority, Southwest Behavioral Health Center – Justice Reinvestment Initiative (JRI), WA County Attorney's Office (JRI), and DOVE Center are able to complete assessments with walk-in individuals/families, upon availability of time. Although some agencies work solely with sub-populations, Switchpoint Community Resource Center and Five County Association of Governments-Community Action are able to do assessments with anyone.

Access points/Coordinated Entry description is listed on the Five County Association of Governments – Community Action and DOVE Center websites. Switchpoint CRC is currently working on adding access points to their websites. 2-1-1 also has homeless individual/families contact Switchpoint CRC for access to coordinated entry. Brochures about local homeless services are also disseminated throughout Washington County (including police departments, sheriff's department, drug court trackers, Adult Parole & Probation, etc.)

Sub-populations: DOVE Center is working primarily with the domestic violence sub-population. JRI is working primarily with those exiting incarceration, those with high criminal background barriers, and/or involved in drug court, as their mission is to reduce incarceration recidivism. St. George Housing Authority primarily works with those wanting to access housing vouchers and other housing programs. Both SSVF and Brad Evans (case manager for the HUD VASH vouchers) work with our homeless veterans. Switchpoint Community Resource Center and Five County Association of Governments – Community Action Partnership are able to work with all other sub-populations, except youth. Utah Youth Futures is currently working towards a location in St. George. Utah Youth Futures plans to work with the youth experiencing homelessness. % / amount of rent

The Washington County COC and ESG grants calculate client rental portion as the highest of 10% of the gross income or 30% of adjusted gross income, whichever is higher.

### **DV permissions (ROI) to Coordinated Entry Lead**

Individuals and families who are entered into the Coordinated Entry system may sign a Release of Information (ROI) just for the CE Lead so that the CE Lead can coordinate and notify the DV shelter when that person is chosen for funding. The ROI is a DOVE Center ROI, where the client must set end dates and specifics about what can be released and for how long. This system has been working very effectively, so much so that many DOVE Center clients have been housed with Rapid Rehousing in Washington County for over a year.

## **Benchmarks**

For monthly reports, System Performance Reports, Data Quality Reports

The 8/31/17 LHCC Summary Report reads 314 people were in need of a full assessment. WA County LHCC would like to see under 175 people on this list by 8/31/18 (55% decrease). Our plan to obtain this goal: Review and update the HMIS Housing Prioritization list every month. This includes full assessment, prescreen, and placement in process lists. One special focus of doing this is to also place people as housed as soon as possible to get those who are housed off these lists. Following this plan should also decrease the "current placement in process" and "current placement in process, top 25<sup>th</sup>%". The "average days from status change to data entry" should improve.

The WA County LHCC will review the "Washington County LHCC Summary Report" every 3 months to ensure the data looks correct. Toni Tuipulotu will request to have this added to the agenda every 3 months.

1. Training Plan for Geographic area, identifying entry points

There are 6 entry points in WA County:

- Switchpoint Community Resource Center,
- DOVE Center,
- Five County Association of Governments – Community Action,
- St. George Housing Authority,
- JRI at Southwest Behavioral Health Center
- JRI at WA County Attorney's Office (coming soon).

If other agencies would like to become an access point, the WA County CE group will support and train them in local addendum, as needed. Currently, there is 1 staff member, who is a case manager, at Southwest Behavioral Health Center, who has been SPDAT trained. There is a plan to invite this person to be part of the Coordinated Entry System for Washington County. There is 1 social worker at Intermountain Health Care, Clint Hughes, who is aware of/participates in the coordinated entry system with Washington County.

All access points currently use the VISPDAT, VIFSPDAT, SPDAT, and FSPDAT to move people through the coordinated entry system. All access points will have at least 1 SPDAT trained staff member to enter homeless individuals/families into the Coordinated Entry system on HMIS. Staff members chosen to be SPDAT trained will be SPDAT trained within 60 days after being hired. The staff member contact information will be provided to the CE Lead and will get invited to the WA Co CE Meetings.

## **Annual trainings for all access point staff members**

CE lead reminds all access point staff members at LHCC to do the refresher VISPDAT and SPDAT trainings. LHCC and CE will work together identifying those staff members that need the update, as well as those that have completed it, through communications with the HMIS team at State Community Services Office (SCSO). The SPDAT refresher course will be offered through the HMIS team with DWS.

## **Status changes in UHMIS**

- **Placement in process:** for those that have a funding spot and are currently looking for housing.
- **Disappeared/unknown:** If a client leaves a shelter and doesn't tell anyone where they are going, they will be removed from the list after 60 days, with several attempts of communication, with the client (email, mail, phone, texting all count as a 1 contact) over a 60-day period.



- **Inactive status:**

- A client leaves the county, unless they're placed outside of the county (put as placed).
- The assessment is more than 160 days old.
- Change in family composition, then complete a new assessment.
- If a client goes (or went) to jail and they will be there longer than 90 days. If a client is going to stay in jail less than 90 days and returning to homelessness, keep them on the HMIS list.

### **LHCC Evaluations**

The WA CO LHCC will review the "WA LHCC Summary Report" quarterly in LHCC meeting. Issues or changes will be addressed. Toni Tuipulotu will handle any issues with HMIS reporting, other changes within the system will be addressed by each access point staff member.

Discussions about effectiveness of Coordination Entry will happen along with the "WA LHCC Summary Report" discussions. Quarterly data integrity and quality reports will be pulled by each agency receiving COC/ESG. The LHCC may look at the aggregate data, discuss ways to improve data, and create a plan to address missing/incorrect data.

WA CO CE Committee will meet annually to review the local addendum and make any needed changes. The meetings will occur after the DWS Homeless Summit (October).

### ***Weber County LHCC Coordinated Entry System Local Addendum***

The Coordinated Entry (CE) process is an approach to coordination and management of a crisis response system's resources that allows users to make consistent decisions from available information to efficiently and effectively connect people to interventions that will rapidly end their homelessness (BOS CE P&P Handbook)

Coordinated entry is a process developed to ensure that all people experiencing a housing crisis have fair and equal access and are quickly identified, assessed for, referred, and connected to housing and assistance based on their strengths and needs.

### **Attendance:**

Homeless Service Providers throughout Northern Utah who receive State or Federal Homeless Funding (e.g. CoC, ESG, Unified Funding) are required to participate in Coordinated Entry.

- Confidentiality – All client information is kept confidential to the CE group in the meeting. When sending emails or correspondences back and forth, the clients HMIS ID will be used or will be sent via password protected email.
- HMIS - Agencies not in HMIS may sign an end user agreement to attend the meetings and participate in coordination. Agencies obtaining placement prioritization lists through UHMIS have already agreed to Agency Partner Agreement for UHMIS which details data security regarding client information sharing.
- Participation – Participation involves (solely) using the Housing Priority List to house homeless individuals and families in their homeless programs. Participation also involves

attending the bi weekly meetings, coordinating with the group, reporting housing data and available resources within your programs.

- Annual Training – All CE participants are required to attend the Weber County annual Coordinated Entry Training completed by the CE lead.

### **Coordinated Entry Meetings:**

Weber County Coordinated Assessment team meets twice a month to discuss clients and programs in Northern Utah. Homeless Providers participating in Coordinated Entry will house homeless individuals and families on their programs based on the clients SPDAT (Service Priority Decision Assistance Tool) score. All available resources will be prioritized and offered to clients at the top of the SPDAT-assessed list, limited only by funding requirements.

- 1st Tuesday of each month – Review of the Housing Prioritization List, Housing availability and client updates.
- 3rd Thursday of each month - Review of the Housing Prioritization List, Housing availability and client updates.

### **LHCC:**

The Coordinated Entry lead will attend all Quarterly LHCC to update the community on the Coordinated Assessment Summary Report and all Data Quality Reports

- Coordinated Entry lead for Weber County:  
Summer Rohwer  
[srohwer.stannes@gmail.com](mailto:srohwer.stannes@gmail.com)  
801-621-5036 ext. 102
- Evaluate the effectiveness of CE via LHCC - The effectiveness of our local CE will be discussed and evaluated on a bi monthly basis at the Weber County LHCC. Data from the LHCC summary report will be passed out and evaluated as well as having a discussion about attendance, issues and any concerns about the process or progress of our CE. Identifying benchmarks and goals will also be discussed and evaluated.

### **Veterans Affairs Coordination via Coordinated Entry:**

Weber County VA Representatives collaborates with the Weber County CE Team by attending the CE meetings and providing services specific to housing. Although the VA Representatives do not administer CE Assessments or have access to HMIS, the VA Representatives work closely with Ogden Housing Authority to coordinate housing through HUD-VASH Vouchers. The VA representatives also collaborates closely with Homeless Veterans Fellowship to ensure all Veterans are identified and service needs are met.

### **Diversion:**

Weber county currently has one agency (Lantern House) currently running a Diversion Program. Diversion Case Management is currently being provided to families who are seeking shelter. Diversion CM's will meet with and evaluate the situation of the family, while helping them seek safe alternatives to shelter. The CM will make arrangements for the family to stay somewhere else temporarily while giving them resources and solutions for permanent housing.

- After Hours – All individuals and families have access to 24-hour shelter services in Weber County. However, there are no diversion services, assessments or case management during weekend or evening hours.
- Delayed Diversion Assessment – Delayed Diversion assessments will occur when families present at the shelter after hours or on weekends.

- Resources for Diversion Activities – Diversion clients will be provided with local resources that meet their current situation and need.

**Outreach Plan:**

WCCE has an organized outreach plan for Weber County while providing specialized outreach efforts to specific populations. Outreach efforts also include identifying and assessing those individuals and families in hopes of getting them to either, come into shelter, or complete a SPDAT for housing resources.

- Chronically Homeless – Efforts to find, identify and house chronically homeless individuals and families is a County wide effort. There are several programs throughout Weber County specific to this population, as well as a continued and ongoing goal to end Chronically Homeless throughout our community.
- Youth - Youth Futures conducts weekly (every Wednesday) outreach services throughout Weber County looking for homeless individuals and providing them with appropriate services (food, clothes, hygiene etc.). CE agencies are encouraged to participate with Youth Futures in their outreach efforts by accompanying them and providing resources and support where needed.
- Veterans - VA conducts outreach services to local agencies (e.g. VA reps are at Lantern house twice a week) and jail systems to catch all Veterans located throughout Northern Utah. Homeless Veterans Fellowship also conducts outreach services to help identify Veterans and link them to the appropriate services.

Rapid Re-Housing Collaboration and benchmarks:

**Domestic Violence and Coordinated Entry:**

Domestic Violence providers in Weber County (YCC) attends the WCCE meetings each month and actively participates in the coordinated entry process. Collaboration and coordination with DV providers have made it possible to rapidly identify and place clients in the appropriate housing solution, while following all local, state and federal confidentiality requirements.

- Confidentiality - DV Client’s information is kept confidential while housing needs are met.
- HMIS - YCC has access to HMIS to complete assessments to participate in CE. The DV client is put under an alias to protect their information. The First name is a code: 15-XXX, the Last name is: YCC (Name of agency)
- Housing Prioritization List – All DV Clients who receive a SPDAT will be placed on the HPL under an alias (#) and will be housed based on their score. After identifying a client that would qualify for a non DV housing solution, the DV case managers will directly refer the DV client to the appropriate agency while never directly releasing any identifying information. The DV client will provide all their own information to the agency providing the housing.

**Benchmarks:**

- LHCC Summary Report
- System Performance Report
- Data Quality Report

**Training Plan for Weber County:**

The CE lead will host a Coordinated Entry Training annually, as well as regular updates and explanations during the LHCC. All participating agencies will keep their case managers trained to complete assessments (SPDATS) as well as having access to HMIS. The CE lead will coordinate trainings with the SCSO office when needed or requested by community partners.

### **Identifying Entry Points into CE System:**

Weber County has several entry points into the CE system. Coordinated Entry can be accessed via 8 different agencies throughout the community. Each agency is trained in conducting SPDATS and has access to HMIS. Our county also has 24-hour 7 day a week access to shelter and resources for individuals and families experiencing homelessness.

## **Appendix J**

### **Coordinated Entry Access Points**

Coordinated entry is an important process through which people experiencing or at risk of experiencing homelessness can access the crisis response system in a streamlined way, have their strengths and needs quickly assessed, and quickly connect to appropriate, tailored housing and mainstream services within the community or designated region. When possible, the assessment provides the ability for households to gain access to the best options to address their needs, incorporating participants' choice, rather than being evaluated for a single program within the system. The most intensive interventions are prioritized for those with the highest needs. The local access points to the coordinated entry system provide the assessment, information and referrals, and other resources to the person seeking housing.

### **BALANCE OF STATE CoC:**

#### **Bear River**

- Bear River Association of Governments – 170 North Main Street, Logan, UT 84321
- CAPSA - 2535 South Hwy 89, Perry, UT 84302
- New Hope Crisis Center – 435 East 700 South, Brigham City, UT 84302

#### **Weber County**

- Weber Housing Authority – 237 26<sup>TH</sup> Street #224, Ogden, UT 84401
- Lantern House – 269 West 33<sup>RD</sup> Street, Ogden, UT 84401
- Ogden Housing Authority – 1100 Grant Ave, Ogden, UT 84404
- Weber Human Services – 237 26<sup>th</sup> Street, Ogden, UT 84401
- Youth Futures – 2760 Adams Ave, Ogden, UT 84403
- Your Community Connection – 2261 Adams Ave, Ogden, UT 84401
- Homeless Veterans Fellowship – 541 23<sup>rd</sup> Street, Ogden, UT 84401
- Family Promise – 340 Washington Blvd, Ogden, UT 84404

#### **Davis County Access Point:**

- Open Doors - 875 E Highway 193, Layton, UT 84040
- Open Doors Clearfield - 1360 E 1450 S, Clearfield, UT 84015
- Davis Behavioral Health - 934 S Main St., Layton, UT 84041
- Safe Harbor Crisis Center - 51 E Mutton Hollow Dr., Kaysville, UT 84037

- Department of Workforce Services - 1290 E 1450 S, Clearfield, UT 84015
- Davis Community Housing Authority - 352 S 200 W, Farmington, UT 84025
- Layton City Police Department - 429 N Wasatch Dr., Layton, UT 84041
- Davis Hospital - 1600 Antelope Dr., Layton, UT 84041
- Davis School District - 45 E State St., Farmington, UT 84025
- Aging Services of Davis County - 22 S State St., 3rd floor, Clearfield, UT 84015
- Davis County Health Department - 22 S State St., Clearfield, UT 84015
- Lantern House - 269 W 33rd St., Ogden, 84401

**Tooele County Access Point:**

- Valley Behavioral Health Resource Center – 38 South Main Street, Tooele, UT 84074

**Duchesne County Access Points:**

- Uintah Basin Association of Governments, located at 330 East 100 South, Roosevelt, UT 84066
- Northeastern Counseling, located at 285 West 800 South, Roosevelt, UT 84066
- Roosevelt City Housing Authority, located at 192 South 100 East, Roosevelt, UT 84066

**Carbon/Emery County Access Points:**

- Southeastern Utah Association of Local Governments, located at 375 South Carbon Ave, Price, UT 84501
- Four Corners Community Behavioral Health – 575 East 100 South Price, UT 84501
- Colleen Quigley Women’s Shelter – Address Anonymous

**Uintah County Access Points:**

- Northeastern Counseling, located at 1140 West 500 South Ste 9, Vernal, UT 84078
- Turning Point Shelter, located at 147 East Main St., Vernal, UT 84078
- Women’s Crisis Center, located in, Vernal, UT 435-781-2264 (24/7 hotline)

**Iron County Access Points:**

- Five County Association of Governments – Community Action Partnership, located at 585 North Main, Cedar City, UT 84721
- Canyon Creek Women’s Crisis Center, located at 95 North Main St. #22, Cedar City, UT 84720
- Iron County Care & Share, located at 222 West 900 North, Cedar City, UT 84721

**Washington County Access Points:**

- Five County Association of Governments – Community Action Partnership, located at 1070 West 1600 South, St. George, UT 84770
- The DOVE Outreach Center, located at 1240 East 100 South #221, St George, UT 84790
- Justice Reinvestment Initiative at Southwest Behavioral Health Center, located at 515 West 300 North, Ste #F, St George, UT 84770
- Switchpoint Community Resource Center, located at 948 North 1300 West, St. George, UT 84770

## Appendix K

1. Templates for assessment data tracking tools (OrgCode):
  - a. Family SPDAT Worksheet
  - b. SPDAT Assessment Worksheet
  - c. VI-SPDAT Client Data