BROWARD COUNTY
FLORIDA
Community Partnerships Division
Homeless Initiative Partnership

Broward Homeless Continuum of Care FL-601: Coordinated Entry Assessment Written Standards

Coordinated Entry Assessment
Written Standards
9/5/2019

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Homeless Initiative Partnership (HIP)

HIP is the State of Florida designated Lead Agency for the Broward County Homeless Continuum of Care (CoC), Homeless Management Information System (HMIS) Lead Agency, HUD CoC Program Collaborative Applicant, CoC Board Coordinator, and performs the administrative functions of the State Designated Local Homeless Coalition. HIP coordinates an array of funding to implement innovative, effective, outcome-based approaches to alleviate homelessness and its causes in Broward County through the Continuum of Care and the HEARTH Act.

Continuum of Care Purpose

The purpose of the Continuum of Care (C0C) is to create a collaborative, inclusive, community- based process and approach to planning for and managing homeless assistance resources and programs effectively and efficiently to end homelessness in the jurisdiction specified by the Department of Housing and Urban Development as FL-601-CoC, in accordance with 24, CFR Part 578, Homeless Emergency Assistance and Rapid Transition to Housing Act (Hearth Act).

Broward County CoC shall align its mission, "A Way Home Plan", to End Homelessness and goals with the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009, the Federal Strategic Plan to End Homelessness, and the United States Interagency Council on Homelessness *Opening Doors* Plan to End Homelessness. Additionally, the CoC shall ensure all shelter providers complete an employment screening that is located in the Homeless Management Information System (HMIS) within the 1st or 2nd engagement at the shelter. This will initiate the process of assessing the employment needs of the individuals so that housing sustainability is more successful. The assessment is located in the appendix of this document. Broward CoC shall set a path to ending homelessness in Broward County by focusing its resource needs on the provision of quality best practice housing focused programs supportive services and employment services located in strong sustainable communities.

Contacts

The Broward CoC oversees a network of housing and service agencies that work together as part of the CEA system to facilitate access to services through designated coordinated entry points. These providers complete assessments specific to the subpopulation by utilizing CoC-mandated standardized processes and intervention tools. The *philosophy* of the system is "no wrong door' approach, however, the CEA has been redesigned to ensure a streamlined systematic approach to ensure designated access points and a standardized and transparent prioritization process. All sites are coordinated as they use the same assessment forms located in the Homeless Management Information System (HMIS), standardized referral process through HMIS in the Zero 2016 virtual referral portal, and individuals experiencing homelessness have equal access to the same set of resources. The CEA system is broken down in three distinctive stages: Multipoint Coordinated Intake and Assessment Process, Employment Assessment, and Housing Placement.

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The Coordinated Entry Assessment (CEA) (Housing, Shelter and Employment)

Diversion: The assessment tools are used to determine each household's housing and service needs. Households that are housed but are unstable or at-risk are eligible for prevention and diversion services, which includes but not limited to: reunification, temporary rent/mortgage assistance, utility assistance, enrollment into the homeless education program and other housing stabilization services.

The Coordinated Entry Assessment (CEA) Shelter

The Program/Project Coordinator with the County will be monitoring the need and process for families to create a more effective Coordinated Entry into Shelters and immediate referrals to Housing.

Outreach/ Coordinated Entry into Shelter for Individuals

In October of 2018, Broward County CoC streamlined access points to shelters that provided our Street Outreach provider TaskForce Fore Ending Homelessness, to become the centralized access point to shelter beds. Although there are multicentral access points that "feed" into Street Outreach, the single point of access is through our Street Outreach. Referrals are entered into HMIS and sent from TaskForce Fore Ending Homelessness to the four shelters, The Salvation Army, Central Homeless Assistance Center, North Homeless Assistance Center and South Homeless Assistance Center. HIP can then track the status of referrals, the reason for declining a referral and other system barriers that may need to be addressed. Other sources that feed

into Street Outreach include, but are not limited to: the Homeless Helpline (helpline); a domestic violence help line (Women in Distress of Broward County); the Broward Behavioral Health Coalition, three (3) Homeless Assistance Centers (HAC), a Safe Haven, and an interfaith community-based shelter network (Salvation Army and HOPE South Florida).

Outreach/Coordinated Entry into Shelter for Families

The Program/Project Coordinator with the County will be monitoring the need and process for families to create a more effective Coordinated Entry into Shelters and immediate referrals to Housing.

Employment Assessment and Placement

During admission in to shelter, employment should be discussed as an end goal in order to make the housing sustainable. Shelter providers are to complete the Employment Assessment with in the first two engagements with the Client. This will help gain an understanding of the Clients employment history, skills, competencies, and needs.

The Coordinated Entry Assessment (CEA) Housing

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

Broward's CEA has **multiple designated access** points to help direct both individuals and families experiencing homelessness to all access points to assist with the appropriate level of housing, a standardized decision-making process, and does not deny services to victims of domestic violence, date violence, sexual assault or stalking services. The CEA system is modeled after a Housing First approach and has migrated from a housing readiness system of care. Additionally, the system is person centered and strengths based.

Broward County CoC will provide a coordinated entry process and will offer multiple access points that are well marketed. All access points will be accessible by individuals experiencing homelessness through designated providers. The coordinated entry process may, but is not required, to include separate access points for HUD determined sub populations to the extent necessary to meet the needs of the following six populations:

- adults without children;
- adults accompanied by children;
- adults first time expecting mothers
- unaccompanied youth;
- households fleeing domestic violence, dating violence, sexual assault,

stalking, or other dangerous or life-threatening conditions (including human trafficking);

HUD's homeless definitions and recordkeeping requirements can be found at: https://www.hudexchange.info/resources/documents/HomelessDefinition_RecordkeepingRequirementsandCriteria.pdf

Employment Initiative

In the 2018 "A Way Home Plan" the CoC Board voted to add a critical element to initiate employment assessment and support at the same time housing assessment was initiating at the Shelters. The assessment is now loaded into HMIS and available for use.

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Approved Access Points

The Broward County CoC has multiple access points through the continuum. Referrals are accepted through those HIP approved access points:

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

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

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

Please See Appendix A for all Standardized Assessments

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

- Adults without children;
- Adults accompanied by children;
- Unaccompanied Youth;
- Households fleeing domestic violence, dating violence, sexual assault stalking or other dangerous conditions (human trafficking);
- Persons at imminent risk of literal homelessness.

Individuals and Families for Housing

Individuals and families (family as defined by HUD) experiencing literal homelessness (categories 1 and 4 as defined by HUD). Applicants should be homeless in Broward County at least 90 days and will be served based on availability of resources and at the discretion of the service provider. Additionally, their current living situation must meet the definition of homelessness according to the Homelessness Emergency and Rapid Transition to Housing (HEARTH) Act. Youth under the age of 21 who are literally homeless will meet the homeless definition for programs funded to serve this population. In Broward County this is Covenant House. Special consideration may be given to victims of domestic violence.

Applicant Rights*:* Applicants have the right to complete a Coordinated Entry standardized housing assessment and have the right to request a Skilled Assessor who speaks their native language or translation services.

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

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

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

Refusals of Housing Assessment: Individuals who do not sign the Release of Information and not complete the assessment, delay or impact their ability to access housing. When assessors encounter individuals, who do not provide a response to any of the first questions, they should stop and acknowledge that the assessment will not provide useful information. The assessor should inform the individual that referrals are not permitted to be sent to service providers without the participants consent. Individuals who are not able to complete either a VI-SPDAT or FSPDAT can request reasonable accommodations which may include the use of TTY: (954)831-3940. If additional assistance is needed, then they may contact the Homeless Helpline through TTY.

When applicants are called by a service provider, they are responsible for responding to the provider and should share if they need supports to connect such as for a housing intake appointment, accessing documents, etc. The service provider should give the applicants five (5) business days and attempt to contact them a minimum of three (3) times. All attempts should be noted in the HMIS system.

The assessments determines client(s) service needs based on HUD's Criteria of Defining Homeless (Categories 1 and 4). Category 4 clients (victim(s) of domestic violence)) are referred immediately to Women in Distress of Broward County, based on availability.

Housing Prioritization

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

The housing eligibility assessment and referral process is built into the Broward CoC Homeless Management Information System (HMIS) to promote accuracy and transparency across service providers. A Release of Information (ROI) is required from all service providers to ensure all providers have access to the individual's information and can provide a consist level of care. The ROI enforces coordination of services and is required before inputting client's information into the HMIS, please see Appendix C. **If the ROI is not completed within the first 24-hour day other providers cannot see information on the client**. It is critical that this is done to avoid duplicate client entries and ensure clients receive the correct services.

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

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

Additionally, HMIS is also used in this process to provide data on client outcomes to case management personnel, housing service providers, and shelter staff service providers to monitor homeless prevention and housing. Finally, HMIS serves as a communication platform for coordinated entry sites to view client placements, share information on the households they serve and reduce duplication. Critical documents are uploaded in the system to assist with the Clients housing process.

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

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Permanent Supportive Housing

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

Program Description	Essential Program Elements	Time Frame	Population	Desired/Expected Outcome
Rental assistance with supportive services for persons who are coming from the street or shelter/interim housing. Majority of programs serve households with a house hold member who has a disabled, but disability requirement with be based on subsidy source requirements.	**Case Management** • Assistance with lease process • Provision of or linkage to: Assessment, Intervention, link to mainstream resources, community building peer to peer and all other services that assist a person in remaining stably housed • Services are voluntary to the clients and are not a condition of the lease • Employment assessment and assistance • Employment training **Rental Subsidy** • Provides a rental subsidy to make the unit affordable • Provide assistance in accessing housing relocation resources/supports (security deposits, utilities, furnishings, etc.) • Ensure coordination between property manager or landlord **Health Care Access** • Wellness services • Physical and mental health services	No time frames	• Any high needs individuals with multiple barriers to housing that is literally homeless (lease-based program) • Specialized eligibility requirements for subsidies including veterans, disable, long term homeless, or domestic violence Prioritizing: Disabling condition and long-term, multiple episodes of homelessness (Vulnerability Index Score of 1 or higher), veterans and other needs factors. Unique Populations: • Families with Children • Elderly	**Outcome: Clients will remain in permanent housing.** 80% of Clients will remain in permanent housing. **Client will increase earned income. Indicators:** Threshold (increasing):56% of all participants have non-employment income. Threshold (increasing): 56% of participants obtain mainstream benefits. Threshold 35% of participants will increase earned income.

Prioritization for Permanent Supportive Housing

Agencies within the Broward CoC have agreed to prioritize clients who are chronically homeless for the Permanent and Supportive Housing (PSH) beds that are not already dedicated to chronically homeless within the CoC as they become open. The following criteria will be followed by all agencies providing this service:

- Housing agencies will hold an open bed for a period of 5 calendar days while searching and make 3 attempts to contact clients who are chronically homeless and document these efforts in HMIS.

- Search methods can include consulting existing waiting lists, contacting Street Outreach, researching last contact in HMIS, contacting local law

enforcement Homeless Outreach Teams (HOT), BBHC and coordinated entry information.

- Agencies will make efforts to help clients who are chronically homeless address program requirement barriers that might otherwise exclude them from qualifying, such as, verification of Chronicity, obtaining an ID, and documentation of disabling conditions.

- If the Individual experiencing homelessness cannot be found within the 5-calendar day time-period, the agency needs to contact the CoC lead agency for more referrals. However, they should continue to search for the individual with the assistance of Street Outreach, researching HMIS and other resources listed above for 14- calendar days prior to closing the referral out as "unable to locate".

- During housing intake, the agency will ensure that the Client has completed an employment assessment in HMIS. If the Client has not done so, the agency will include this in the intake process.

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

1. Prioritizing PSH Beds Dedicated to Serve Chronically Homeless Clients:

   i. Priority – Chronically Homeless clients, with the longest history of homelessness, the most severe service needs and acuity as determined by the VI-SPDAT.
   ii. The type of Permanent and Supportive Housing that is available.

CH + Longest History + Highest Level of Need

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

2. Priority – Homeless clients with a disability and most severe service needs (consider age) who are not Chronic,

   i. Streets, safe havens, shelter for any period including

   ii. Clients exiting an institution where they have resided for less than ninety (90) days and were on the streets, safe have, shelter immediately before the institution

Homeless+ Longest History + Disability + Highest Level of Need

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

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

Housing Navigators: Clients will be referred to the two (2) Housing Navigators through BPHI, who in turn will assist individuals and families to locate and obtain permanent housing. Referrals will be made to the Housing Navigators through HMIS. The role of the Housing Navigators is:

- Provide assistance with housing search
- Work collaboratively with the Housing Case Manager
- Provide resources for housing units

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Housing Prioritization for Rapid Rehousing

Rapid Re-Housing

Program of stabilization and assessment, focusing on re-housing all persons, regardless of disability or background, as quickly as possible in appropriate permanent housing.

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

Clients, as well as veterans who are not eligible for Supportive Services for Veteran Families (SSVF), TIP, and GPO can be referred to RRH program if they express an

interest in the program. Based on the quantity of available units, RRH placement will use the following prioritization process:

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

The Broward CoC Lead generates the HMIS housing placement prioritization wait lists which are reviewed by an assigned CoC By Name workgroup to determine appropriate housing placements.

By Name List Process

Purpose

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

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

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

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

Goal

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

Broward County has five (5) By Name Lists that are monitored at least monthly. These lists include:

1) **Youth:** – review monthly youth ages 18-24 who are experiencing homelessness (literally homeless -HUD categories 1 and 4). This will be a face to face meeting to discuss and prioritize the youth.

   Attendees:

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

2) **Families:** This will be a monthly meeting to review those families identified as experiencing homeless. Family is defined as an adult with minor (under age 18) children. This will be a face to face meeting to discuss and prioritize. Families must be literally homeless (HUD categories 1 and 4).

   Attendees:

   - Broward School
   - ChildNet
   - BPHI North and Central HAC
   - BOC – South HAC

- BPHI Housing
- The Salvation Army
- Hope South Florida
- BCHA
- BHS
- VOA
- CareerSource Broward
- FSAD
- TaskForce
- BBHC
- Camelot
- Gulf Coast
- Henderson
- Silver Impact

3) Chronic: This is a monthly meeting that is face to face to discuss those individuals who are identified as chronically homeless. This meeting will review their status and prioritize placement.

Attendees:

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

4) Individuals (not Chronic): This is a monthly meeting to review those individuals who are not chronic but are high multi-system users. This meeting will be to review their status and prioritize them for placement. These may at time be inclusive of encampments.

Attendees:

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

5) Veterans: This is a monthly face to face and a monthly call.

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

Equal Access Rule (Both Shelter and Housing Providers)

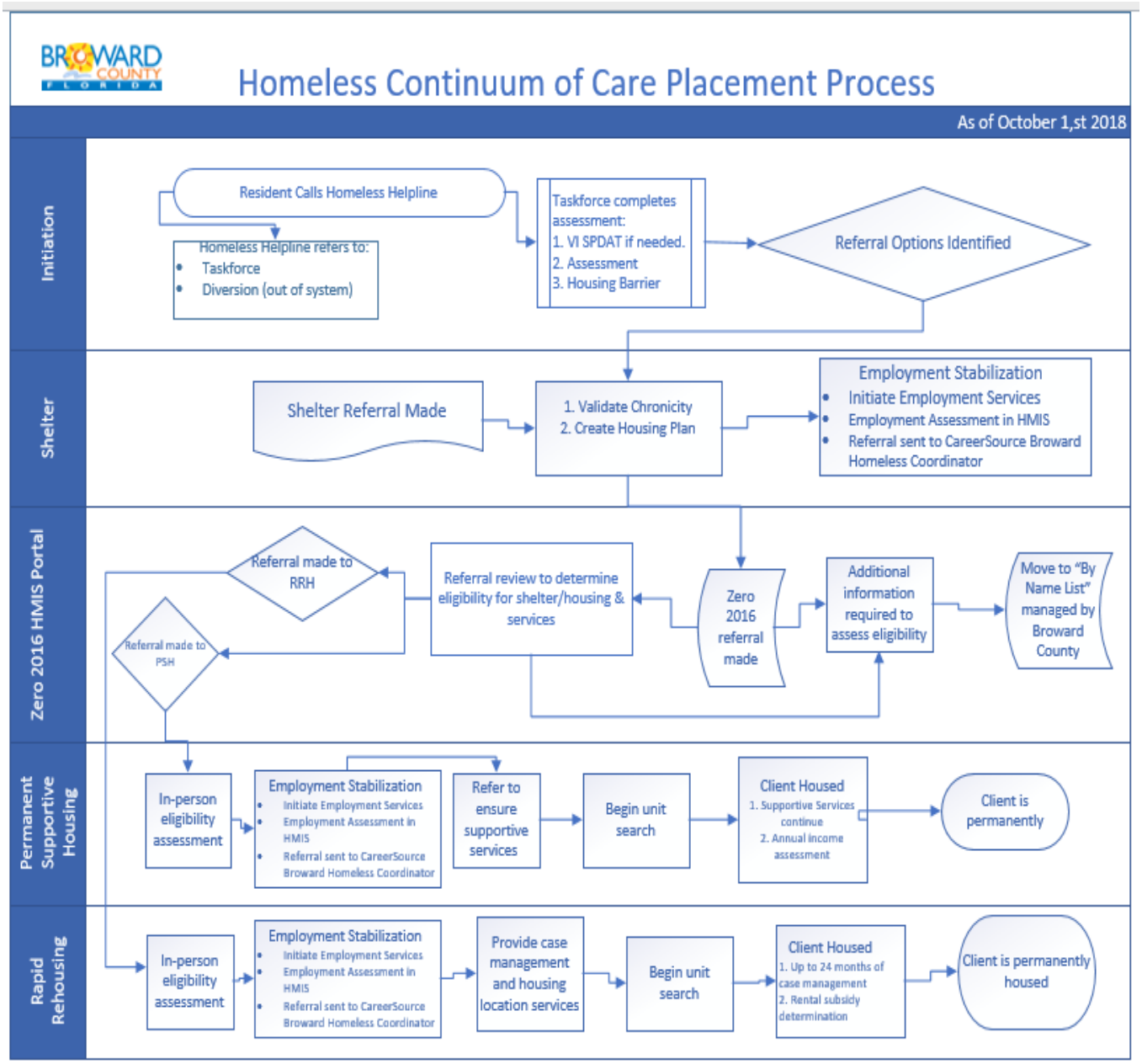
Housing funded by Broward's CoC will be available to individuals and families without regard to actual or perceived sexual orientation, gender identity, or marital status in accordance with "Equal Access to Housing in HUD Programs Regardless of Sexual Orientation or Gender Identity" 24 CFR 5.105 (a)(2).

Nondiscrimination Requirements: All recipients and sub-recipients that participate in the Broward CoC regardless of their funding source and the type of service/housing that they provide must comply with the nondiscrimination provisions of Federal civil right laws, including, but not limited to, the Fair Housing Act, Section 504 of the Rehabilitation Act, Title VI of the Civil Rights Act, and Title II of the Americans with Disabilities Act, as applicable.

CoC Interim Rule

The Continuum of Care (CoC) Interim Rule establishes these coordinated entry assessment responsibilities and minimum requirements for a CoC's coordinated entry assessment in (578.7 (a) (8). The HUD notice, *CPD-17-01: Notice Establishing Additional Requirements for a Continuum of Care Centralized or Coordinated Entry Assessment System* is also incorporated into the CoC's CEA. In addition, HUD Notice CPD-16-11 issued on July 25, 2016, Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing, details the minimum requirements for CoC's to adopt for their written standards.

Multipoint Coordinated Intake and Assessment Process



Process of CEA

Shelter: This process will be updated through the HIP Section of the County.

Individuals:

Street Outreach has multiple locations they engage individuals. An individual can meet with the team who will assess their level of need and prioritize their placement. It is important that individuals work with the team to secure a shelter bed. Due to the need most individuals will not get access to a bed on their first engagement.

Families

The Project/Program Coordinator through HIP will be developing a process that includes not just shelter but housing referrals to expedite families into permanent housing.

Housing

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

I. The staff person who completes the assessments refers the client to the CoC Lead for the appropriate housing intervention (RRH, TH, PSH) and when a shelter placement is available and appropriate the client is referred through HMIS Service Point.
II. As housing program openings become available, the Broward CoC lead prioritizes households through the CEA process, for referral to various programs based on the Housing Placement Prioritization process.
III. The Broward CoC lead sends the referral via HMIS Service Point to the identified agency. This is the Agency that has an opening and can best meet the needs of the individual. Agency staff begins to work with the client to find housing and appropriate support services
IV. After appropriate housing is identified, agency staff administer ongoing assessment, housing placement services and case management as appropriate.

Employment Services

The goal is from initial engagement to ensure individuals are being assessed to determine the best course of action to assist with employment stabilization. Shelter providers will complete the employment assessment in HMIS must be completed to help with the creation of a short-term plan and long-term service plan to address the employment needs. When completed the assessment should be forwarded to the

designated CareerSource Broward Homeless Coordinator after information releases have been signed by the individual.

I. Identifying Those Who Meet the HUD Homeless Definition

The chart below is a tool that provides a quick and simple category determination.

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

II. Housing Components within our Continuum of Care

The **Housing First Model** is an approach to quickly and successfully connect individuals and families experiencing homelessness to permanent housing, removing barriers to entry, such as sobriety, treatment or service participation requirements. Supportive services are offered to maximize retention in the housing program, increase housing stability and prevent returns to homelessness.

- **Permanent Supportive Housing (PSH)**
  - Permanent supportive housing is permanent housing with lifetime rental assistance paired with supportive services to assist homeless persons with a disability or families with an adult or child member with a disability achieve housing stability.
- **Rapid Re-Housing (RRH)**
  - Rapid re-housing provides up to 24 months of rental assistance to move homeless persons and families (with or without a disability) as rapidly as possible into permanent housing. The intention of this program is to provide critical time intervention services, encouraging a return to self-sufficiency.

Employment First (Back to Work)

The CoC believes that employment is a critical element to the success of sustaining housing. Each individual who touches the system must engage in discussions and an assessment regarding employment needs. These assessments should be sent to CareerSource Broward's Homeless Coordinator using the process devised for that purpose.

Transitional Housing (TH)

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

Transitional Housing

Time-limited housing where individuals that are homeless may stay and receive support services, that are designed to enable individuals to move into permanent housing.

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

Housing Providers Role in Coordinated Entry

All agencies in Broward CoC that provide services to those individuals experiencing homelessness must:

- Identify if the housing intervention is PSH, RRH, or TH.
- Housing Providers must notify the Broward CoC Lead when they have open with 2 days of knowledge of that opening. Monthly, housing providers must provide an update on their current housing inventory.
- Housing Providers must follow the Housing Prioritization process for PSH, RRH and TH.
- Matches will be made via the HMIS and the monthly By Name List Meetings.
- Housing Providers will receive five (5) referrals via Zero 2016 for everyone opening/vacancy they have. Referrals will primarily be from the By Name Lists meetings. This helps promote choice on behalf of client referred and the Housing Provider.
- Upon accepting referrals, the Housing Provider will first contact individual and set an intake appointment. All referrals must be addressed (accept, decline and reason) within 5 business days of the referral being sent. Referrals cannot sit without some action being taken within this 5-day period. This should be done with three (3) business days of accepting the referral. They will then contact the Housing Navigator(s) for those clients who are having difficulty finding a unit.
- Housing Providers must communicate to the Broward CoC Lead through HMIS when each match does not lead to successful program entry and provide the reasons why they were not housed so that client(s) can be un-assigned from the HMIS Provider in the HMIS. This must be done using the Pick List in the referral denial in HMIS with 5 days of receiving the referrals. Communication of a referral denial must also be done via email.
- Housing Providers must communicate to the Broward CoC Lead through HMIS when each match leads to a successful program entry via documentation in HMIS; and
- Update the client status in HMIS.
- Affirmatively market their housing and supportive services to eligible persons regardless of race, color, national origin, religion, sex, age, gender identity, familial status, or disability who are least likely to apply in the absence of special outreach, and maintain records of those marketing activities in accordance with 24 CFR 578.93(c).

Housing Placement/Move Ins, Un-assignments & Reexperiences

Housing providers must record move-in dates for the assigned program into HMIS within two business days of acceptance into housing program. Placement date or move-in date acknowledges that the client has a housing subsidy and is actively

looking for affordable housing. The physical location in the assigned unit can take 60-90 days based on housing inventory.

Move-In Date:

- Date of housing move-in, recorded in HMIS under move in date. The move in date is not the date of referral or intake. There is a date of referral accepted, date of intake (process for eligibility) and then the move in date (date the individual gets keys to a unit). These three thresholds are measure by the County and must be completed in HMIS with 3 calendar days.
- Exit date from the program is the date the individual either exited from the unit or became self-sufficient and is no longer in need of services or subsidy or has been discharged from the program.

Emergency Shelter Process for Individuals

- Shelters: Referrals to the four shelter providers are made by our Street Outreach provider TaskForce Fore Ending Homelessness. As of October 2, 2018, the Help Line no longer assigns beds.
  - The three Homeless Assistance Centers (HACs) are strategically placed in North, Central, and South Broward County to provide services to families, single men & women who are experiencing homelessness.
  - The Salvation Army provides low barrier shelter beds for individuals and families.
  - Hope South Florida provides shelter to families only.
  - Admission to shelters is not guaranteed, as there is a waitlist and lottery system.

Emergency Shelter Process for Families

The Project/Program Coordinator at the County will set up a system that operationalizes both families to shelter and housing. Families will have referrals to both types of services simultaneously.

Special Population Emergency Services

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

(Serves women and children fleeing domestic violence)

Homeless Helpline Phone Number

- 954-563-4357 / 954-563-HELP

Record and Financial Recordkeeping Requirements:

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

- Recordkeeping Requirements:
    - All records containing personally identifying information must be kept secure and confidential.
    - Programs must have a written confidentiality/privacy policy and notice a copy of which should be made available to participants if requested.
    - Documentation of homelessness (following HUDs guidelines as mentioned in CPD-16-11. Documentation of Homelessness must follow HUD's guidance, listed below in order of preference below and explained in Appendix D:
        - Literally Homeless (Category 1): third party verification; written observation by an outreach worker; or certification by the individual or head of household seeking assistance stating he/she was living on the streets or in a shelter.
        - Imminent Risk of Homelessness (Category 2): a court order resulting from an eviction action notifying the individual or family they must leave within 14 days; OR for an individual or family leaving a hotel or motel evidence they lack the financial resources to stay; OR a documented written or oral statement that the individual or family will be literally homeless within 14 days AND self-certification or other written documentation that the individual lacks the financial resources and support needed to obtain permanent housing.
        - Chronically Homeless Individuals and Families with the most Service Needs (Category 3): third party verification; written observation by an outreach worker; or certification by the individual or head of household seeking assistance stating he/she was living on the streets or in a shelter.
        - Fleeing or Attempting to Flee Domestic Violence (Category 4): For Victim Service Providers: An oral statement by the individual or head of household seeking assistance which states: they are fleeing; they have no subsequent residence and they lack resources. Statement must be documented by a self-certification or certification by the intake worker.

For Non-Victim Service Providers

For non-victim Service Providers an oral statement by the individual or head of household seeking assistance that they are fleeing. This statement is documented by a self-certification or by the caseworker. Where the safety of the individual or family is not jeopardized, the oral statement must be verified; and Certification by the

individual or head of household that no subsequent residence has been identified; and Self-certification or other written documentation that the individual or family lacks the financial resources and support networks to obtain other permanent housing.

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

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

Financial Recordkeeping Requirements

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

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Quick Reference List

Appendix A VI-SPDAT

Appendix B VI-FSPDAT

Appendix C VI-FSPDAT for Youth

Appendix D Taskforce Assessment

Appendix E Rapid Rehousing Barrier Assessment

Appendix F Employment Assessment

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Vulnerability Index -

Service Prioritization Decision Assistance Tool

(VI-SPDAT)

Prescreen Triage Tool for Single Adults

AMERICAN VERSION 2.01

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

COMMUNITY SOLUTIONS

Welcome to the SPDAT Line of Products

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

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

VI-SPDAT Series

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

Current versions available:

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

All versions are available online at

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

SPDAT Series

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

Current versions available:

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

Information about all versions is available online at

www.orgcode.com/products/spdat/

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

SPDAT Training Series

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

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

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

Current SPDAT training available:

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

Other related training available:

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

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

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

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

Administration

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

Opening Script

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

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

Basic Information

First Name	Nickname	Last Name

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

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

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

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

A. History of Housing and Homelessness

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

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

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

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

B. Risks

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

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

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

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

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

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

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

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

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

C. Socialization & Daily Functioning

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

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

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

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

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

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

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

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

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

D. Wellness

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

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

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

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

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

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

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

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

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

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

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

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

Scoring Summary

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

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

Follow-Up Questions

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

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

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

Appendix A: About the VI-SPDAT

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

The VI-SPDAT

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

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

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

Version 2

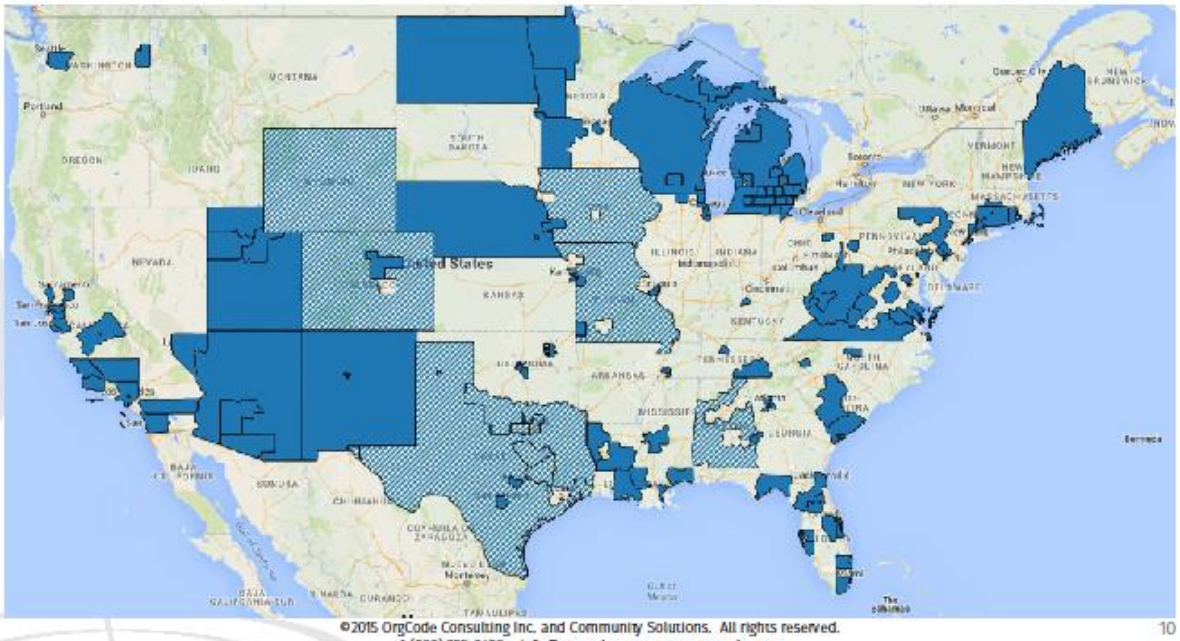
Version 2 builds upon the success of Version 1 of the VI-SPDAT with some refinements. Starting in August 2014, a survey was launched of existing VI-SPDAT users to get their input on what should be amended, improved, or maintained in the tool. Analysis was completed across all of these responses. Further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

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

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

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

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



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

Alabama
- Parts of Alabama Balance of State

Arizona
- Statewide

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

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

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

District of Columbia
- District of Columbia

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

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

Hawaii
- Honolulu

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

Iowa
- Parts of Iowa Balance of State

Kansas
- Kansas City/Wyandotte County

Kentucky
- Louisville/Jefferson County

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

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

Maryland
- Baltimore City
- Montgomery County

Maine
- Statewide

Michigan
- Statewide

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

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

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

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

North Dakota
- Statewide

Nebraska
- Statewide

New Mexico
- Statewide

Nevada
- Las Vegas/Clark County

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

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

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

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

Rhode Island
- Statewide

South Carolina
- Charleston/Low Country
- Columbia/Midlands

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

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

Utah
- Statewide

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

Washington
- Seattle/King County
- Spokane City & County

Wisconsin
- Statewide

West Virginia
- Statewide

Wyoming
- Wyoming Statewide is in the process of implementing

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

Vulnerability Index -

Service Prioritization Decision Assistance Tool

(VI-SPDAT)

Prescreen Triage Tool for Families

AMERICAN VERSION 2.0

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

COMMUNITY SOLUTIONS

Welcome to the SPDAT Line of Products

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

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

VI-SPDAT Series

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

Current versions available:

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

All versions are available online at

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

SPDAT Series

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

Current versions available:

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

Information about all versions is available online at

www.orgcode.com/products/spdat/

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

SPDAT Training Series

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

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

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

Current SPDAT training available:

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

Other related training available:

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

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

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

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

Administration

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

Opening Script

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

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

Basic Information

PARENT 1

First Name	Nickname	Last Name

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

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

PARENT 2

☐ No second parent currently part of the household

First Name	Nickname	Last Name

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

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

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

Children

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

First Name	Last Name	Age	Date of Birth

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

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

SCORE:

A. History of Housing and Homelessness

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

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

SCORE:

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

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

SCORE:

B. Risks

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

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

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

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

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

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

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

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

C. Socialization & Daily Functioning

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

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

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

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

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

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

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

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

D. Wellness

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

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

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

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E. Family Unit

32. Are there any children that have been removed from the family by a child protection service within the last 180 days?	☐ **Y**	☐ N	☐ Refused	
33. Do you have any family legal issues that are being resolved in court or need to be resolved in court that would impact your housing or who may live within your housing?	☐ **Y**	☐ N	☐ Refused	
IF "YES" TO ANY OF THE ABOVE, SCORE 1 FOR **FAMILY LEGAL ISSUES.**				**SCORE:**
34. In the last 180 days have any children lived with family or friends because of your homelessness or housing situation?	☐ **Y**	☐ N	☐ Refused	
35. Has any child in the family experienced abuse or trauma in the last 180 days?	☐ **Y**	☐ N	☐ Refused	
36. *IF THERE ARE SCHOOL-AGED CHILDREN:* Do your children attend school more often than not each week?	☐ Y	☐ **N**	☐ N/A or Refused	
IF "YES" TO ANY OF QUESTIONS 34 OR 35, OR "NO" TO QUESTION 36, SCORE 1 FOR **NEEDS OF CHILDREN.**				**SCORE:**
37. Have the members of your family changed in the last 180 days, due to things like divorce, your kids coming back to live with you, someone leaving for military service or incarceration, a relative moving in, or anything like that?	☐ **Y**	☐ N	☐ Refused	
38. Do you anticipate any other adults or children coming to live with you within the first 180 days of being housed?	☐ **Y**	☐ N	☐ Refused	
IF "YES" TO ANY OF THE ABOVE, SCORE 1 FOR **FAMILY STABILITY.**				**SCORE:**
39. Do you have two or more planned activities each week as a family such as outings to the park, going to the library, visiting other family, watching a family movie, or anything like that?	☐ Y	☐ **N**	☐ Refused	
40. After school, or on weekends or days when there isn't school, is the total time children spend each day where there is no interaction with you or another responsible adult...				
a) 3 or more hours per day for children aged 13 or older?	☐ **Y**	☐ N	☐ Refused	
b) 2 or more hours per day for children aged 12 or younger?	☐ **Y**	☐ N	☐ Refused	
41. *IF THERE ARE CHILDREN BOTH 12 AND UNDER & 13 AND OVER:* Do your older kids spend 2 or more hours on a typical day helping their younger sibling(s) with things like getting ready for school, helping with homework, making them dinner, bathing them, or anything like that?	☐ **Y**	☐ N	☐ N/A or Refused	
IF "NO" TO QUESTION 39, OR "YES" TO ANY OF QUESTIONS 40 OR 41, SCORE 1 FOR **PARENTAL ENGAGEMENT.**				**SCORE:**

Scoring Summary

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

RESULTS

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

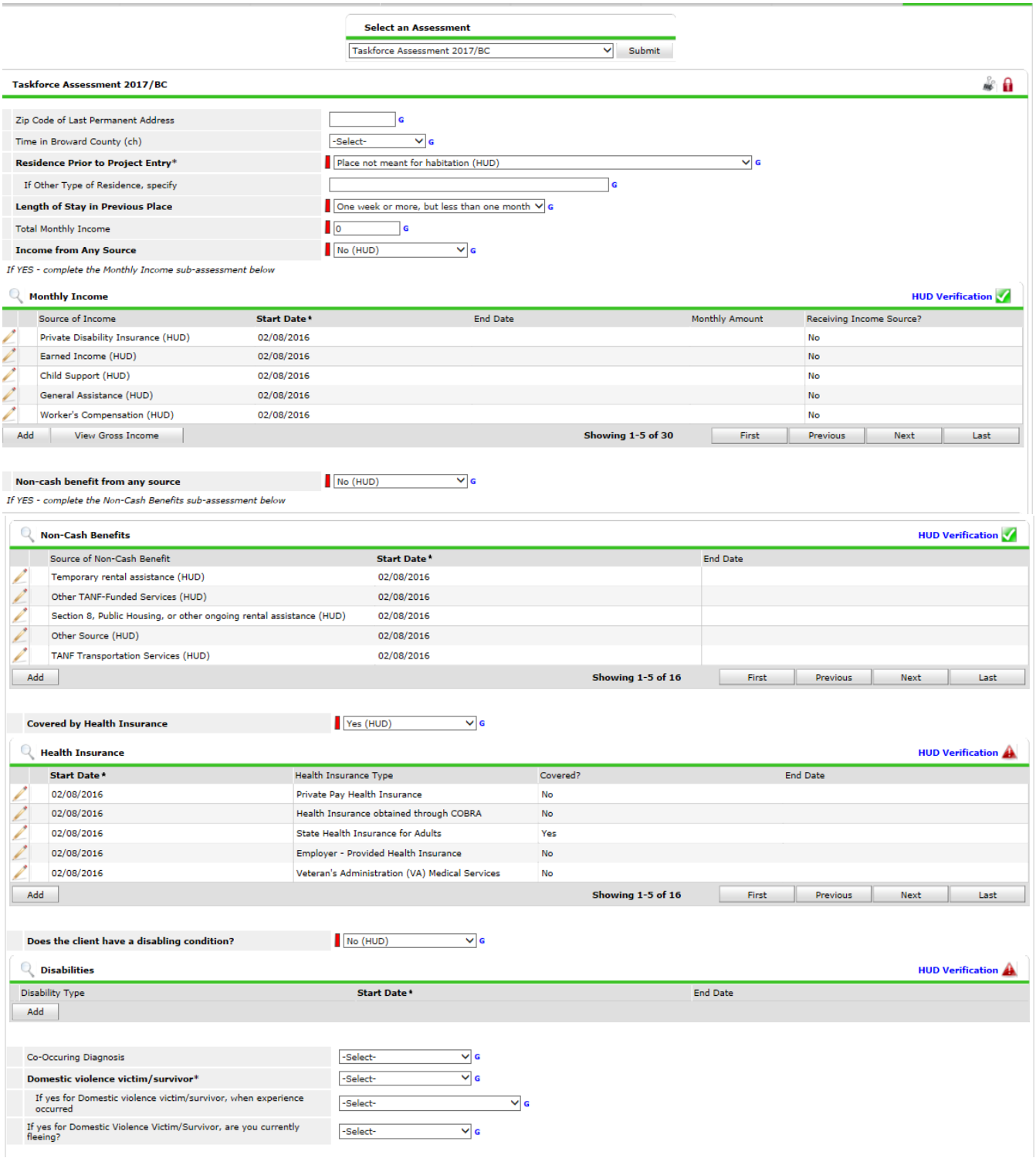
Follow-Up Questions

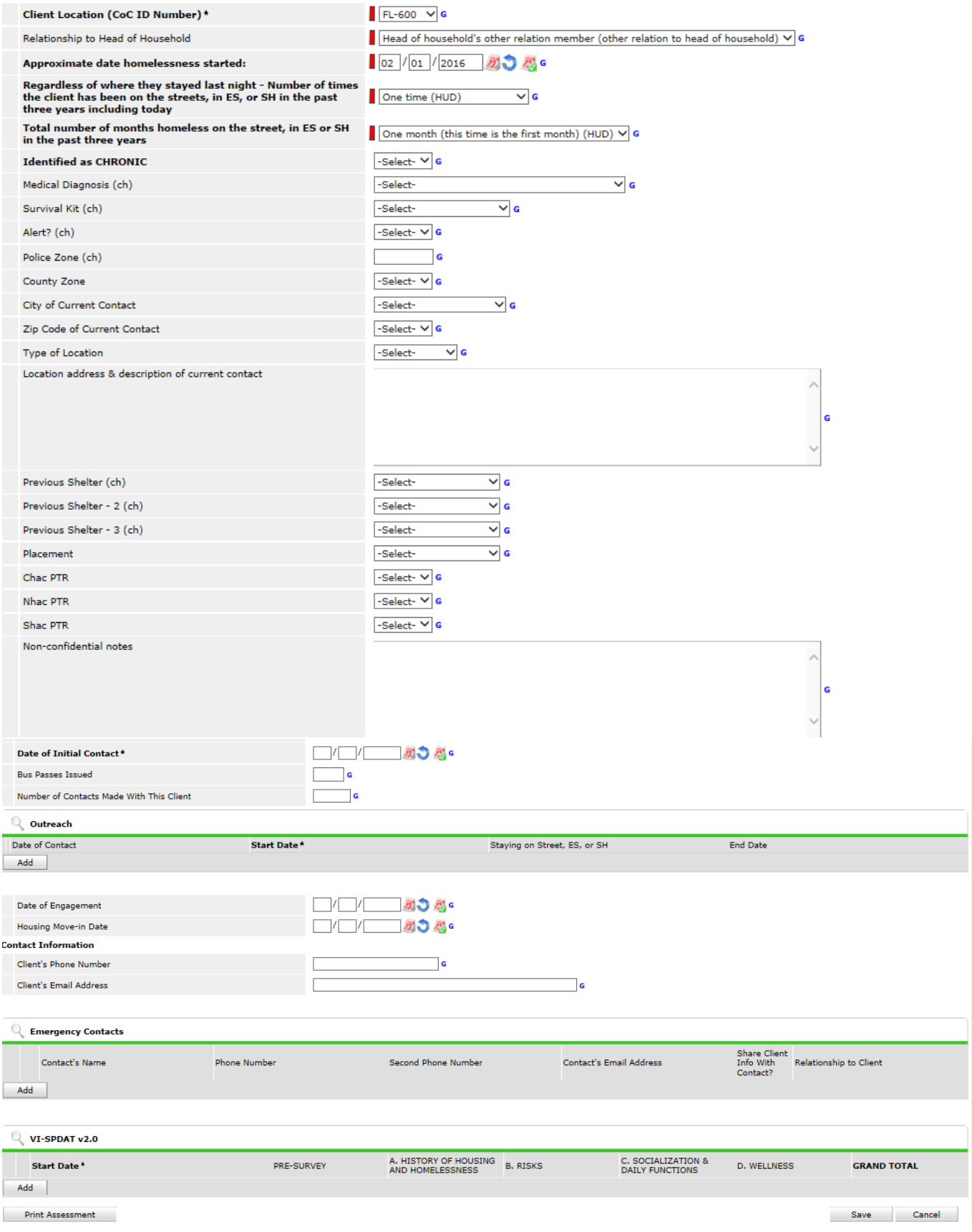
On a regular day, where is it easiest to find you and what time of day is easiest to do so?	place: _____ time: ___ : ____ or
Is there a phone number and/or email where someone can safely get in touch with you or leave you a message?	phone: (____) _____ - _____ email: _____
Ok, now I'd like to take your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

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

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

Taskforce Assessment




Client Location (CoC ID Number) *
FL-600
Relationship to Head of Household
Head of household's other relation member (other relation to head of household)
Approximate date homelessness started:
02 / 01 / 2016
Regardless of where they stayed last night - Number of times the client has been on the streets, in ES, or SH in the past three years including today
One time (HUD)
Total number of months homeless on the street, in ES or SH in the past three years
One month (this time is the first month) (HUD)
Identified as CHRONIC
-Select-
Medical Diagnosis (ch)
Survival Kit (ch)
Alert? (ch)
Police Zone (ch)
County Zone
City of Current Contact
Zip Code of Current Contact
Type of Location
Location address & description of current contact
Previous Shelter (ch)
Previous Shelter - 2 (ch)
Previous Shelter - 3 (ch)
Placement
Chac PTR
Nhac PTR
Shac PTR
Non-confidential notes
Date of Initial Contact *
Bus Passes Issued
Number of Contacts Made With This Client
Outreach
Date of Contact
Start Date *
Staying on Street, ES, or SH
End Date
Add
Date of Engagement
Housing Move-in Date
Contact Information
Client's Phone Number
Client's Email Address
Emergency Contacts
Contact's Name
Phone Number
Second Phone Number
Contact's Email Address
Share Client Info With Contact?
Relationship to Client
Add
VI-SPDAT v2.0
Start Date *
PRE-SURVEY
A. HISTORY OF HOUSING AND HOMELESSNESS
B. RISKS
C. SOCIALIZATION & DAILY FUNCTIONS
D. WELLNESS
GRAND TOTAL
Add
Print Assessment
Save
Cancel

Broward County Rapid Re-Housing Barrier Assessment

Head of Household Name: _____ **[Client ID No.]:** _____		**Score**
Homelessness	☐ First time homeless ☐ Homeless once before ☐ Homeless several times in past ☐ Experienced chronic homelessness ☐ Is fleeing, or attempting to flee, domestic violence	
Financial/Employment History	☐ Good employment history; no significant barriers except financial; insufficient emergency reserve. Credit history is good, except for a few late utility and credit card payments ☐ History of inconsistent or erratic employment, poor budgeting skills. Credit history shows pattern of late or missed payments ☐ Periods of unemployment, no emergency reserves, lacks or has poor budgeting skills. Credit history includes late payments and possible court judgments for debt, closed bank and/or credit accounts ☐ Multiple, extended periods of unemployment or inability to be employed due to disability. Credit history is poor, late payments, may include judgment for debt to a landlord, closed accounts	
Disability Status	☐ No mental illness, alcohol/substance use dependency, physical or cognitive condition that affects housing retention ☐ No serious mental illness, alcohol/substance use dependency, physical or cognitive condition that affects housing retention. Has some level of impairment that warrants some service ☐ Problems with mental health or alcohol/substance use dependency, physical or cognitive condition that somewhat impacts ability to comply with tenancy requirements ☐ Active and serious mental illness, alcohol/substance use dependency, physical or cognitive condition that impacts ability to access housing and/or comply with tenancy requirements	

Criminal History	☐ Household/Individual has no criminal history ☐ No serious criminal history, but may have a few minor offenses such as moving violations or a misdemeanor ☐ Household has some criminal history, but none involving drugs or serious crimes against persons or property ☐ Criminal history, violations include alcohol/drug offense or crime against persons or property ☐ Extensive criminal background	
Tenant/Rental History	☐ An established local rental history. No evictions ☐ Rental history is limited or out-of-state. May have one or two explainable evictions ☐ Rental history includes up to three evictions ☐ Rental history includes up to five evictions and/or lease violations ☐ Extremely poor rental history, multiple evictions, serious damage to apartment, complaints	
Family Abuse	☐ No abuse issues ☐ History of battery but abuser is not in the area ☐ Recent abuse in the family unit ☐ Current abuse in the family unit	
Family Dynamics	☐ One Parent/Child household ☐ Large family (4+ members) ☐ Head of household under 18 ☐ History DCF/ChildNet ☐ Open Child Protection Case (DCF/ChildNet)	
Misc. Housing Barriers	☐ No High School Diploma ☐ Non-English Speaking ☐ Immigration Status ☐ Pets	
	TOTAL SCORE	

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

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

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

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

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

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

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

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

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

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

Homeless Definition

Homeless Definition

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

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

_____
[AGENCY NAME]

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

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

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

Who can have access to your information?

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

How will my data be protected?

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

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

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

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

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

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

_____
[AGENCY NAME]

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

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

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

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

_____ _____
SIGNATURE OF CLIENT OR GUARDIAN DATE

_____ _____
PRINT NAME DATE

_____ _____
SIGNATURE OF AGENCY WITNESS DATE

_____ _____
PRINT NAME DATE

_____
[AGENCY NAME]

Exhibit - A
Participating Agencies and/or Organizations

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

Client initials: _____ Date: _____

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

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

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

Table of Contents

I. Purpose

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

A. Background

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

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

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

B. Goal of this Notice

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

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

HUD seeks to achieve three goals through this Notice:

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

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

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

C. Applicability

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

D. Key Terms

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

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

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

   (a) An individual who:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Coordinated Assessment Requirement

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

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

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

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

C. Standardized Assessment Tool Requirement

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

D. Nondiscrimination Requirements

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

V. Recordkeeping Requirements

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

A. CoC Records

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

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

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

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

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

B. Recipient Recordkeeping Requirements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

iii. **Evidence of diagnosis with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability (as defined in Section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000 (42 U.S.C. 15002), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability.** Evidence of this criterion must include one of the following:

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

(2) Written verification from the Social Security Administration;

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

(4) Intake staff (or referral staff) observation that is confirmed by written verification of the condition from a professional licensed by the state to diagnose and treat the condition that is confirmed no later than 45 days of the application for assistance and accompanied with one of the types of evidence above; or

(5) Other documentation approved by HUD.

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

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

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

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

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

VI. Questions Regarding this Notice

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

Appendix A

Coordinated Assessment Process and Standardized Assessment Tool: Key Considerations

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

Recommendations for Effective Implementation of a Coordinated Assessment Process

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Recommended Qualities of a Good Standardized Assessment Tool

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

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

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

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

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

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

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

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

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

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

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