# INTRODUCTION AND PURPOSE

In July 2012, HUD published the new Continuum of Care (CoC) Program Interim Rule. The CoC Program Interim Rule requires that the CoC establish and consistently follow written standards for providing CoC assistance, in consultation with recipients of the ESG Program.

At a minimum, these written standards must include:

- Policies and procedures for the evaluation of the eligibility of persons experiencing homelessness for assistance in the CoC Program; and,
- Policies and procedures for determining and prioritizing which persons experiencing homelessness will receive assistance for permanent supportive housing assistance, transitional housing assistance, and rapid rehousing assistance.

The goals of the written standards are to:

- Establish community-wide expectations on the operation of projects within the community;
- Ensure that the system is transparent to users and operators;
- Establish a minimum set of standards and expectations in terms of the quality expected of projects;
- Make the local priorities transparent to recipients and subrecipients of funds;
- Create consistency and coordination between recipients' and subrecipients' projects within the Honolulu City and County CoC; and,
- CoC Program standards must be in accordance with Violence Against Women Act (VAWA) regulations.

The Coordinated Entry System is Oahu's approach to organizing and providing services and assistance to persons experiencing a housing crisis within the Continuum of Care. All persons are seeking homeless or homelessness prevention assistance are directed to defined entry points, assessed in a uniform and consistent manner, prioritized for housing and services, and then linked to available interventions in accordance with the intentional service strategy defined by Partners in Care leadership. Each service participant's acuity level and housing needs are aligned with a set of service and program strategies that represent the appropriate intensity and scope of services needed to resolve the housing crisis.

# VISION STATEMENTS AND GUIDING PRINCIPLES

In 2016-17, through a series of community planning meetings, Partners in Care developed and agreed upon the following shared vision statements for the single adult, family, and youth/TAY process within the Coordinated Entry System. The vision statements enumerate:

- The purpose and intent of the coordinated entry processes;
- The key principles of the coordinated entry processes; and,
- The key elements of the coordinated entry processes.

For more information, please see the complete Vision Statement(s) located in the Appendix to this document.

# FAIR HOUSING, TENANT SELECTION, AND OTHER LEGAL REQUIREMENTS

All CoC projects in the Coordinated Entry System must include a strategy to ensure CoC resources and Coordinated Entry System options (referral options) are eligible to all individuals and families regardless of race, color, national origin, religion, sex, age, familial status, disability, actual or perceived sexual orientation, gender identity, or marital status. Special outreach to individuals and families who possess or identify with one or more of these attributes ensures the Coordinated Entry System is accessible to all persons.

All CoC projects in the Coordinated Entry System must ensure that all people in different populations and subpopulations throughout the geographic area, including people experiencing chronic homelessness, veterans, families with children, youth, and survivors of domestic violence have fair and equal access to the coordinated entry process, regardless of the location or method by which they access the crisis response system.

All CoC projects participating in the Coordinated Entry System must document steps taken to ensure effective communication with persons with disabilities. Access points must be accessible to persons with disabilities, including physical locations for those who use wheelchairs, as well as people in Hawaii who are least likely to access homeless assistance.

# STAFFING ROLES AND PARTICIPATION RESPONSIBILITIES

**Coordinated Entry System Continuum of Care Leadership**

Leadership from Partners in Care (the Honolulu City and County CoC) will conduct oversight and monitoring of Coordinated Entry functions to ensure consistent application of Coordinated Entry System Policies and Procedures and high quality service delivery for persons experiencing a housing crisis.

During the early stages of Coordinated Entry System implementation, CoC leadership shall meet monthly to monitor progress, hear appeals, and implement changes and updates to Coordinated Entry System operations. Aloha United Way (AUW) is identified by HUD as the "collaborative applicant" on behalf of Oahu for homeless funds. Meeting minutes for Coordinated Entry System implementation in Oahu will be posted online by Partners in Care at www.partnersincareoahu.org. The DHS Housing Programs Office (HPO) is identified by HUD as the collaborative applicant on behalf of the neighbor island counties for homeless funds, including the responsibility for posting meeting minutes at http://humanservices.hawaii.gov/bessd/home/hp/bridging-the-gap-meeting-minutes.

After meeting monthly during the early stages of Coordinated Entry System implementation, CoC leadership may adjust the meeting schedule as appropriate if it determines that is desirable (e.g., quarterly meetings, if more appropriate). Efficacy in monitoring progress, hearing appeals, and implementing changes will be assessed on an ongoing basis.

**Coordinated Entry System Administrators**

Partners in Care, acting through the CoC Board, will identify and designate subpopulation-specific Coordinated Entry System Administrators for each of the coordinated entry processes for single adults, families, youth/TAY, and survivors of domestic violence. At a minimum, the CES Administrators are responsible for the following in relationship to their respective subpopulations:

- Communicating with participating housing and service providers and other CES Authorized Agencies regarding the expectations and requirements of the Coordinated Entry System;
- Communicating with the CoC Board and CES Oversight Group regarding suggested or necessary alterations to the coordinated entry process to improve the overall performance of the Coordinated Entry System;
- Maintaining and ensuring the accuracy of the Community Queue;
- Promptly identifying and referring appropriate and eligible clients for available vacancies reported to the CES Administrator by participating housing and service providers.

**Continuum of Care Providers Serving Persons Experiencing Homelessness**

Providers participating in the Coordinated Entry System are required to:

- Adopt and follow Coordinated Entry System Policies and Procedures. Coordinated Entry System participating providers shall maintain and adhere to these policies and procedures for Coordinated Entry System operations, and as established by the Coordinated Entry System Continuum of Care Leadership for access points, assessment procedures, prioritization, and referral to available housing and services.
- Maintain low barriers to enrollment. Providers serving persons experiencing homelessness shall limit barriers to enrollment in housing and services. No person may be turned away from crisis response services or homeless-designated housing due to lack of income, lack of employment, disability status, or substance use unless the project's primary funder requires the exclusion or a previously existing and documented neighborhood covenant/good neighbor agreement has explicitly limited enrollment to persons with a specific set of attributes or characteristics. Providers maintaining restrictive enrollment practices must maintain documentation from project funders, providing justification for the enrollment policy. CoC providers offering prevention and/or short-term rapid rehousing assistance (i.e., 0-3 months of financial assistance) may choose to apply some income or employment standards for their enrollment determinations, unless otherwise required by the terms of their grants.
- Maintain fair and equal access. Coordinated Entry System participating providers shall ensure fair and equal access to Coordinated Entry System programs and services for all persons, regardless of actual or perceived race, color, religion, national origin, age, gender identity, pregnancy, citizenship, familial status, household composition, disability, veteran status, or sexual orientation. If a program participant's self-identified gender or household composition creates challenging dynamics among residents within a facility, the house program should make every effort to accommodate the person or assist them in locating alternative accommodation that is appropriate and responsive to their particular needs. Coordinated Entry System participating providers shall offer universal program access to all subpopulations as appropriate, including chronically homeless individuals, veterans, youth, transgender individuals, and persons fleeing domestic violence. Population-specific projects and those projects maintaining specific affinity focus (e.g., women-only, native Hawaiian only, veterans only, etc.) are permitted to maintain eligibility restrictions as currently defined and continue to operate and receive prioritized referrals. Any new project wishing to institute exclusionary eligibility criteria will be considered on a case by case basis and receive authorization to operate as such on a limited basis from the Coordinated Entry System Continuum of Care Leadership and their funders.

- Provide appropriate safety planning. Coordinated Entry System participating providers shall provide necessary safety and security protections for persons fleeing or attempting to flee domestic violence, stalking, dating violence, or other domestic violence situations. Minimum safety planning must include a threshold assessment for presence of participant safety needs and referral to appropriate trauma-informed services if safety needs are identified.
- Create and share written eligibility standards. Provide detailed written guidance for individual eligibility and enrollment determinations. Eligibility criteria should be limited to that required by the funder and any requirements beyond those required by the funder will be reviewed and a plan to reduce or eliminate them will be discussed. Include funder specific requirements for eligibility and program-defined requirements such as individual characteristics, attributes, behaviors or histories used to determine who is eligible to be enrolled in the program. These standards will be shared with the Coordinated Entry System Continuum of Care Leadership as well as funders.
- Communicate vacancies. Homeless providers must communicate project vacancies, either bed, unit, or voucher, to the Coordinated Entry System Continuum of Care Leadership in a manner determined by and outlined in these policies and procedures.
- Limit enrollment to participants referred through the defined Coordinated Entry System access point(s). Each bed, unit, or voucher that is required to serve someone who is homeless must receive their referrals through the prioritization criteria outlined below. Any agency filling homeless mandated units from alternative sources will be reviewed with funders for compliance. Coordinated Entry System access points will need to be informed of every opening and how and when they were filled.
- Participate in Coordinated Entry System planning. CoC projects shall participate in Coordinated Entry System planning and management activities as defined and established by Coordinated Entry System Continuum of Care Leadership.
- Contribute data to HMIS (or comparable database, when appropriate) if mandated per federal, state, county, or other funder requirements. Each provider with homeless dedicated units will be required to participate in HMIS. Providers should work with the Hawaii HMIS Lead Agency with funding sources to determine specific forms and assessments required for HUD compliance within HMIS.
- Ensure staff who interact with the Coordinated Entry System process receive regular training and supervision. Each provider must notify Coordinated Entry System Continuum of Care Leadership to changes in staffing, in order to ensure employees have access to ongoing training and information related to the Coordinated Entry System.
- Ensure individual rights are protected and families are informed of their rights and responsibilities. All clients shall have rights explained to them verbally and in writing when completing an initial intake. At a minimum, these rights include:
    - The right to be treated with dignity and respect;
    - The right to appeal Coordinated Entry System decisions;
    - The right to be treated with cultural sensitivity;
    - The right to have an advocate present during the appeals process;
    - The right to request a reasonable accommodation in accordance with the project's tenant/family selection process;
    - The right to accept housing/services offered or to reject housing/services; and,
    - The right to confidentiality and information about when confidential information will be disclosed, to whom, and for what purposes, as well as the right to deny disclosure.

**Coordinated Entry System Authorized Agency**

Organizations that participate in the Coordinated Entry System through housing, surveying, acquiring documentation, or otherwise aiding the coordinated entry workflow process as listed in these policies and procedures qualify as CES Authorized Agencies and may have access to protected personal information of clients as it relates to housing these persons. All HMIS-participating service providers will be a CES Authorized Agency. Non-HMIS-participating agencies will require approval from the CES Oversight Group to participate in case conferencing, referrals, or other parts of the coordinated entry process that require access to the protected personal information of clients.

**Case Conferencing**

For persons experiencing homelessness, referral to transitional housing, rapid rehousing, and permanent supportive housing interventions will be intentionally and primarily made in a centralized manner, following the prioritization categories outlined in these policies and procedures. To ensure that all clients are matched to appropriate resources based on objective determinations of vulnerability and need, the role of case conferencing will be limited to the following activities:

- Ensuring Successful Placement: Address the needs of the most challenging or difficult-to-serve clients in order to ensure that they are able to access the resources for which they have been referred;
- Ensuring Document Readiness: Ensure the document readiness of all clients is being addressed, beginning with those in Priority Group 1 and continuing in order;
- Ensuring Effective Client Navigation of the Coordinated Entry System: Ensure that clients are not excluded from accessing resources for which they are eligible and are appropriate to their needs if they would otherwise remain on the housing queue for an extended period of time. If clients are appropriate for less-intensive housing or services, the case manager or other CES stakeholder should contact the appropriate CES Administrator. Eligible exceptions may include:
    - Placing an individual or family into bridge or interim housing if they have already been referred to an appropriate permanent supportive housing program;
    - Prioritizing individuals or families able to present documentation from an appropriate medical professional regarding a terminal illness or imminent serious health danger to a member of the household due to homelessness;
    - Determining whether an individual or family who would otherwise be prioritized for more intensive housing or services would benefit from and be eligible for less intensive interventions (such as rapid rehousing or transitional housing);
    - Determining eligibility for a single adult, couple, or other family without children to understand if family reunification would be possible upon placement into housing.
- Ensuring an Accurate Community Queue: Ensure that individuals and families on the Community Queue have accurate assessment results and that those no longer requiring services are promptly removed from the housing queue. Where an individual or family has been unassigned due to failure to contact or locate, this client will be brought to case conferencing to determine whether they should remain in the Coordinated Entry System.

Case conferencing meetings should generally be open to all agencies participating in coordinated entry that can contribute valuable information regarding any of the above-listed items that are appropriate for case conferencing participating. This may include any combination of: the appropriate CES Administrator, case managers, street outreach staff, or others that may have information regarding the client's vulnerability and need. The CES Oversight Group retains authority to limit participation in case conferencing meetings where doing so would be in the interests of more quickly identifying and prioritizing individuals and families for housing and services.

# COORDINATED ENTRY SYSTEM WORKFLOW AND POLICIES

**Coordinated Entry Workflow Overview**

Street outreach, day center, emergency shelter, transitional housing, rapid rehousing, permanent supportive housing, and other CES Authroized Agency staff will work to ensure that all persons they engage are:

- Assessed using the appropriate assessment tool;
- Readily able to be located;
- Motivated to pursue housing;
- In possession of the appropriate documentation required for potential housing options; and,
- Successfully engaged by Continuum of Care providers seeking to resolve their housing crisis.

**Pre-Screening Tool (Draft Only)**

All clients should be administered the common pre-screening tool prior to receiving a full coordinated entry assessment. This tool is designed to accomplish three discrete goals:

- Immediate safety needs. The pre-screening tool is designed to capture information regarding the client's immediate safety needs, including whether the client requires immediate medical attention, police assistance, or is currently experiencing domestic violence. Where a client has an immediate safety need, the client should be directed to the appropriate assistance prior to continuing the pre-screening tool or receiving the full coordinated entry assessment. If the individual or family appears to have obvious and immediate medical or victim-service safety needs, the surveyor should use their best judgment regarding how to proceed in a manner designed to ensure the individual or family's health and well-being.
- Basic information regarding the client. The pre-screening tool is designed to capture basic information regarding the client, including their age, veteran status, current living situation, and contact information. This information can be used to estimate the likelihood that the client meets the HUD definition of homelessness (and is thus eligible for homeless assistance), identify the appropriate coordinated entry assessment to administer to the client, and assist in locating the client upon referral to housing.
- Housing preferences. The pre-screening tool is designed to capture information regarding the individual or family's housing preferences, most notably the region(s) of Oahu in which the client is willing to accept housing. This facilitates greater incorporation of client choice into the coordinated entry process.

For more information, please see the Draft Pre-Screening Tool located in the Appendix of this document.

**Survey: Explaining What You're Doing and Why**

Upon completion of the pre-screening tool and determination that the client has no immediate safety needs requiring emergency services, the client will receive the appropriate full coordinated entry assessment. The Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT) suite of products, developed and owned by OrgCode and Community Solutions, are a set of triage tools that assist in informing an appropriate 'match' to a housing intervention based on a person's acuity in several core areas. Within those recommended housing interventions, the VI-SPDAT tools allow for prioritization based on presence of vulnerability primarily across four components: (A) history of housing and homelessness; (B) risks; (C) socialization and daily functioning; and, (D) wellness (including physical health, substance use, mental health,

medications, and abuse and trauma). Partners in Care is implementing the VI-SPDAT assessment tools for the following subpopulations:

- Single Adults: VI-SPDAT (Version 2)
- Families: Family VI-SPDAT (Version 2)
- Youth and TAY: TAY VI-SPDAT (Version 2)
- Survivors of Domestic Violence: TBD

Partners in Care has agreed to use the VI-SPDAT products as universal assessment tools across the Continuum of Care for screening and matching persons experiencing homelessness in Hawaii. Partners in Care, the CES Administrators, participating providers, and other CES Authorized Agencies should jointly ensure that all staff administering any of the SPDAT tools are trained to do so by an authorized trainer.

Persons engaged by providers representing the Coordinated Entry System should receive the same information regarding what that process involves. Assessors should communicate the survey process and its results clearly and consistently across the community. This ensures both that the benefits of participation in the survey are described clearly to encourage people to participate, but also that they understand that participating does not guarantee (and may not result in) housing. It is also important that people assessed receive a clear understanding of where their information will be shared. An example of what to standardize follows below:

- The name of the assessor and their affiliation (e.g., organization that employs them, volunteer as part of a Point in Time Count, etc.);
- The purpose for which the assessment is being completed;
- That it usually takes less than 30 minutes to complete;
- That only "Yes," "No," or one-word answers are being sought;
- That any question can be skipped or refused;
- That the information is going to be stored in the Homeless Management Information System (HMIS);
- That other providers conducting assessments and the housing providers connected to the Coordinated Entry System will have access to the information so that the person does not need to complete the assessment multiple times, that housing providers can identify people to target for housing resources as they come available, and for planning purposes (the ability to share client-level data depends on client consent; as such, it is vitally important to obtain client consent from the maximum number of clients);
- That if the participant does not understand a question, clarification can be provided; and,
- 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.

**Additional Subpopulation Considerations**

*Veterans:* Providers serving veterans may require a Health Insurance Portability Accommodations Act (HIPAA)-compliant Release of Information to enable representatives from the Department of Veterans Affairs, the State, and other relevant stakeholders to ensure veterans can access the full spectrum of housing resources designated for this subpopulation. Most veterans are additionally eligible for veteran-specific resources through the Department of Veterans' Affairs (VA). Clients who are eligible for these resources, including housing and services, should be connected to the VA as soon as possible to ensure they can access appropriate resources for which they are eligible.

*Survivors of Domestic Violence:* While people currently experiencing homelessness have often previously survived domestic violence, the Violence Against Women Act (VAWA) prevents providers dedicated to serving this subpopulation from inputting their personally identifiable information within a Homeless Management Information System (HMIS) because of the additional safety precautions. While the VI-SPDAT is not primarily a domestic violence-specific triage tool, providers dedicated to serving survivors of domestic violence can assess individuals or families that desire access to the broader range of housing options dedicated to persons experiencing homelessness. Those results will need to be stored within a VAWA-compliant electronic system or in paper files secured according the full requirements of the law. Clients served in this way who are later matched to outside providers will have further provider-specific security precautions, outlined in the Universal Access section below.

**Survey Refusals**

For limited instances when persons refuse specific questions throughout the assessment process, the assessor may request permission to ask additional questions in order to utilize their conversation with the client, surveyor observation, documentation, and information from other professionals in order to provide responses. When staff encounter clients 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 if the person receiving assessment does not want to participate. Staff should utilize continued progressive engagement and rapport building with these persons until they are willing to be assessed. The assessment should be completed in one engagement (although not necessarily first contact).

**Survey: Concluding the Engagement**

Upon completion of the assessment, the assessor may ask if the person is currently working with a provider towards one of those forms of housing assistance. If so, the person receiving the survey should be encouraged to continue to engage with their existing case management supports. If not, staff can provide a brief description of the resources currently available within the community and ask if the person is interested in specific forms of housing assistance.

Assessors should emphasize the importance of having reliable and comprehensive information regarding the best time and place to contact the client. Staff should collect information on whereabouts across a 24-hour period, beginning with where the wake up until they bed down at night, with notations for days when location patterns changed, and record that information within the assessment. This includes where meals are obtained, transportation methods and times to and from meal and shelter providers, cross streets of locations where they receive services, outside agency names and staff with whom they engage, etc.

Assessors may emphasize that while completion of the assessment does not make them now the person's case manager, it remains critically important that the assessor possesses the most reliable methods possible for locating the person being assessed, especially if that includes an outside agency or staff attempting to contact the person at a later date.

**Next Steps: Collection of Housing Documentation**

Once the assessment is completed, or as part of the initial engagements for persons already assessed, staff should determine which essential documents the client currently possesses, and begin working with them to begin collecting missing documents, as staff time and resources allow. Assessors should emphasize that specific documentation is required for many programs, including but not limited to government issued photo identification, social security card, birth certificate, proof of income or zero income, verification of homelessness, and DD-214 for families who have served in the United States armed forces (regardless of discharge status or length of service).

To facilitate this process, providers are responsible for providing the CES Administrator with relevant, up-to-date eligibility requirements, including documentation requirements.

**The Community Queue: Prioritization for Housing and Service Providers**

Upon successful assessment completion, Continuum of Care providers including transitional housing, rapid rehousing, and permanent supportive housing will fill their caseload (for services-only programs) and/or beds (for housing programs) solely through the Coordinated Entry System according to the prioritization criteria outlined below. Within any prioritization category, each of the prioritization criteria within the category must be met by the individual or family. Where two clients meet all criteria within a single priority category, providers will prioritize servicing individuals and families as follows:

| **Single Adult Tiebreakers:** | **Family Tiebreakers:** | **Youth and TAY Tiebreakers:** |
|---|---|---|
| 1. Assessment score<br>2. Assessment or encounter date within the current calendar year<br>3. Assessment or encounter date within the past 12 months<br>4. Document readiness<br>5. Greatest age (unless program guidelines specifically identify a particular age group)<br>6. Greatest collective length of homelessness<br>7. Greatest utilization of emergency services | 1. Assessment score<br>2. Largest household size<br>3. Children under 5 years of age or medically verified pregnancy<br>4. Document readiness | 1. Assessment score<br>2. Assessment or encounter date within the current calendar year<br>3. Assessment or encounter date within the past 12 months<br>4. Document readiness<br>5. Greatest age (unless program guidelines specifically identify a particular age group)<br>6. Greatest collective length of homelessness<br>7. Greatest utilization of emergency services |

Providers may request through the case conferencing administration process, for clients to be considered for advancement on any category of the Community Queue when there is clear, documented evidence of greater need, and such advancement meets the long-term, sustainable, housing needs, related to the conditions of consideration. Such documentation will evidence one or a combination of the following conditions:

- Vulnerability to illness or death;
- Undergoing life-sustaining medical treatment which efficacy is significantly negated by conditions of homelessness and housing instability;
- Vulnerability to victimization, including physical assault and abuse;
- Functional impairments causing long-lasting physical or mental capacity to meet essential requirements for physical health, safety, or self-care; or,
- Other specific factors determined by the community that are based on severity of needs, including terminal illness.

Providers may also request through the case conferencing administration process, for clients to be considered for rapid re-housing prioritization under the following conditions:

- Rental assistance is needed in order to access a permanent housing solution, i.e. foster care home, section 8 choice voucher program, where but for this instance, this permanent housing solution could not be reasonably obtained and there is evidence of authentic need through the verified eligibility determination of said permanent housing solution's program.
- Clients actively enrolled and participating in a professionally recognized employment development program and as part of the homeless service provider's housing, service, or case management plan, may be considered for rapid re-housing prioritization when identified by the respective programs to CES administration.

| **Intervention:** Where a vacancy occurs in the following program types… | **Single Adults Prioritization:** …Individuals will be matched to the vacancy per the following criteria. An individual must meet all elements within a Priority Category and no individual falling in a later Priority Category should be referred for the vacancy prior to eligible persons in prior Categories. | **Family Prioritization:** …Families will be matched to the vacancy per the following criteria. A family must meet all elements within a Priority Category and after chronically homeless families with minor children are served in advance of chronically homeless adult only families, no households falling in a later Priority Category should be referred for the vacancy prior to eligible persons in prior Categories. | **Youth and TAY Prioritization:** …Youth and TAY will be matched to the vacancy per the following criteria. Youth and TAY must meet all elements within a Priority Category and no youth or TAY falling in a later Priority Category should be referred for the vacancy prior to eligible persons in prior Categories. |
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| **Homelessness Prevention** | **Priority Category 1:**<br>• Imminent risk of homelessness<br>• Low income individuals | **Priority Category 1:**<br>• Imminent risk of eviction with documentation | **Priority Category 1:**<br>• Imminent Risk of Homelessness<br>• Low Income Families |
| **Street Outreach and Emergency Shelter** | **Priority Category 1:**<br>• Individuals matched to transitional housing, rapid re-housing, or permanent supportive housing | **Priority Category 1:**<br>• Families matched to transitional housing, rapid re-housing, or permanent supportive housing | **Priority Category 1:**<br>• Individuals matched to transitional housing, rapid re-housing, or permanent supportive housing |
| **Transitional Housing** | **Priority Category 1:**<br>• VI-SPDAT Score Range: 4-10<br>• Tri-Morbidity:<br>  ○ Mental Health;<br>  ○ Physical Health (e.g., HIV/AIDS); and,<br>  ○ Substance Use | **Priority Category 1:**<br>• Same as PSH if unavailable | |
| | **Priority Category 2:** | **Priority Category 2:** | |

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| | • VI-SPDAT Score Range: 4-10<br>• 2+ HUD Disabling Condition(s):<br>  ○ Mental Health;<br>  ○ Physical Health (e.g., HIV/AIDS);<br>  ○ Substance Use; and/or<br>  ○ Developmental Disability or Cognitive Impairment | • Same as RRH if unavailable | |
| | **Priority Category 3:**<br>• VI-SPDAT Score Range: 4-10<br>• 1+ HUD Disabling Condition(s):<br>  ○ Mental Health;<br>  ○ Physical Health (e.g., HIV/AIDS);<br>  ○ Substance Use; and/or<br>  ○ Developmental Disability or Cognitive Impairment | **Priority Category 3:**<br>• VI-SPDAT Score Range: 0-8<br>• Any of the following:<br>  ○ Substance Use;<br>  ○ Domestic Violence;<br>  ○ Incarceration; and/or<br>  ○ Head of Household 24 or Younger | |
| | **Priority Category 4:**<br>• VI-SPDAT Score Range: 4-10<br>• Client matched to RRH, PSH, HCV, or other permanent housing resource but awaiting unit identification | **Priority Category 4:**<br>• VI-SPDAT Score Range: 0-3<br>• No Income | |
| | **Priority Category 5:**<br>• VI-SPDAT Score Range: 4-10 | **Priority Category 5:**<br>• Families without Income | |
| | | **Priority Category 6:**<br>• Families with Income | |
| **Rapid Rehousing** | **Priority Category 1:**<br>• VI-SPDAT Score Range: 4-10 | **Priority Category 1:**<br>• VI-SPDAT Score Range: 4-8<br>• Chronic Homelessness | **Priority Category 1:**<br>• TAY VI-SPDAT Score Range: 4-7 |

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| | • Chronic Homelessness | | • Active employment<br>• Active involvement in youth programs or attending school/classes<br><br>Tiebreaker: Date of first intake |
| | **Priority Category 2:**<br>• VI-SPDAT Score Range: 4-10<br>• 1+ HUD Disabling Condition(s):<br>  ○ Mental Health;<br>  ○ Physical Health (e.g., HIV/AIDS);<br>  ○ Substance Use; and/or<br>  ○ Developmental Disability or Cognitive Impairment | **Priority Category 2:**<br>• VI-SPDAT Score Range: 4-8<br>• 1+ HUD Disabling Condition(s):<br>  ○ Mental Health;<br>  ○ Physical Health (e.g., HIV/AIDS);<br>  ○ Substance Use; and/or<br>  ○ Developmental Disability or Cognitive Impairment | **Priority Category 2:**<br>• TAY VI-SPDAT Score Range: 8+<br>• Active employment<br>• Active involvement in youth programs or attending school/classes<br><br>Tiebreaker: Date of first intake |
| | **Priority Category 3:**<br>• VI-SPDAT Score Range: 4-10 | **Priority Category 3:**<br>• VI-SPDAT Score Range: 4-8 | **Priority Category 3:**<br>• TAY VI-SPDAT Score Range: 4-7<br>• No employment<br>• No involvement in youth programs or attending school/classes<br><br>Tiebreaker: Date of first intake |
| | **Note:** Clients scoring 11+ on the VI-SPDAT may be considered for rapid rehousing if:<br>• The client meets other rapid rehousing prioritization criteria (e.g., chronic homelessness, disabling conditions, etc.);<br>• The client is referred to case conferencing based on objective, community-wide criteria (including | | **Priority Category 4:**<br>• TAY VI-SPDAT Score Range: 8+<br>• No employment<br>• No involvement in youth programs or attending school/classes<br><br>Tiebreaker: Date of first intake |

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| | employment and/or income); and,<br>• Through case conferencing, the community determines that there is a substantial likelihood that rapid rehousing will meet the client's housing and service needs. | | |
| **Permanent Supportive Housing** | **Priority Category 1:**<br>• VI-SPDAT Score Range: 11+<br>• Chronic Homelessness<br>• Tri-Morbidity:<br>  ○ Mental Health;<br>  ○ Physical Health (e.g., HIV/AIDS); and,<br>  ○ Substance Use | **Priority Category 1:**<br>• VI-SPDAT Score Range: 9+<br>• Chronic Homelessness<br>• Tri-Morbidity:<br>  ○ Mental Health;<br>  ○ Physical Health (e.g., HIV/AIDS); and,<br>  ○ Substance Use | |
| | **Priority Category 2:**<br>• VI-SPDAT Score Range: 11+<br>• Chronic Homelessness<br>• 2+ HUD Disabling Conditions:<br>  ○ Mental Health;<br>  ○ Physical Health (e.g., HIV/AIDS);<br>  ○ Substance Use; and/or<br>  ○ Developmental Disability or Cognitive Impairment | **Priority Category 2:**<br>• VI-SPDAT Score Range: 9+<br>• Chronic Homelessness<br>• 2+ HUD Disabling Conditions:<br>  ○ Mental Health;<br>  ○ Physical Health (e.g., HIV/AIDS);<br>  ○ Substance Use; and/or<br>  ○ Developmental Disability or Cognitive Impairment | |
| | **Priority Category 3:**<br>• VI-SPDAT Score Range: 11+<br>• Chronic Homelessness | **Priority Category 3:**<br>• VI-SPDAT Score Range: 9+<br>• Chronic Homelessness | |
| | **Priority Category 4:**<br>• VI-SPDAT Score Range: 11+<br>• 1+ HUD Disabling Conditions:<br>  ○ Mental Health;<br>  ○ Physical Health (e.g., HIV/AIDS);<br>  ○ Substance Use; and/or | **Priority Category 4:**<br>• VI-SPDAT Score Range: 9+<br>• 1+ HUD Disabling Conditions:<br>  ○ Mental Health;<br>  ○ Physical Health (e.g., HIV/AIDS);<br>  ○ Substance Use; and/or | |

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| | ○ Developmental Disability or Cognitive Impairment | ○ Developmental Disability or Cognitive Impairment | |
| | **Priority Category 5:**<br>• VI-SPDAT Score Range: 11+ | **Priority Category 5:**<br>• VI-SPDAT Score Range: 9+ | |

**Getting Connected: The Matching and Referral Process**

When there is a resource vacancy (including beds, units, or vouchers) within a participating provider, the provider will inform the appropriate CES Administrator, who will refer a client for placement based on the prioritization order above and the client's placement on the community housing queue. To facilitate this process, it is essential that participating providers:

- Promptly notify the CES Administrator of any available resource vacancies;
- Ensure that the CES Administrator has complete, up-to-date eligibility requirements regarding each of their programs that they will be dedicating to the Coordinated Entry process (including documentation requirements); and,
- Provide the CES Administrator with point of contact information to ensure that the CES Administrator can communicate with relevant staff;

The CES Administrator will run an HMIS report of the community housing queue (including assessment results, eligibility information, and other prioritization factors for all persons experiencing homelessness). Following the prioritization scheme outlined above, the CES Administrator will refer the highest prioritized client for placement into the program. Due to the high level of demand for limited homeless housing and service resources, clients are required to maintain contact with the homeless response system on an ongoing basis (at least yearly) in order to remain active on the Community Queue. Clients may be encouraged and/or required to retake the appropriate assessment, per the Coordinated Entry System Re-Screening Policy (outlined below) should there be any indication that the client's circumstances have changed since the date of first assessment. To ensure that clients are able to be located in a timely manner and maximize utilization of homeless housing and services, only those clients that have made contact with the homeless response system within the past year will be eligible for referral from the Community Queue. "Contact" may include: enrollment in a program, engagement with street outreach, emergency shelter stays, or other indication that the client remains homeless and in need of assistance. Providers will receive referrals via email designating the:

- Housing resource to which the client is matched (i.e., housing project);
- HMIS unique identifier for the client;
- Date of the referral; and,
- Point of contact for outreach and engagement to the individual or family.

Providers will receive up to three matches for every one opening/vacancy they have at the discretion of the CES administration. If the match is unsuccessful, the CES Administrator will make a new referral as soon as the prior referral is "unassigned" and the client returned to the community housing queue. This promotes choice on behalf of both the client referred and the project. See "Process for Unsuccessful Matches" section below for additional detail.

| Referral Time Standards | Permanent Supportive Housing | Rapid Rehousing | Transitional Housing | Veterans Rapid Rehousing | PSH Choice Voucher Programs |
|---|---|---|---|---|---|
| Provider of record to connect with housing program | 3 business days | 3 business days | 3 business days | 3 business days | 3 business days |
| Housing program to connect with client and conduct initial intake and eligibility prescreening | 14 days/ 2 full weeks | 14 days/ 2 full weeks | 14 days/ 2 full weeks | 14 days/ 2 full weeks | 14 days/ 2 full weeks |
| Complete eligibility determination and record matched or unassigned with/from program | 30 days / 1 month | 30 days / 1 month | 21 days / 3 weeks | 30 days / 1 month | 30 days / 1 month |
| Complete and record housing placement | 60 days / 2 months | 60 days / 2 months | 30 days / 1 month | 90 days / 3 months | 90 days / 3 months |

Once a referral is made following the prioritization and process outlined above, the provider of record and housing program are expected to incorporate the specified time standards outlined below to complete the referral process:

NOTE: CES time standards for housing shall serve as guidelines during the referral, matching, and housing placement process. If a provider is not able to meet these housing placement benchmarks with their client, then any client without a record of active participation towards housing placement may be unassigned by CES administration and returned to community queue but only after a CES Administrator has made contact with the provider to discuss the status of the case. "By Name List" to be considered for future housing opportunities.

Specified Time Standards Recommended as follows:

NOTE: *Safe Haven Service Model Programs:

1. Safe Haven, as defined in the Supportive Housing Program, is a form of supportive housing that serves hard-to-reach homeless persons with severe mental illness who come primarily from the streets and have been unable or unwilling to participate in housing or supportive services.

2. Safe haven projects as defined are for literally homeless individuals (as defined in the CoC Program interim rule in paragraph (1)(i) and (1)(iii) who reside on the streets or places not meant for human habitation and who have severe and persistent mental illness.
3. Housing programs that share similar operational models of a Safe Haven project to include service to the same client demographic, should follow the same time standards as other permanent supportive housing programs. However such "Safe Haven" model programs may request to reactivate a previously unassigned referral at any time the current VI-SPDAT is still active, should the original client present as "housing ready" and willing to accept housing support services.

Upon successful placement, providers should ensure that the client is exited, as appropriate, from prior housing programs. The housing provider commits to communicating in writing with the Continuum of Care leadership when more than 50% of matches do not lead to successful program entry to facilitate more successful referrals (further outlined below). If a client experiences three or more unsuccessful assignments, he or she should be referred to case conferencing for additional attention.

The housing provider will document any unsuccessful matches and provide both (1) the reason(s) why they were not housed; and, (2) the date of unsuccessful match/"un-assignment" within HMIS so that the person can be reassigned to additional providers (further outlined below). The housing provider will also document when each match does lead to successful program entry and providing the date the family moves into housing within HMIS.

Participating providers may not fill bed vacancies through any other process; all bed vacancies must be filled through the coordinated entry process outlined in this document.

**Process for Unsuccessful Matches**

By the Client: Clients may reject a housing referral due to the health, safety or wellbeing of the person being compromised by the potential referral. Respecting client choice and preference, clients may also reject a housing referral due to an inability to work with the housing provider to which they are referred. Rejections of housing referrals by clients should be infrequent and must be documented in HMIS. Repeated rejections on behalf of staff, programs, and/or agencies may require case conferencing and additional guidance from Continuum of Care leadership.

By Housing Provider: Hawaii CoC providers and program participants may deny or reject referrals from the Single Adults Coordinated Entry System, although service denials should be infrequent and must be documented in HMIS. The specific allowable criteria for denying a referral shall be published by each project and be reviewed and updated annually or as they change, whichever happens first. All participating projects shall provide the reason for service denial, and may be subject to a limit on the number of service denials. Agencies that would like to deny a referral that is incompatible with their programming must include details about the reason for denial. Documentation should include communication attempts with the client, specific reasons that prevent acceptance of referral, or other similar details.

Denial of a referral by a provider generally have three different consequences depending upon the reason for the denial: 1) The client is placed back on the housing queue for a future referral; 2) The client is referred for case conferencing to resolve the issue that led to the denial of the referral; or, 3) The client is removed from the housing queue. Specific circumstances are as follows.

The client should be placed back on the housing queue for a future referral in the following circumstances:

- The client is not document-ready and will not be so within one month – appropriate application(s) for identification documentation has been submitted;
- The client does not meet required criteria for program eligibility;

The client should be referred for case conferencing to resolve a specific issue in the following circumstances:

- The client is not document-ready and will not be so within one month – application(s) for identification documentation have not been submitted;
- The housing provider is unable to locate the client within fourteen days following the date on which the referral was made, or the client has been unresponsive to repeated and numerous communication attempts;
- The client's needs, health, or well-being would be negatively impacted because the program does not offer the services, staffing, location, and/or housing supports necessary to successfully serve the household (e.g., where an individual or family is better-suited for project-based housing than independent living), or the client's health or well-being or the safety of current program participants would be negatively impacted due to staffing, location, or other programmatic issues;
- The client refused placement because he or she does not wish to work the provider receiving the referral;
- The client refused placement because he or she does not wish to live in the geographic area in which the program operates;
- The client was previously evicted by the program or organization, or there is a conflict of interest on the part of the provider in housing the person.

The client should be removed from the housing queue in the following circumstances:

- The person is no longer residing on the island (moved out of CoC area);

If the denial is the result of a third-party property management/landlord (private or partner of service provider) rejecting the client's application, the rejection will trigger a case conferencing meeting. If the client chooses to appeal this decision, a new referral will not be provided to the housing program until the appeal process has reached its conclusion.

The housing provider will document any unsuccessful matches and provide both (1) the reason(s) why they were not housed; and, (2) the date of unsuccessful match/"un-assignment" within HMIS so that the client can be reassigned to additional providers. The housing provider will also document when each match does lead to successful program entry and providing the date the client moves into housing within HMIS. Where a client is unassigned because due to a lack of document-readiness, the client will not receive a subsequent assignment until appropriate documentation is available; for this reason, it is essential that the community, through case conferencing, work to ensure that all clients (beginning with those in Priority Group 1) are document-ready.

**Re-Screening**

While clients generally do not need to be surveyed multiple times with any particular assessment tool, there are circumstance under which clients who have been screened would qualify to be re-screened, including the following:

- The client has not had contact with the homeless services system for one year or more since the initial assessment date (contact with the homeless service system may be made by taking another assessment, enrolling in a program, or having a documented encounter);
- The client has encountered a significant life change;

- In rare occurrences, a client who is screened and referred to a housing program may be eligible for re-screening if the program determines after extensive efforts that the client needs a higher level of support than can be offered in that level of intervention.
- The client who has a known, extensive history within the shelter and other emergency systems but their acuity is not accurately depicted on their first screening.

Prior to initiating a new assessment, the assessor should ensure that previous assessment is exited in HMIS as each client may have only one assessment score associated with a given unique HMIS identifier.

**Universal Access Across Subpopulations**

Universal access for all persons: Hawaii Continuum of Care providers shall provide directly or plan through other means to ensure universal access to crisis response services including shelter for individuals and families seeking emergency assistance at all hours of the day and all days of the year.

Crisis response during non-business hours: Continuum of Care providers shall document planned after-hours emergency services and publish hours of operation in an easily accessible location or posted publicly on the internet. After hours' crisis response access may include telephone crisis hotline access, coordination with police and/or emergency medical care.

Persons fleeing domestic violence or sexual assault: Continuum of Care providers shall be trained on the complexity of responding to individuals and families fleeing domestic violence, privacy and confidentiality, and safety planning, including how to handle emergency situations at access points. CoC providers shall make safety referrals to victim service providers as determined to be clinically appropriate or at the request of the client. Providers participating in the Coordinated Entry System will work in partnership with advocacy organizations/shelters serving survivors of domestic violence to ensure considerations are made to address the specific safety and privacy needs of victims. This includes giving individuals and families the ability to decline housing in neighborhoods that would compromise their location, the choice to be entered anonymously into a separate database, and have full access to housing options.

# TRANSFERS

There are circumstances under which a client enrolled with one housing provider may benefit from transferring to another program or provider. For example:

- The client has lost several scattered-site housing placements due to problems with visitors.
- A client in a site-based setting is unable to comply with funder-imposed rules around sobriety or the environment is not conducive to mental or physical well-being.

The Coordinated Entry System seeks to minimize the number of persons who are exited back to homelessness, only to have to be re-screened, and re-prioritized, and wait again for supportive housing. If the current housing provider is unable to continue serving a household, staff should contact the appropriate Coordinated Entry System Continuum of Care Leadership representative to discuss options besides exiting to homelessness.

If a transfer within the same level of service intervention (i.e., one PSH provider to another PSH provider) is being considered, the referral should come through the Coordinated Entry System process. To do so, the current housing provider must

contact Coordinated Entry System Continuum of Care Leadership to determine what other housing providers have available capacity. Housing programs shall not initiate transfers between providers without the involvement and permission of Coordinated Entry System Continuum of Care Leadership.

Housing providers are prohibited from transferring an individual or family from one service intervention to another (i.e., TH to PSH, internally or externally) without permission from the Continuum of Care. If a provider has an opening in a PSH program, they must receive the referral through the Coordinated Entry System, and may not fill that opening internally via transfer from a lower service intervention program. Additionally, if it is identified that a client may need a higher intervention than what was determined initially, the housing provider should discuss this with Coordinated Entry System Continuum of Care Leadership. If a program is terminated or otherwise ends, the provider should work with Partners in Care and the CES Administrator to ensure that current clients are not exited to homelessness.

# COORDINATED ENTRY SYSTEM MONITORING AND EVALUATION

Continuum of Care providers shall adhere to HUD-defined monitoring and reporting plans for the Coordinated Entry System. A Coordinated Entry Oversight Group will be established to monitor and evaluate coordinated entry for all subpopulations, as well as design and implement policies and procedures related to the integration of all subpopulations (including veterans). The Oversight Group will consist of CoC leadership and representatives of all key stakeholders, including:

- The Chair of the CoC Planning Committee;
- The Chair of the Statewide Data Committee;
- CES Administrators for each subpopulation;
- The HMIS Administrator;
- The Governor of Hawaii's Office;
- The Mayor of Honolulu's Office;
- The Partners in Care Director's Office;
- Subpopulation representatives for chronically homeless persons, survivors of domestic violence, families, veterans, and youth;

The monitoring process will report on performance objectives related to Coordinated Entry System utilization, efficiency, and effectiveness. HUD has developed the following seven system-level performance measures to help communities gauge their progress in preventing and ending homelessness:

1. Length of time persons remain homeless;
2. The extent to which persons who exit homelessness to permanent housing destinations return to homelessness;
3. Number of homeless persons;
4. Jobs and income growth for homeless persons in CoC Program-funded projects;
5. Number of persons who become homeless for the first time;
6. Homelessness prevention and housing placement of persons defined by Category 3 of HUD's homeless definition in CoC Program-funded projects; and,
7. Successful housing placement.

The purpose of these measures is to provide a more complete picture of how well a community is preventing and ending homelessness. The number of homeless persons measure (#3) directly assesses a CoC's progress toward eliminating homelessness by counting the number of people experiencing homelessness both at a point in time and over the course of a year. The six other measures help communities understand how well they are reducing the number of people who become homeless and helping people become quickly and stably housed.

Reductions in the number of people becoming homeless are assessed by measuring the number of persons who experience homelessness for the first time (#5), the number who experience subsequent episodes of homelessness (#2), and homelessness prevention and housing placement for people who are unstably housed (Category 3 of HUD's homelessness definition) (#6). Achievement of quick and stable housing is assessed by measuring length of time homeless (#1), employment and income growth (#4), and placement when people exit the homelessness system (#7).

The performance measures are interrelated and, when analyzed relative to each other, provide a more complete picture of system performance. For example, the length of time homeless measure (#1) encourages communities to quickly re-house people, while measures on returns to homelessness (#2) and successful housing placements (#7) encourage communities to ensure that those placements are also stable. Taken together, these measures allow communities to evaluate the factors more comprehensively that contribute to ending homelessness.

The Oversight Group and/or the CES Administrator should also identify and implement other processes and/or measures to evaluate the ongoing implementation and operation of coordinated entry. In addition to the seven HUD-mandated System Performance Measures, regular review should occur related to the following seven metrics (at a minimum):

1. The total and change to the number of people on the housing queue (including by subpopulation and by Priority Group);
2. The total and change to the number of people who are document-ready on the housing queue (including by subpopulation and by Priority Group);
3. The total and change to the number of new assignments and total placements from the housing queue (including by subpopulation and by Priority Group);
4. The total and change to the number of successful and unsuccessful placements (including by subpopulation, Priority Group, and component type);
5. The total and change to the reason of unsuccessful placements (including by subpopulation, Priority Group, and component type);
6. The mean and median length of time from assessment to referral (including by subpopulation, Priority Group, and component type); and,
7. The mean and median length of time from referral to placement into a housing unit (including by subpopulation, Priority Group, and component type).

Some metrics may require additional information, apart from the information currently in HMIS, to complete. The Oversight Group should work with the HMIS Administrator to identify both available and desirable data to effectively measure performance utilizing these metrics.

For more information, please see the Draft Coordinated Entry Oversight Report template located in the Appendix.

# TERMINATION

Any participating or Authorized Agency may terminate their participation in the Coordinated Entry System by providing written notice to the CES Administrator, the CES Oversight Group, and the CoC Board. Housing programs that are required to participate in coordinated entry due to HUD guidelines may not terminate participation without HUD approval.

# Coordinated Entry System

# Policies and Procedures Manual

# Appendix

**Partners in Care**

**HI-501: Honolulu City and County Continuum of Care (CoC)**

February 8, 2018

# COORDINATED ENTRY SYSTEM TERMS

**Literally Homeless (Category 1 of the HUD Homeless Definition)**

An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:

(1) An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;

(2) An individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, State, or local government programs for low-income individuals); or,

(3) An individual who is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

**At Imminent Risk of Homelessness (Category 2 of the HUD Homeless Definition)**

An individual or family who will imminently lose their primary nighttime residence, provided that:

(1) The primary nighttime 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, e.g., family, friends, faith-based or other social networks, needed to obtain other permanent housing.

**Homeless Under Other Federal Statutes (Category 3 of the HUD Homeless Definition)**

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 section 387 of the Runaway and Homeless Youth Act (42 U.S.C. 5732a), section 637 of the Head Start Act (42 U.S.C. 9832), section 41403 of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2), section 330(h) of the Public Health Service Act (42 U.S.C. 254b(h)), section 3 of the Food and Nutrition Act of 2008 (7 U.S.C. 2012), section 17(b) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)), or section 725 of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a);

(2) Have not had a lease, ownership interest, or occupancy agreement in permanent housing at any time during the 60 days immediately preceding the date of application for homeless assistance;

(3) Have experienced persistent instability as measured by two moves or more during the 60-day period immediately preceding the date of applying for homeless assistance; and,

(4) Can be expected to continue in such status for an extended period of time because of chronic disabilities; chronic physical health or mental health conditions; substance addiction; histories of domestic violence or childhood

abuse (including neglect); the presence of a child or youth with a disability; or two or more barriers to employment, which include the lack of a high school degree or General Education Development (GED), illiteracy, low English proficiency, a history of incarceration or detention for criminal activity, and a history of unstable employment.

**Fleeing Domestic Abuse or Violence (Category 4 of the HUD Homeless Definition)**

Any individual or family who:

(1) Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual 57 assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence;

(2) Has no other residence; and,

(3) Lacks the resources or support networks, e.g., family, friends, and faith-based or other social networks, to obtain other permanent housing.

**At Risk of Homelessness (HUD Definition)**

(1) An individual or family who:

(a) Has an annual income below 30 percent of median family income for the area, as determined by HUD;

(b) Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the —Homeless definition in this section; and,

(c) Meets one of the following conditions:

(i) Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;

(ii) Is living in the home of another because of economic hardship;

(iii) Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days of the date of application for assistance;

(iv) Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;

(v) Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons, or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

(vi) Is exiting a publicly funded institution, or system of care (such as a healthcare facility, a mental health facility, foster care or other youth facility, or correction program or institution); or,

(vii) Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

(2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e- 2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or,

(3) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him.

**Chronically Homeless (HUD Definition)**

(1) An individual who:

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

(b) 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 (totaling one year combined); and,

(c) 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;

(2) 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, before entering that facility; or,

(3) 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, including a family whose composition has fluctuated while the head of household has been homeless.

**Disability (HUD Definition)**

An individual who:

(1) Has a disability as defined by Section 223 of the Social Security Act (42 U.S.C. 423); or,

(2) Is determined by HUD regulations to have a physical, mental, or emotional impairment that:

(a) Is expected to be of long, continued, and indefinite duration;

(b) Substantially impedes his or her ability to live independently; and,

(c) Is of such a nature that more suitable housing conditions could improve such disability; or,

(3) Has a developmental disability as defined in the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 15002(8)); or,

(4) Has the disease Acquired Immunodeficiency Syndrome (AIDS) or any conditions arising from the etiologic agent for Acquired Immunodeficiency Syndrome (HIV).

The definition does not include a person whose disability is based solely on any drug or alcohol dependence for the purpose of qualifying for low-income housing under HUD public housing and Housing Choice Voucher programs.

**Homeless Management Information System (HMIS)**

A Homeless Management Information System is an electronic web-based data collection and reporting tool designed to record and store client-level information on the characteristics and service needs of homeless individuals and families throughout a Continuum of Care (CoC) jurisdiction. Usage of the HMIS is mandated by the U.S. Department of Housing and Urban Development (HUD) for any person experiencing homelessness.

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

The Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT) developed and owned by OrgCode and Community Solutions is a triage tool that assists in informing an appropriate "match" to a housing intervention to individuals based on their acuity in several core areas. Within those recommended housing interventions, the VI-SPDAT allows for prioritization based on presence of vulnerability across four components: (A) history of housing and homelessness; (B) risks; (C) socialization and daily functioning; and, (D) wellness (including physical health, substance use, mental health, medications, and abuse and trauma). Version 2 of the VI-SPDAT was released in 2015 and is currently being implemented for both single adults and families. Hawaii's Single Adults Coordinated Entry System has agreed to use the VI-SPDAT as the universal assessment tool across the Continuum of Care for screening and matching individuals experiencing homelessness in Hawaii. Staff administering any of the SPDAT tools should be trained by an authorized trainer.

# SINGLE ADULTS VISION STATEMENT AND GUIDING PRINCIPLES

Background: This Vision Statement is intended to contain the general principles that will be incorporated into the coordinated entry process. All future planning efforts should be measured against the goals contained in this document.

Intent: Implement a transparent coordinated entry process to ensure that people experiencing homelessness in Hawaii are able to rapidly access the most appropriate homeless housing and services to meet their individual needs.

Purpose of Coordinated Entry: Participation in a coordinated entry system is a requirement for all Continuum of Care (CoC) and Emergency Solutions Grant (ESG) funded programs under the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009. By the terms of the CoC Interim Rule, coordinated entry is "…a centralized or coordinated process designed to coordinate program participant intake, assessment, and provision of referrals… [that] covers the geographic area, is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool." More importantly, though, development and implementation of

coordinated entry in Hawaii is an opportunity to think critically about our homeless response system. Through this process, we aim to increase the speed at which people seeking assistance are able to access the system, match those people to appropriate housing and services by prioritizing those with the most acute needs for placement, reserve the most intense services for those with the greatest vulnerability, improve efficiency by maximizing document readiness and minimizing vacancies throughout the response system, unify a fragmented response system, and ensure that we have a comprehensive array of housing and services to meet the needs of our community.

Key Principles of Hawaii's Coordinated Entry System: Through a community process, we have identified the following key principles as essential to our coordinated entry system:

- *Access* to the resources of our homeless response system should be fast, transparent, and open to anyone experiencing (or at-risk of) homelessness throughout Hawaii.
- The intake, assessment, and referral processes should be *streamlined* to ease the burden on both clients and frontline service staff by reducing redundancy within the system.
- Housing First should be implemented at the programmatic and systemic levels to *reduce barriers to entry* and ensure that the most vulnerable clients can access the most intensive resources.
- People experiencing (or at-risk of) homelessness should be *prioritized for resources* based on vulnerability and need, while still accounting for and maximizing client choice.
- Homeless housing and service providers, along with other mainstream service providers, should maintain a *cooperative approach* to problem-solving, goal setting, and systemic orientation.
- The coordinated entry system should prioritize *quality assurance* to ensure consistency in tools, standards, staff training, and opportunity for people experiencing (or at-risk of) homelessness throughout Hawaii.

Key Elements of Hawaii's Coordinated Entry System: Through a community process, we have identified the following key decisions regarding structural components of the coordinated entry system that have already been made:

- *Access Model:* People experiencing (or at-risk of) homelessness will be able to access the coordinated entry system through: (1) program sites within the CoC; (2) street outreach teams for those encountered in unsheltered environments by outreach staff; and, (3) a complimentary phone system for those unable to access a physical location (likely operated by Aloha United Way 2-1-1).
- *Assessment Tool:* The coordinated entry system will use the VI-SPDAT as its primary assessment tool. The VI-SPDAT, or subpopulation specific versions such as the F-SPDAT as appropriate, may be supplemented by additional screening/triage tools as needed to: (1) address the health/safety of vulnerable persons (e.g., victims of domestic violence or other persons in immediate distress); and, (2) meet the specialized needs of particularly vulnerable subpopulations (e.g., mental illness, substance abuse, etc.).
- *Prioritization:* People experiencing (or at-risk of) homelessness will be prioritized in a transparent, consistent manner that considers the individual's vulnerability and needs. Prioritization will be a transparent process for the benefit of both providers and those seeking assistance. This prioritization scheme may include: (1) VI-SPDAT scores; (2) length of time homeless; (3) physical and mental health conditions; (4) age; (5) document readiness; (6) client choice; and, (7) other factors that are consistent with identifying vulnerability and need.
- *Housing Navigation:* The coordinated entry system will incorporate housing navigation services that improve the ability of people experiencing (or at-risk of) homelessness to move through the homeless response system, increase efficiency in housing placement, and reduce the overall burden on individual programs.

# DRAFT COORDINATED ENTRY PRE-SCREENING TOOL

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*All clients should be administered this pre-screening tool prior to a full coordinated entry assessment (VI-SPDAT, Family VI-SPDAT, TAY VI-SPDAT, etc.). If the individual or family appears to have obvious and immediate medical or victim-service safety needs, the surveyor should use their best judgment regarding how to proceed in a manner designed to ensure the individual or family's health and well-being.*

**Pre-Screening Date:** _____

**1. SAFETY NEEDS**

**Q1. Do you need immediate medical attention? Would you like us to help you go to the hospital now?**

☐ Yes ☐ No

**Q2. Do you need immediate police assistance? Would you like us to contact the police for you now?**

☐ Yes ☐ No

**Q3a. Are you currently residing with, or trying to leave, a family member, intimate partner, or someone who threatens you, makes you feel fearful, or forces you to do something against your will?**

☐ Yes ☐ No

**Q3b. [Only if "yes" to Q3a] Do you want services that are specifically geared to help people who've experienced violence from a family member or an intimate partner, and do you need a safe place to stay?**

☐ Yes ☐ No

*Surveyor Instructions: If the client answers "yes" to any of Q1-3b, they should be assisted to access appropriate emergency services prior to continuing this tool (if necessary) or receiving the full coordinated entry assessment. The full coordinated entry assessment should be administered only after the client's immediate safety needs have been stabilized.*

- *If "yes" to Q1: Assist the client to access appropriate medical care*
- *If "yes" to Q2: Assist the client to access appropriate police assistance*
- *If "yes" to Q3a or 3b: Assist the client to access appropriate victim service provider*

**2. BASIC INFORMATION**

**Q4. What is your date of birth?**

_____

**Q5. Are you a veteran?**

☐ Yes ☐ No

**Q6a. Including you, how many total members are in your household?**

_____

**Q6b. Including you, how many adults (ages 18 and up) are in your household?**

_____

**Q6b. Including you, how many children under the age of 18 are in your household?**

_____

**Q7a. Where did you sleep last night?**

- ☐ Streets/Outdoors
- ☐ Emergency Shelter
- ☐ With Family or Friends
- ☐ Hotel or Motel
- ☐ Other: (Please Explain) _____

**Q7b. In what area of Oahu did you sleep last night?**

- ☐ Downtown Honolulu: Salt Lake to Piikoi St
- ☐ Ewa: Aiea to Kapolei
- ☐ Upper Windward: Kahaluu to Kahuku
- ☐ Waianae Coast
- ☐ East Honolulu: Piikoi St to Hawaii Kai, Waikiki
- ☐ Windward: Kaneohe to Waimanalo
- ☐ North: Wahiawa to North Shore

**Q8a. Do you have a place to sleep tonight?**

☐ Yes ☐ No

**Q8b. [Only If "yes" to Q8a] Where will you sleep tonight?**

Description: (Same or New Location Detail) _____

**Q8c. [Only if "yes" to Q8a] Can you stay in that same place for the next two weeks?**

☐ Yes ☐ No

**Q8d. [Only if "no" to Q8c] Why do you think that you'll need to find a new place to sleep? When do you think that you need to find a new place by?**

Reason: _____
Date: _____

**Q8e. [Only if "no" to Q8a] Would you like us to try to help you access an emergency shelter tonight?**

☐ Yes ☐ No

**Q9. What's the best way for us to safely contact you or leave you a message so that we can help you access housing resources that may be available to you?**

- ☐ Phone/Voicemail: _____
- ☐ Email: _____
- ☐ Physical Location: _____
- ☐ Other: (Detail) _____

The individual or family likely meets the **HUD definition of homelessness** if:

- The individual or family slept on the streets last night (Q7a);
- The individual or family slept in an emergency shelter last night (Q7a);
- The individual or family has no place to sleep tonight (Q8a); or,
- The individual or family stayed with family or friends or in a hotel or motel last night (Q7) and they expect to lose that option within the next two weeks (Q8c and Q8d)

If the individual or family is not likely to meet this definition of homelessness, refer the individual or family to mainstream resources.

## 3. HOUSING PREFERENCES

**Q10. What region(s) of Oahu are you not willing to accept housing in? (Select as many as applicable)**

- ☐ Downtown Honolulu: Salt Lake to Piikoi St
- ☐ Ewa: Aiea to Kapolei
- ☐ Upper Windward: Kahaluu to Kahuku
- ☐ Waianae Coast
- ☐ East Honolulu: Piikoi St to Hawaii Kai, Waikiki
- ☐ Windward: Kaneohe to Waimanalo
- ☐ North: Wahiawa to North Shore

**Q111. [Only if under 24 years of age on Q4] Would you be willing to share an apartment with another youth?**

- ☐ Preferred
- ☐ Acceptable
- ☐ No
- ☐ Not Sure

# DRAFT COORDINATED ENTRY OVERSIGHT REPORT

| | |
|---|---|
| **Subpopulation:** | |
| **Date:** | |

This oversight report should be provided by the four subpopulation-specific Coordinated Entry System Administrators to the Coordinated Entry Oversight Group on a monthly basis. The data contained in the following four charts will provide that group with the information it needs to conduct effective oversight of the Coordinated Entry System. The four charts include:

1. Monthly referral comparison showing placements and unassignments.
2. Unassignment overview showing unassignments due to: already housed, failure to locate, higher level of care needed, client choice, moved outside of CoC, and other comments.
3. Placement rates by housing type showing: total referrals, unassignments, placements, average days to house.
4. Placement rates by housing program showing: total referrals, unassignments, placements, average days to house.