



**Winston-Salem/Forsyth County
Continuum of Care**

Community Intake Center Policy and Procedure Manual

Coordinated Entry Overview

In 2012, the Winston-Salem/Forsyth County Continuum of Care (WSFC CoC) developed a coordinated entry system for its full geographic area, known as the Community Intake Center. United Way of Forsyth County was chosen by the WSFC CoC to provide the backbone support and staffing to implement the coordinated entry process. In 2017, the WSFC CoC initiated a process to improve the delivery of housing and crisis response services and assistance for people experiencing homelessness or at imminent risk of homelessness by refining the community's process for access, assessment, eligibility determination and referrals across the Continuum of Care.

This Coordinated Entry System process, known as the Community Intake Center, institutes consistent and uniform access, assessment, prioritization, and referral processes to determine the most appropriate response to each person's immediate housing needs. This system of Coordinated Entry is recognized nationally as a best practice which can improve efficiency within systems, provide clarity for people experiencing homelessness, and can help serve more people quickly and efficiently with assistance targeted to address their housing needs. In August 2017, the City of Winston-Salem, initiated a process to formalize and codify the policies and procedures for the coordinated entry system to ensure compliance with the mandate from the Department of Housing and Urban Development (HUD) that every CoC establish and operate a coordinated entry process (24 CFR 578).

This Community Intake Center Policies and Procedures document is an operational manual, providing guidance and direction for the day to day operation, management, oversight, and evaluation of Winston-Salem's coordinated entry system.

This manual will be updated and revised on an on-going basis as the actual application and practical experience of implementing a coordinated entry system design principles are refined and improved.

This manual was developed by the Winston-Salem/Forsyth County Continuum of Care in consultation with OrgCode Consulting, Inc.

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Introduction and Purpose of Coordinated Entry

As a part of its commitment to serving all people experiencing a housing crisis in Forsyth County, NC, the WSFC CoC began development of a coordinated entry system in 2012. This process was guided by the Continuum of Care (CoC) Program interim rule, published by HUD in July 2012. The CoC Program interim rule (24 CFR 578) and the ESG interim rule (24 CFR 576) require the CoC to establish and operate a coordinated entry process. In addition, the CoC Program interim rule (24 CFR 578) and the ESG interim rule (24 CFR 576) require that the CoC establish and consistently follow written standards for providing CoC assistance, in consultation with recipients of the ESG program. As such, all programs operating in Forsyth County, NC that receive funding from either the Continuum of Care grant program or the Emergency Solutions Grant (either as a sub-grantee of the City of Winston-Salem or through the State of North Carolina) are required to participate in the coordinated entry process.

The WSFC CoC shall encourage all other agencies providing services to people experiencing homelessness in Forsyth County to participate in and support program participants in accessing the Community Intake Center, the WSFC CoC's coordinated entry system.

At a minimum, HUD requires these written standards:

- Policies and procedures for evaluating eligibility for assistance in the CoC Program
- Policies and procedures for determining and prioritizing which eligible people will receive assistance for permanent supportive housing assistance, transitional housing assistance, and rapid re-housing assistance

The goals of these written standards are to:

- Establish community-wide expectations on the operations of projects dedicated to serving people experiencing homelessness within Forsyth County;
- Ensure that the system of care for people who are homeless is transparent to both program 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 sub-recipients of funds;
- Create consistency and coordination between recipients' and sub-recipients' projects within the CoC, including both CoC-funded and ESG-funded projects;
- CoC Program standards must be in accordance with the Violence Against Women Act (VAWA) regulations;

The Community Intake Center is Winston-Salem, North Carolina's approach to organizing and providing services and assistance to people experiencing a housing crisis throughout the Continuum of Care. People who are seeking homelessness assistance or homelessness prevention assistance in Forsyth County will be directed to defined entry points. These points will include, but not be limited to all homeless shelters, drop-in centers, and street outreach programs. Staff from the defined entry points shall assess people seeking assistance in a uniform and consistent manner. Staff also will provide, through the NC HMIS system the information necessary to prioritize people seeking help for housing and services, and then link them to available interventions in accordance with the intentional service strategy defined by the WSFC CoC Operating Cabinet. Each service participant's acuity level and housing needs shall be

aligned with available service and program strategies that represent the appropriate intensity and scope of services needed to resolve the housing crisis.

Guiding Principles

The Community Intake Center serves as the system to help both centralize and standardize connection to the most critical resources in our community, expediting permanent housing for people experiencing homelessness. The initial access points will be all emergency shelters, day centers for the homeless, and street outreach programs, and other programs/agencies as approved by the CoC Operating Cabinet.

The guiding principles for the CIC include:

- **Housing First:** When an individual or family is homeless the service priority shall be to reconnect them with housing, and then to other services in the community which will help them maintain their housing at the intensity of service that the household requires to maintain their housing stability.
- **Client-centered:** Based on the identified needs of the household, the CIC will focus on connecting household members with community resources designed to achieve housing stability.
- **System-wide prioritization of limited supportive housing resources:** Winston-Salem/Forsyth County has a limited number of moderate to intensive housing supports including rapid re-housing slots, public housing units and vouchers, specialized housing vouchers for people experiencing homelessness and case management services. The Community Intake Center will help prioritize access to these limited resources on a community-wide basis.

Fair Housing, Tenant Selection and Other Statutory and Regulatory Requirements

All projects receiving CoC or ESG funding and operating in Forsyth County, NC shall participate in the CIC. The CIC will develop strategies to ensure community resources and referral options are available within the community to serve all people 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 people who might be or identify with one or more of these attributes ensures the coordinated entry system is accessible to all people.

To ensure that the CoC affirmatively markets housing and supportive services to eligible persons regardless of race, color, national origin, religion, sex, age, familial status, handicap or who are least likely to apply in the absence of special outreach, participating agencies shall ensure that their current program and agency information is provided to NC211. In addition, information on any opportunity or initiative sponsored by the CoC that is marketed to the public shall be advertised in media outlets with wide circulation in the community.

All CoC and ESG funded projects 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.

Recipients and subrecipients of CoC Program and ESG Program-funded projects must comply with the nondiscrimination and equal opportunity provisions of Federal civil rights laws, including the following:

- A. Fair Housing Act prohibits discriminatory housing practices based on race, color, religion, sex, national origin, disability, or familial status.
- B. Section 504 of the Rehabilitation Act prohibits discrimination on the basis of disability under any program or activity receiving Federal financial assistance.
- C. Title VI of the Civil Rights Act prohibits discrimination on the basis of race, color, or national origin under any program or activity receiving Federal financial assistance.
- D. Title II of the Americans with Disabilities Act prohibits public entities, which includes State and local governments, and special purpose districts, from discriminating against individuals with disabilities in all their services, programs, and activities, which include housing, and housing related services such as housing search and referral assistance.
- E. Title III of the Americans with Disabilities Act prohibits private entities that own, lease, and operate places of public accommodation, which include shelters, social service establishments, and other public accommodations providing housing, from discriminating on the basis of disability.

All CoC and ESG funded projects must document steps taken to ensure effective communication with people with disabilities. Access points must be accessible to people with disabilities, including physical locations for people who use wheelchairs, as well as people in Winston-Salem who are least likely to access homeless assistance.

When the CIC staff or Assessment Team identifies gaps in services to any subpopulation of people, they will notify the WSFC Commission on Ending Homelessness (COEH) of these gaps in the system of care within the community. The Commission will be responsible for working with the City of Winston-Salem, Forsyth County, and other local agencies and departments to address the gap in services and ensure that all residents of Forsyth County have access to appropriate services to address their housing crisis.

Definitions

For the purposes of this policy and procedure manual, for those definitions identified in this section as a HUD Definition, the actual definition provided by HUD shall supersede those enumerated in this document.

Chronically Homeless (HUD Definition)

HUD defines a chronically homeless person as follows:

A person who:

1. Is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
 - a. 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 three years, where the cumulative total of the four occasions is at least one year. Stays in institutions of 90 days or less will not

- constitute a break in homelessness, but rather such stays are included in the cumulative total; and
- b. 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. 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 the criteria in paragraph (1) of this definition, before entering that facility; or
 3. Who meets all of the criteria in paragraph (1) of this definition.

Disability (HUD Definition)

HUD defines a person with disabilities as a person who:

1. Has a disability as defined in 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 ability, 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).

To qualify for low income housing under HUD public housing and Section 8 programs, the definition does not include a person whose disability is based solely on any drug or alcohol dependence.

Literally Homeless (HUD Homeless Definition Category 1)

A person who lacks a fixed, regular, and adequate nighttime residence

1. An individual 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, camping ground; or
2. An individual 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 program for low-income individual); 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 (HUD Homeless Definition Category 2)

A person who will imminently lose their housing (within 14 days) and become literally homeless

Homeless under other Federal statutes (HUD Homeless Definition Category 3)

A person defined as "homeless" by other federal statute (e.g., Dept. of HHS, Dept. of Ed.)

Fleeing domestic abuse or violence (HUD Homeless Definition Category 4)

A person fleeing or attempting to flee domestic violence, stalking, dating violence, or sexual assault

At Risk of Homelessness

1. Category 1: A person who:
 - a. Has an annual income below 30% of median income for the area; AND
 - b. Does not have sufficient resources or support networks immediately available to prevent them from moving to an emergency shelter or another place defined in Category 1 of the “homeless” definition; AND Meets one of the following conditions:
 - i. Has moved because of economic reasons 2 or more times during the 60 days immediately preceding the application for assistance; OR
 - ii. Is living in the home of another because of economic hardship; OR
 - iii. Has been notified that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance; OR
 - iv. Lives in a hotel or motel and the cost is not paid for by charitable organizations or by Federal, State, or local government programs for people with low-income; OR
 - v. Lives in an SRO or efficiency apartment unit in which there reside more than 2 persons or lives in a larger housing unit in which there reside more than one and a half persons per room; OR
 - vi. Is exiting a publicly funded institution or system of care; 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. Category 2: A child or youth who does not qualify as homeless under the homeless definition, but qualifies as homeless under another Federal statute
3. Category 3: An unaccompanied youth who does not qualify as homeless under the homeless definition, but qualifies as homeless under section 725(2) of the McKinney-Vento Homeless Assistance Act, and the parent(s) or guardian(s) or that child or youth if living with him or her.

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 person-level information on the characteristics and service needs of people experiencing homelessness 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 program receiving CoC or ESG funds.

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 which assists in informing an appropriate ‘match’ to a particular housing intervention to people 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 five components: (A) history of housing and homelessness (B) risks (C) socialization and daily functioning, (D) wellness - including chronic health conditions, substance usage, mental illness and trauma, and (E) family unit. Version 2 of the VI-SPDAT for both people and families was released May 2015 and is currently undergoing implementation. The Winston-Salem Coordinated Entry System has agreed

to use the VI-SPDAT as the universal assessment tool across the Continuum of Care for screening and matching people experiencing homelessness in Winston-Salem. Staff administering any of the SPDAT tools shall be trained. The CIC staff shall be responsible for ensuring access to training is available to staff at all access points for the coordinated entry system on an on-going basis.

Planning, Staffing Roles and Participation Responsibilities

Oversight and Monitoring

WSFC CoC Operating Cabinet members shall adopt policies and procedures for the Community Intake Center that are consistent with the HUD requirements from 24 CFR 578 and 24 CFR 576 and the vision and strategic plan of the WSFC CoC.

The WSFC CoC Operating Cabinet shall conduct oversight and monitoring of the Community Intake Center and the functions it coordinates to ensure consistent application of these policies and procedures and high quality service delivery for people experiencing a housing crisis.

The WSFC CoC Operating Cabinet shall conduct oversight and monitoring of the Community Intake Center and the functions it coordinates to ensure consistent application of these policies and procedures and high quality service delivery for people experiencing a housing crisis. The United Way of Forsyth County shall staff the CIC as determined by the WSFC CoC Operating Cabinet to be necessary for its operation.

Continuum of Care and ESG funded Providers Serving People Experiencing Homelessness Participation Responsibilities

1. **Policies:** CoC and ESG funded providers shall maintain and adhere to the policies and procedures for the Community Intake Center operations, and as established for access points, assessment procedures, prioritization, and referral to available services and housing.
2. **Participation:** Agencies and Programs operating within the geographic bounds of the WSFC CoC who serve people who are homeless but do not receive either CoC or ESG funds are encouraged to participate in the Community Intake Center and the coordinated entry processes to facilitate the access to provide supportive services and supportive housing resources for the people they serve.
3. **Maintain low barriers to enrollment:** Providers receiving CoC or ESG funding who are serving people experiencing homelessness shall limit barriers to enrollment in services and housing. 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 people with a specific set of attributes or characteristics. Although a person may not be turned away due to their disability status, if their disability makes them unable to care for themselves they could be directed to services and facilities that can meet their needs. Providers maintaining restrictive enrollment practices must maintain documentation providing justification for the enrollment policy. Accommodations for registered sex offenders may be limited or restricted in order to comply with state law.

4. **Income Standards:** CoC providers offering Prevention and/or Short-Term Rapid Re-housing assistance (i.e. 0 – 24 months of financial assistance) may choose to apply some income standards for their enrollment determinations.
5. **Evaluation:** The Winston-Salem Forsyth County Commission on Ending Homelessness shall, as a part of its annual assessment of services needs, review the array of services available in the community that offer low barrier services to ensure that within the geographic bounds of the community low-barrier services are available to all sub-populations of people experiencing homelessness. Where gaps exist, the Commission on Ending Homelessness shall be responsible for developing a strategic plan to address the lack of services.
6. **Maintain Fair and Equal Access:** CIC access points and referral programs shall ensure fair and equal access to programs and services for all people regardless of actual or perceived race or ethnicity, color, religion, national origin, age, gender identity, pregnancy, citizenship, familial status, household composition, disability, veteran status, or sexual orientation.
7. **Gender:** If a program participant's self-identified gender creates challenging dynamics among residents within a CoC or ESG-funded residential facility, the host program shall make every effort to accommodate the person or assist in locating alternative accommodation which are appropriate and responsive to the person's needs. All CoC and ESG funded programs shall offer universal program access to all subpopulations as appropriate, including chronically homeless people, veterans, youth, transgender people and people fleeing domestic violence.
8. **Universal Program Access:** All programs serving people who are homeless within the geographic bounds of the WSFC CoC are encouraged to offer universal program access to all subpopulations as appropriate, including chronically homeless people, veterans, youth, transgender people and people fleeing domestic violence.
9. **Population-focused projects:** Population-specific projects and those projects maintaining affinity focus (e.g. women only, veterans only, etc.) are permitted to maintain eligibility restrictions as currently defined and will continue to operate and receive prioritized referrals. The Commission on Ending Homelessness and the WSFC CoC Operating Cabinet will work with agencies wishing to develop new projects or programs focused only on specific sub-populations to ensure the projects meet an identified need within the CoC for services. In the event that the Commission on Ending Homeless identifies an unmet need within the community that no current program is able or willing to serve, the Commission shall work with the full CoC and other community leaders to develop strategies to meet the unmet need.
10. **Provide appropriate safety planning:** CIC and participating programs shall provide necessary safety and security protections for people fleeing or attempting to flee family violence, stalking, dating violence, or other domestic violence situations when accessing the CIC or participating programs. Minimum assessment requirements for all persons entering a homeless service within the WSFC CoC must include a threshold assessment

for presence of participant safety needs and referral to appropriate trauma-informed services if safety needs are identified.

11. **Lethality Assessment:** For participants who identify there is a present risk of family violence, stalking, dating violence, or other domestic violence, in addition to the VI-SPDAT, a Lethality Assessment shall be administered. The results from the Lethality Assessment will be an additional prioritization tool when assessing prioritization of households at risk for family violence, stalking, dating violence, or other domestic violence.
12. **Written Standards:** Create and share written eligibility standards. All CoC and ESG funded programs shall provide detailed written guidance for eligibility and enrollment determinations. Eligibility criteria should be limited to what is required by the funder and any requirements beyond those 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 characteristics, attributes, behaviors or histories used to determine who is eligible to be enrolled in the program. These standards will be shared with the CIC staff well as the WSFC CoC Operating Cabinet.
13. **Communicate vacancies:** All participating service providers must communicate project vacancies (either bed, unit, or voucher) to the CIC staff within 7 days of availability.
14. **Limit enrollment to participants referred through CIC:** Each CoC or ESG -funded bed, unit, or voucher that is required to serve someone who is homeless must receive their referrals from the CIC's By-Name List, using the prioritization criteria outlined in these policies and procedures. Any agency filling homeless mandated units from alternative sources will be reviewed by the CoC Operating Cabinet and if determined to be out of compliance with these policies and procedures the CoC Operating Cabinet may direct its leadership to inform the leaders of the CoC Ratings Panel and other community based funders of the non-compliance with the CoC's established policies and procedures. The CIC Assessment Team shall be informed of every opening in homeless dedicated services and how and when they were filled.
15. **Participation in Coordinated Entry System planning:** All CoC and ESG funded projects shall participate in the CIC planning development and implementation. Other agencies and programs operating in the geographic bounds of the WSFC CoC are encouraged to participate in the planning and implementation of the CIC and coordinated entry system to ensure all people experiencing homelessness are able to access supportive housing and services dedicated to the homeless as prioritized by the WSFC CoC.
16. **Contribute data to the Homeless Management Information System (HMIS):** Each provider with homeless dedicated units is encouraged to participate in NC HMIS; WSFC CoC's designated HMIS system. Providers receiving funding for homeless services from any federal, state, county or other funder that requires participation in HMIS shall participate in the NC HMIS system. Providers should work with the CoC's Local System Administrator (LSA) and the HMIS Lead Agency for training and support on the specific forms, assessment and requirements of the NC HMIS implementation for WSFC CoC.
17. **Ensure all staff who interacts with the CIC receives regular training and supervision:** Each provider should notify the CIC Coordinator of new staff who need

training, in order to ensure employees have access to ongoing training and information related to the coordinated entry system.

18. Ensure individual rights are protected and people are informed of their rights and responsibilities: People shall have their rights explained to them verbally and in writing when completing an initial intake. At a minimum, rights will include:

- The right to be treated with dignity and respect;
- The right to appeal CIC 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/person selection process;
- The right to accept housing/services offered or to reject housing/services;
- The right to confidentiality and to be informed about when confidential information will be disclosed, to whom, and for what purposes, as well as the right to deny disclosure;
- The right to file a grievance for violation of nondiscrimination policies.

19. Advertising: CIC policies, procedures and services shall be advertised on the CoC's website. Also, providers participating in the CIC shall post, on their premises in a location clearly visible to program participants, a notice stating participation in the WSFC CoC's CIC and providing contact information for the CIC. Finally, the script for administration of the coordinated assessment tool, the VI-SPDAT, shall state that the reason that participants are surveyed using the VI-SPDAT is to provide entry to the system of services in a coordinated manner.

Coordinated Entry System Workflow and Policies

I. Coordinated Entry Workflow Overview

Provider staff will work to ensure as many of the people they engage will be assessed with a VI-SPDAT, can be located, have been encouraged to pursue housing, and are working toward obtaining the documentation required for potential housing options.

CIC outreach staff shall be available to assess people with the VI-SPDAT seeking homeless services that have not previously been assessed by a street outreach program, shelter, transitional housing program, day center or other homeless dedicated provider. Priority for CIC outreach staff shall be to assess people on the By-Name List who have been homeless for 14 days or more and are not enrolled in a homeless shelter service or who have been identified by relevant mainstream providers (i.e. probation, jail, hospitals and courts).

Once a participant has completed a VI-SPDAT the data shall be entered into NC HMIS by the access point staff as soon as possible, but no later than 24 hours after the VI-SPDAT has been administered.

II. Access Models and Accessibility – Comprehensive, Accessible and Understood

Winston-Salem, North Carolina utilizes a “no wrong door” access model for adults without children, adults accompanied by children, unaccompanied youth, households fleeing violence and

persons at risk of homelessness. Households who are included in more than one of these populations (for example, a parenting unaccompanied youth or an adult who presents both as unaccompanied and with children to different providers) will receive service at each of the access points for which they qualify as a target population. Regardless of initial access point(s), people experiencing homelessness or at risk of homelessness are provided the same assessment approach, including standardized decision-making and assessment tools specific to each population (adults without children, adults accompanied by children, unaccompanied youth and persons at risk of homelessness).

In the event a household is identified through the CIC prioritization process, which has accessed multiple services and has presented in more than one household configuration, the CIC staff shall work with the household members to determine what household configuration they would like to be housed as, and a program match shall be made based on the preferred household composition.

III. Safety Planning and Domestic Violence

Upon a household entering the homeless services system, providers conduct safety assessments to determine whether the household is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions which relate to violence against the household. The household should be processed in accordance with the following protocol:

- a. If during the initial engagement, concerns are identified about the household's immediate safety, the client should be referred to local law enforcement (911) and to a domestic violence shelter, through virtual access to the Family Services Domestic Violence 24 hour Crisis Line (336-723-8125) or the Crisis Line at Next Step Ministries (336-413-5858) or to the Cardinal Innovations Crisis line (888-581-9988).
- b. If the client needs a domestic violence or other form of a protective order, they should be referred to Safe on Seven to obtain such an order.

In the event that a household presents to the CIC for program matching and there is reason to believe there is domestic violence between the adults in the household, each adult in the household shall be matched to a separate program for purposes of assessing the safety of all household members and the development of safety plans. If after initial assessment by the supportive service providers the adult household members both continue to request being housed as a single household despite the presence of an on-going pattern of domestic violence, the entire household shall be presented for case conferencing to the CIC Assessment Team.

In the event an adult member of a household which has been matched to a supportive housing service flees the household because of the presence of domestic violence, the prior match shall not prohibit the person fleeing the domestic violence from being re-prioritized by the CIC for a new supportive housing match.

Assessment of Safety Risk by client to self or others:

If during the assessment, it is determined that the client presents an immediate safety risk to themselves or others, the individual performing the assessment should immediately contact 911

and/or Cardinal Innovations Access Line to assist in determining the appropriate course of action to ensure the safety of the clients and those around the client.

V. Accessibility of Services

CIC staff shall work with all access point providers to ensure the physical locations are accessible to people with disabilities, including accessible locations for people who use wheelchairs. When an individual seeking access to services has a disability which limits their ability to access designated CIC access points, CIC Outreach staff shall make arrangements to meet the individual at a mutually agreeable location that is accessible to the person with the disability and provides sufficient privacy for the administration of the intake and VI-SPDAT interviews. CIC outreach staff shall prioritize outreach services with a particular focus on people experiencing homelessness that are least likely to access homeless assistance.

Providers partnering with the CIC must ensure effective communication with people with disabilities, including provision of appropriate auxiliary aids and services necessary to ensure effective communication (e.g. Braille, audio, large type, assistive listening devices, and sign language interpreters) at the person's request.

Providers working with the CIC must also take reasonable steps to offer CIC materials and instruction in multiple languages to meet the needs of minority, ethnic, and groups with Limited English Proficiency (LEP).

CIC outreach and administrative staff shall coordinate with shelter providers to visit each participating shelter at least quarterly to review program services and accessibility.

V. Initial Homeless System Access

All CoC providers must operate with as few barriers to entry as possible. Individuals and families facing a housing crisis may access emergency services, such as emergency shelter, independent of the operating hours of the CICs intake and assessment processes, by calling 211 or in the event of an emergency 911. All WSFC CoC members are responsible for ensuring their current program and agency information is provided to NC211. This information should be updated whenever changes are made to program offerings, eligibility, or contact information. All agencies should review their 211 profile at least annually.

During the shelter stay or street outreach engagement, when concerns are raised about the household's immediate safety, the individual or family should be referred either to local law enforcement and/or domestic violence shelters through section III: Safety Planning and Domestic Violence.

When an emergency shelter or street outreach staff engages an individual or families experiencing homelessness, they should update the participant's existing NC HMIS record or create a new NC HMIS record if no prior record exists. The service provider should review the NC HMIS record to ensure all information entered into the NC HMIS is both complete and accurate.

Prior to NC HMIS data input, the person performing initial intake of the household must obtain a signed written Release of Information detailing the person's permission or denial of permission for the access point program to share the individual's or families information with the CIC, and

other CIC participating agencies. For families with adults and children experiencing homelessness, the consent form should be signed by all adults in the household. The head of household or authorized representative should also sign the consent forms on behalf of children in the household who are below the age of eighteen (18).

VI. Use of the 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 which assists in informing an appropriate 'match' to a housing intervention to people 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 for unaccompanied individuals and five components for families: (a) history of housing and homelessness (b) risks (c) socialization and daily functioning (d) wellness - including chronic health conditions, substance usage, mental illness and trauma and (e) family unit. WSFC CoC has selected the VI-SPDAT as the universal assessment tool to be used across the CoC for screening and matching people experiencing homelessness in Forsyth County and is currently implementing Version 2 of the VI-SPDAT, released May 2015. Staff administering any of the SPDAT tools should be trained.

People engaged by service providers acting as access points for the CIC should receive the same information regarding what to expect from the coordinated entry process no matter what access point they use. Assessors should communicate how the survey process works and how the results will be used to apply a clear and consistent prioritization across the community. See Appendix B for suggested script.

This ensures that the benefits to participating in a survey are described clearly to encourage people to participate, but is equally important to make sure people understand that participating does not guarantee (and may not result in) housing. It is also important people receive a clear understanding of where their information will be shared. An example of what to standardize follows below, and is further described in Appendix B – Example Messaging:

- 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
- It usually takes less than 10 minutes to complete
- Only “Yes,” “No,” or one-word answers are being sought
- Any question can be skipped or refused
- The information is going to be stored in the NC HMIS
- 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; housing providers can identify people to target for housing resources as they become available, and for planning purposes.
- If the participant does not understand a question, clarification can be provided
- The importance of relaying accurate information to the assessor and not feeling there is a correct or preferred answer they need to provide, nor information they need to conceal

VII. Population Specific 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 are able to access the full spectrum of housing resources designated for this subpopulation.

Survivors of Domestic Violence:

People experiencing homelessness or at-risk of homelessness may not be denied access to the CIC on the basis that the person is or has been a victim of domestic violence, dating violence, sexual assault or stalking. The Violence against Women Act (VAWA) prevents providers dedicated to serving domestic violence victims from inputting their personally identifiable information into a Homeless Management Information System (HMIS). If a person receiving services from a domestic violence specific provider chooses to seek additional services through a non-domestic violence service provider/CIC access point, the staff shall assess the safety needs of the individual pursuant to the policies here within.

If a person who is receiving services from a domestic violence specific service provider desires to be considered for homeless specific supportive services and housing services, but determines accessing the CIC through an access point is not consistent with their safety plan, the program participant may authorize the domestic violence service provider to refer them to the CIC outreach staff for assessment or may request the domestic violence service provider to perform the assessment and release only the VI-SPDAT score and chronic status for purposes of program matching.

VIII. Client's Right to Refuse to Answer Questions

At all stages of engagement with programs operating in the WSFC CoC a program participant shall be freely allowed to decide what information they provide during any assessment process, to refuse to answer assessment question and to refuse housing services options without retribution or limiting their access to other forms of assistance. This includes the right to refuse disclosure of specific disabilities or diagnosis.

If the client provides specific diagnosis information, this information may only be used for the purpose of determining program eligibility and to make appropriate referrals for supportive services. It may not be used to screen people out of or add additional requirements to a person's participation in programs they are otherwise eligible for.

During the administration of the VI-SPDAT, a client has the right to refuse to answer any or all questions. The client's exercise of this right shall not prohibit their eligibility for any service for which they are eligible. For limited instances when people refuse specific questions throughout the assessment process, the assessor may request permission to ask additional questions in order to utilize their conversation with the person, surveyor observation, documentation and information from other professionals in order to provide responses. When staff encounter people who do not provide a response to any of the first questions, they should stop and acknowledge 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 people until they are willing to be assessed. The VI-SPDAT should be completed in one engagement (although not necessarily first contact).

People who respond better to a conversational approach may benefit from the more comprehensive full SPDAT, further described in Appendix C – Full SPDAT Process.

IX. VI-SPDAT – Concluding the Engagement

Upon completion of the VI-SPDAT, the Assessor may ask if the person is currently working with a provider towards 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 to the participant the importance of having reliable and comprehensive information regarding the best time and place to contact the person in the event they are matched to an available program or need additional information. Assessment staff should collect information from the participant on their whereabouts across a 24 hour period, beginning with where they wake up until they bed down at night, with notations for days when location patterns change, and record this information within the VI-SPDAT. This includes where they most often obtain meals, transportation methods and times to and from meal and shelter providers, cross streets of locations where they hang out or receive services, agency names and staff with whom they engage for all services including non-homeless specific providers, etc. Assessors may also record the name and contact of additional friends or family members who are able to reliably get in contact with them in the event the CIC staff needs to contact the participant for any reason.

Assessors should 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.

X. Next Steps – Collecting Documentation for Housing

Once the VI-SPDAT is completed, or as part of the initial engagements for people already assessed, staff should identify which essential documents (i.e. birth certificate, social security card, DD-214 etc.) the person currently possesses, and begin working with them to collect missing documents, as staff time and resources allow. Assessor should ask for permission to copy essential documents the participant has in their possession and keep a copy attached to their record.

Assessors should emphasize 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 people who have served in the United States armed forces (regardless of discharge status or length of service). Clients should be encouraged to focus on collecting these critical documents, and when necessary matched to services in the community that can assist them in this endeavor.

Prioritization of Referrals

Upon successful VI-SPDAT completion, access point staff shall enter the client's data from the VI SPDAT into the NC HMIS, no later than 24 hours after the assessment is completed. This data is critical to the generation of the community By-Name List from which providers including homelessness prevention, street outreach, transitional housing, rapid re-housing and permanent supportive housing will fill vacancies in their case load (for services only programs) and/or beds (for housing programs).

All Providers either required to accept referrals from the CIC or choosing to receive referrals from the CIC shall provide CIC staff with written documentation of the program eligibility criteria. The CIC Coordinator shall maintain a record of all homeless services offered within the geographic bounds of the CoC and their eligibility criteria.

When a program notifies the CIC Coordinator they have a program opening for a new client/household the CIC Coordinator shall, in consultation with the CIC Assessment team, run a By-Name List report from the NC HMIS. The individual or household with the highest rank on the By-Name List which meets the eligibility criteria for the program shall be matched to that program.

Once a match is made, the CIC staff shall communicate this match with the client and the program to which they have been matched. This communication shall include informing the client of the next steps they are expected to take to complete program enrollment, and their rights and obligations once they are accepted into the program.

The CIC staff will also communicate with the program director of the program, to which the client has been matched, or their designee, the referral information necessary for the program to successfully connect to and complete the program enrollment of the matched client. The responsibility of initiating contact with a matched client shall be incumbent upon the program staff from the matched program. However, CIC staff and other outreach staff shall encourage the client to be proactive in contacting the program they have been matched to.

Programs accepting referrals from the CIC shall notify, in writing, the coordinator of any matches which were unsuccessful for any reason, including if the client proved to be ineligible for the service, the client was unable to be located after 30 days of proactive searching based on available information, or after meeting with the provider the client refused the service.

If more than 50% of the matches referred to a program during any quarter are unsuccessful, the CIC Coordinator and Program lead staff shall have a review meeting to identify and resolve any barriers to successfully matching clients to this program.

The Housing Provider will document any unsuccessful matches and provide: (A) reason(s) why they were not enrolled in the program (B) date of unsuccessful match/"un-assignment" and (C) name of the project being unassigned within NC HMIS so the person can be reassigned to a different provider (further outlined below).

The housing provider will also document, by enrolling the client in the correct NC HMIS program page when each match does lead to successful program entry and shall record in the client's NC HMIS record the date the person moves into housing. The Date of move-in to permanent housing shall be recorded within 24 business hours of the client moving into their housing unit.

Prioritization Standards by Program type:

For program types with multi-level prioritization criteria, individuals/households will be referred to actual open slots in programs from the by-name list, as generated by the NC HMIS. Individuals/Households from subsequent priorities shall not be matched to a program opening unless there are no individuals/households on the BNL from a higher priority.

Once an individual or household is entered into a supportive housing program (TH, RRH, PH or PSH) they shall be filtered from the By-Name List for purposes of matching with additional supportive housing programs.

If individuals fall into multiple prioritization categories (i.e. they have a high acuity score from the VI-SPDAT and they are Chronically Homeless), they shall be prioritized based on the highest level of priority they qualify for.

A. Homelessness Prevention Programs:

Referral to homelessness preventions programs by the CIC and its participating agencies will be prioritized to individuals and families who have documentation to show they are at imminent risk of eviction.

B. Street Outreach Programs

People experiencing homelessness will be referred to **Street Outreach** per the following prioritization criteria:

Priority 1:

Persons residing on the streets, in vehicles or other places not meant for human habitation that have refused or are unlikely to engage with other homeless service providers in the community; or people residing on the streets, in vehicles or other places not meant for human habitation and are matched to transitional housing, rapid re-housing or permanent supportive housing but are not yet housed.

C. Emergency Shelter Programs

Individuals and families may be referred by CIC to Emergency Shelters with a request for prioritization for beds if they have been matched and referred to transitional housing, rapid re-housing or permanent supportive housing programs and are awaiting placement in one of those programs. However, any such request shall not preempt shelter policies.

D. Transitional Housing Prioritization

People experiencing homelessness may be referred to Transitional Housing by CIC with the request that the following prioritization criteria be applied (only proceeding to the next category when no one remains in the initial/previous category):

Priority 1:

People not experiencing chronic homelessness

Priority 2:

Highest VI-SPDAT score

E. Rapid Re-Housing Prioritization

People will be referred to **Rapid Re-Housing** per the following prioritization criteria (only proceeding to the next category when two or more people remain in the initial/previous category):

Priority 1:

Same as Permanent Supportive Housing (PSH) when PSH is not available

Priority 2:

Highest Rapid Re-Housing recommended score (4-7 for people and 4-8 for families)

Priority 3:

Chronic homelessness

Priority 4:

Length of time homeless

Priority 5:

Overall wellness (domain D score of the VI-SPDAT)

F. Permanent Supportive Housing Prioritization

People experiencing homelessness will be referred to **Permanent Supportive Housing** per the following prioritization criteria (only proceeding to the next category when no people remain in the initial/previous category):

Priority 1:

Highest VI-SPDAT score

Priority 2:

Chronic homelessness

Priority 3:

Length of time homeless

Priority 4:

Overall wellness (domain D score of the VI-SPDAT)

G. Connection to Mainstream providers

Individuals on the Prioritization list who may benefit from a connection to a mainstream service provider, such as Goodwill, Department of Social Services, Legal Aid, Financial Pathways, Cardinal Innovations, income based housing or other service may be provided a referral by CIC staff or assisted by CIC staff to connect to these mainstream providers. All mainstream service referrals shall be documented in the NC HMIS and shall not prohibit the prioritization or matching into a supportive housing program for which the individual or household is eligible at the time a match is identified.

The CIC staff shall engage key mainstream service providers identified by the CIC Assessment Team and develop referral protocols to streamline the connection between a mainstream service and a CIC access point, including the use of CIC outreach staff, to assess and connect

individuals/households identified by mainstream service providers as homeless or at imminent risk of homelessness.

Unsuccessful Matches Process

An unsuccessful match shall be defined as when a client who is matched to a program or service cannot be enrolled in that program or service for any reason within 30 days of the match made by the CIC.

By Person Experiencing Homelessness:

People may reject a housing referral due to the health, safety or wellbeing of the person being compromised by the potential referral. Respecting choice and preference, people may also reject a housing referral due to not being willing to work with the housing provider to which they are referred. Rejections of housing referrals by people should be infrequent and must be documented in HMIS. Repeated rejections by participants of matched services, programs, and/or agencies may require case conferencing and additional assessment by CIC staff to address the needs and concerns of the individual/household.

By Housing Provider:

Winston-Salem CoC providers and program participants may deny or reject referrals from the CIC, although service denials should be infrequent and must be documented in NC 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 in writing to the CIC Coordinator, and may be subject to a limit on the number of service denials.

Agencies who 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 person, specific criminal or housing history that prevents acceptance of referral, or other similar details. Some examples of denials that will need additional details or documentation include the following:

- Confirmed as doubled up/unhappily housed but not residing on streets/shelter
- Confirmed as relocating out of area
- Person unable to be located after multiple, documented attempts
- Ineligible for assigned provider
- Declined services from assigned provider
- Person confirmed as incarcerated
- Person confirmed as deceased

If the denial is the result of a third-party property management/landlord (private or partner of service provider) rejecting the person's application, the rejection will trigger a case conferencing meeting. If the household 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 (A) the reason(s) why they were not housed and (B) the date of unsuccessful match/ "un-assignment" within NC HMIS so the person can be reassigned to additional providers. The housing provider will also document when each match does lead to successful program entry and provide the date the person moves into housing within NC HMIS.

Re-Screening With the VI-SPDAT

While people generally do not need to be surveyed multiple times with the VI-SPDAT, there are circumstances under which people who have been screened using the VI-SPDAT would qualify to be re-screened, including the following:

- a. Someone has not had contact with the homeless services system for one year or more since the initial VI-SPDAT screening;
- b. Someone has encountered a significant life change defined as one of the following items: an adult member added or removed to their household, re-unification with child, or SPMI identified by a credentialed professional;
- c. In rare occurrences, someone who is screened and referred to a housing program may be eligible for re-screening if the program identifies, after extensive efforts, the person needs a higher level of support than can be offered in that level of intervention;
- d. Someone who has a known extensive history within the shelter and other emergency systems but whose acuity is not accurately depicted on their first screening.

Note: People who qualify under items C and D, listed above may benefit from the more comprehensive full SPDAT (or SPDAT) further described in Appendix C – Full SPDAT Process.

Re-prioritization after Return to Homelessness

An individual or household who has been successfully matched to a supportive housing program covered under these policies and procedures will be removed from the By-Name List. If after three months they remain in the program without entering permanent housing, they may be recommended by their program lead staff for case conferencing by the CIC Assessment Team. Also, if after 12 months of program participation in permanent housing the individual/household has been unable to successfully complete the program, they may be recommended by their program lead staff for case conferencing by the CIC Assessment Team. In such cases, at the case conferencing meeting, the Assessment Team may recommend additional interventions, services, or resources including but not limited to re-assessment of their original VI-SPDAT, assessment through the more comprehensive full SPDAT, or connection to other services in the community including mental health services, payee services, or disability support services.

The individual/household may return to the By-Name List for prioritization if the individual/household returns to homelessness. In the event that the individual/household previously matched to a supportive housing program returns to the prioritization list, both the CIC Coordinator and the household's case manager shall communicate to the individual or head of household that the prioritization does not mean they will receive a more intensive supportive housing service, only that they may be re-prioritized if an appropriate resource is available and there are no other individuals/households with a higher priority on the list.

Data Sharing

The WSFC CoC has designated the NC HMIS as the HMIS system for all participating programs in our CoC. The NC HMIS has adopted a privacy policy based on the Health Information and Privacy Portability Act (HIPPA) that all staff in the WSFC CoC licensed to use the NC HMIS, and all personnel participating in any aspect of the coordinated entry process including serving at an access point, working within a referring or referral program or participating on the CIC Assessment Team, whether or not they have a license for the NC HMIS shall complete the NC HMIS Privacy training on an annual basis and provide certification of successful completion of this training to the WSFC HMIS Local System Administrator.

The WSFC CoC members have developed and entered into data sharing relationships which are supported through defined agreements clarifying the limitations, use and protections relevant to shared data. As a part of these sharing agreements is the underlying principal that the individual has the right to determine what, if any, personal information may be shared outside of the program with which they are engaged. When using an HMIS or any other data system to manage coordinated entry data, all participant information requires privacy protections according to the HMIS Data and Technical Standards at (CoC Program interim rule) 24 CFR 578.7(a) (8). Providers may not deny services to people if they refuse to allow their data to be shared unless Federal statute requires collection, use, storage, and reporting of a participant's personally identifiable information (PII) as a condition of program participation.

Community Intake Center Monitoring and Evaluation

Monitoring and Reporting of the Coordinated Entry System

The WSFC CoC is obligated as a condition of receiving both CoC and ESG funds from HUD to establish and operate a coordinated entry system. 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;
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 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 those placements are also stable. Taken together, these measures allow communities to evaluate the factors more comprehensively that contribute to ending homelessness.

The WSFC CoC Operating Cabinet shall perform an annual evaluation of CoC performance, including the impact of the CIC and each participating program on system performance. This evaluation shall include a review of the CoC's progress on the HUD system measures, and shall include feedback from providers, currently homeless persons, people enrolled in supportive housing programs, and people who have exited from the homeless service system. Results of the annual evaluation of CoC performance shall be presented to the Commission on Ending Homelessness each year.

Amendment of these Policies and Procedures

On an annual basis, as part of the CIC evaluation, the WSFC CoC Operating Cabinet shall conduct a review of these policies and procedures.

Any member of the CoC Operating Cabinet may propose modification or amendment to these policies and procedures at any time. A written request for consideration of modification or amendment to the CIC policies and procedures shall be submitted to the CoC Administrator. The CoC Administrator shall review the proposed amendment with CIC Staff and CIC participating agencies and present the proposal and comments from relevant parties to the WSFC CoC Operating Cabinet for review and consideration.

Training

The CIC Coordinator shall identify training opportunities for all staff from all programs participating in the CIC, including staff working at access points and staff participating in the CIC Assessment Team. Trainings may be in any format which adequately supports the learning and skill development for participants in the relevant material.

On an annual basis, staff participating in any aspect of coordinated intake or assessment shall complete training on the following topics:

- Privacy (must complete the NC HMIS privacy training and provide certification of completion to the HMIS LSA)
- VI-SPDAT training, for all staff involved in the administering of or interpreting of the VI-SPDAT
- Fair Housing, and non-discrimination/equal access

- CIC policy and procedure training/review, including how assessment information is used to determine prioritization and the criteria for uniform decision making and referrals
- Safety Planning for victims of domestic violence, sexual assault, stalking and trafficking
- Other training upon request of the CoC Operating Cabinet

Additional, recommended trainings include:

- Mental Health First Aid
- Trauma Informed Care
- Critical Time Intervention
- Motivational Interviewing

Appendices

Appendix A

Coordinated Entry System Program Component Definitions

Component definitions provide detailed descriptions of each CoC program type available through the Coordinated Entry System.

Street Outreach

Component Type	Essential Elements	Target Population
Emergency services and engagement intended to link unsheltered households who are homeless and in need of shelter, housing, and support services.	<p>Low-demand, street and community-based services that address basic needs (e.g., food, clothing, blankets) and seek to build relationships with the goal of moving people into housing and engaging them in services over time.</p> <p>In addition, outreach staff should provide or link people with: case manager, assistance to develop a person-centered case management plan, housing placement and housing location support, on-site psychiatric and addictions assessment, medication, other immediate and short-term treatment, and assessment to other programs and services.</p>	<p>Homeless people on the streets, frequently targeting those living with mental illness(s), severe addiction(s), or dual-diagnoses</p> <p>As providers funded to end homelessness match people to their available housing resources, street outreach will target people connected to a housing resource through these providers in order to demonstrate Coordinated Entry participation</p>

Prevention

Component Type	Essential Elements	Target Population
<p>Prevention from homelessness includes financial assistance and services to prevent people and families from becoming homeless and help those who are experiencing homelessness to be quickly re-housed and stabilized. The funds under this program are intended to target people and families who would be homeless but for this assistance.</p>	<p>Programs can provide a variety of assistance, including: short-term or medium-term rental assistance and housing relocation and stabilization services, including such activities as mediation, credit counseling, security or utility deposits, utility payments, moving cost assistance, and case management.</p>	<p>People who are "at risk of homelessness."</p>

Emergency Shelter

Component Type	Essential Elements	Target Population
<p>Emergency Shelter programs providing stabilization and assessment; focusing on quickly moving all people to housing, regardless of disability or background. Short-term shelter that provides a safe, temporary place to stay (for those who cannot be diverted from shelter) with focus on initial housing assessment, immediate housing placement and linkage to other services.</p>	<p>Entry point shelter with:</p> <ul style="list-style-type: none"> • showers, • laundry, • meals, • other basic services, • and linkage to case manager and housing counselor (co-located on-site), with the goal of helping households move into stable housing as quickly as possible. Shelters include an array of stabilization options which allow for varying degrees of participation and levels of support based on needs and engagement at the time they enter the system (i.e., for those with chronic addictions, mental illness, and co-occurring disorders). On-site supportive service staff should conduct the VI-SPDAT of repeat people 	<p>People experiencing homelessness</p> <p>As providers funded to end homelessness match people to their available housing resources, emergency shelters will target people connected to a housing resource through these providers in order to demonstrate Coordinated Entry participation</p>

	<p>requesting such assessment following 7+ shelter nights to determine housing needs (e.g., unit size, rent levels, location), subsidy needs, and identify housing barriers, provide ongoing case management, and manage ongoing housing support and services that the person will need to remain stably housed</p>	
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Rapid Re-Housing

Component Type	Essential Elements	Target Population
<p>Rapid re-housing is an intervention designed to help people and families exit homelessness quickly and return to permanent housing. Rapid re-housing assistance is offered without preconditions (such as employment, income, absence of criminal record, or sobriety) and the resources and services provided are typically tailored to the unique needs of the household. While a rapid re-housing program must have all three core components available, it is not required that a single entity provide all three services nor that someone will utilize all of them.</p>	<p>Housing Identification</p> <ul style="list-style-type: none"> Recruit landlords to provide housing opportunities for people and families experiencing homelessness. Address potential barriers to landlord participation such as concern about short term nature of rental assistance and tenant qualifications. <p>Rent and Move-In Assistance (Financial)</p> <ul style="list-style-type: none"> Provide assistance to cover move-in costs, deposits, and the rental and/or utility assistance (typically six months or less) necessary to allow people and families to move immediately out of homelessness and to stabilize in permanent housing. 	<p>People experiencing homelessness with temporary barriers to self-sufficiency</p>

	<p>Rapid Re-Housing Case Management and Services</p> <ul style="list-style-type: none">• Help people and families experiencing homelessness identify and select among various permanent housing options based on their unique needs, preferences, and financial resources.• Help people and families experiencing homelessness address issues that may impede access to housing (such as credit history, arrears, and legal issues).• Help people and families negotiate manageable and appropriate lease agreements with landlords.• Make appropriate and time-limited services and supports available to families and people to allow them to stabilize quickly in permanent housing.• Monitor participants' housing stability and be available to resolve crises, at a minimum during the time rapid re-housing financial assistance is provided.• Provide or assist households with connections to resources that help them improve their safety and well-being and achieve their long-term goals. This includes providing or ensuring the person	
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	<p>has access to resources related to benefits, employment and community-based services (if needed/appropriate) so they can sustain rent payments independently when rental assistance ends.</p> <ul style="list-style-type: none"> • Ensure services provided are person-directed, respectful of people' right to self-determination, and voluntary. Unless basic, program-related case management is required by statute or regulation, participation in services should not be required to receive rapid re-housing assistance. • Assist households to find and secure appropriate rental housing. 	
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Transitional Housing

Component Type	Essential Elements	Target Population
<p>Safe, temporary housing or shelter that focuses on housing planning, addictions treatment, stabilization, and recovery for people and families with temporary barriers to self-sufficiency.</p>	<p>Safe units located in site-based or scattered site housing or facilities that focuses on housing planning, addictions treatment, stabilization, and recovery for people and families with temporary barriers to self-sufficiency. Recognizing a zero tolerance approach does not work for all people, transitional housing programs employ a harm reduction, or tolerant, approach to engage people and help them maintain housing stability Housing</p>	<ul style="list-style-type: none"> • People experiencing homelessness contemplating recovery or newly in recovery • youth • ex-offenders, • veterans (choosing Grant Per Diem programs) • People who are actively fleeing domestic violence

	<p>assistance may be provided for up to two years, including rental assistance, housing stabilization services, landlord mediation, case management, budgeting, life skills, parenting support, and child welfare preventive services.</p> <p>Housing plan within two weeks.</p> <p>Average stay is six months. Could stay up to two years.</p> <p>All programs provide follow up case management post exit.</p> <p>Expectation of six months of post placement tracking to assess success</p>	
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Permanent Supportive Housing

Component Type	Essential Elements	Target Population
Project-based, clustered and scattered site permanent housing linked with supportive services which help residents maintain housing.	Permanent housing with supports which helps people maintain housing and addresses barriers to self-sufficiency. PSH programs should provide subsidized housing or rental assistance; tenant support services recognizing that relapse is part of the recovery process, PSH programs should hold units open for 30 days while people are in treatment or in other institutions. If a person returns to a program after 30 days and their unit was given to someone else, staff should work with that person to keep	People experiencing long-term homelessness, living with disabilities, and significant barriers to self-sufficiency.

	<p>them engaged and place them in a unit when one is available. Some PSH programs should have a tolerant, or harm reduction, approach to engage people with serious substance abuse issues. While in PSH, people should receive supportive services appropriate to their needs from their case manager and/or the ACT multidisciplinary team.</p>	
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Permanent Housing – Market Rate

Component Type	Essential Elements	Target Population
<p>Housing where people may stay indefinitely with temporary or long-term rental assistance and/or supportive services.</p>	<p>Broad range of clustered or scattered-site permanent housing options for people with temporary barriers to self-sufficiency, including group living arrangements, shared apartments, or scattered-site apartments. People can receive rental subsidies (transitional or permanent, deep, or shallow) and supportive services. Both length and intensity of housing subsidy and services are defined on a case-by-case basis depending on their needs. Once people are housed, a multi-disciplinary case management team (lead by the primary case manager of an assigned PH provider) should conduct a comprehensive assessment and develop a long-term case management plan based on their needs. People should</p>	<p>People who were formerly homeless</p>

	maintain the same primary case manager for as long as they are in the homeless system, but members of the multi-disciplinary team may change as the person's needs change.	
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Appendix B

Example Messaging When Conducting VI-SPDATs

"My name is [] and I work for a group called []. I have a 10 minute survey I would like to complete with you. The answers will help us determine how we can go about providing supports. Most questions only require a "yes" or "no." Some questions require a one-word answer. All I need from you is to be honest in responding, there isn't a "correct" or preferred answer you need to provide, or information you need to conceal. We can come back to or skip any question you don't feel comfortable answering, and I can explain what I mean for any question that's unclear.

The information collected goes into the Homeless Management Information System, which will ensure that instead of going to agencies all over town to get on waiting lists, you will only have to fill out this paperwork one time. If you have a case manager who is helping you apply for housing, you should still work with them once you have finished this survey.

After the survey, I can give you some basic information about resources that could be a good fit for you. I want to make sure you know there are very few housing resources connected to this survey, so it's possible but unlikely that you would be housed through this process. The primary benefit to doing this survey is to help give you and me a better sense of your needs and what resources I can refer you to. The reason we do this survey is because we want to provide entry to the system of services in the most coordinated manner that we can.

Would you like to take the survey with me?"

Appendix C

SPDAT Process

While the VI-SPDAT is a pre-screen or triage tool which looks to confirm or deny the presence of more acute issues or vulnerabilities, the SPDAT (or "full SPDAT") is an assessment tool looking at the depth or nuances of an issue and the degree to which housing may be impacted.

To provide a safety net for people that are presumed to be highly vulnerable but score to low on the VI-SPDAT to qualify for permanent supportive housing (i.e., 7 or below), those people may be recommended for the full SPDAT assessment. The primary reason for recommending a SPDAT is when the person being assessed either under or over-reports what the assessor observes or knows through outside observation.

By allowing for assessors to spend the time to complete this more in-depth analysis, the small set of people whose full depth of vulnerability may not be reflected within their VI-SPDAT assessment may still be considered for street outreach or housing assignments. In a subset of these very limited instances, it is possible for a full SPDAT to produce different results than the VI-SPDAT because it is a multi-method assessment that incorporates more comprehensive outside information than the primarily self-reported information collected through the VI-SPDAT. Those who have received a full SPDAT assessment will periodically be reviewed through case conferencing and housing match processes.

In instances where people have both a full SPDAT and VI-SPDAT assessment, whenever possible, referral for housing placement will prioritize the full SPDAT and not solely the VI-SPDAT score.