SPRINGFIELD-HAMPDEN COUNTY CONTINUUM OF CARE

COORDINATED ENTRY
Policies & Procedures

January 2018

Contents

SECTION 1: INTRODUCTION

Purpose

The Springfield-Hampden County Continuum of Care (CoC) uses a coordinated entry system to prioritize people who are most in need of housing assistance. Coordinated entry is an approach to ending homelessness that requires comprehensive coordination of all housing and service resources in a community to better match people experiencing homelessness to appropriate permanent housing placements. In addition to targeting resources effectively, the use of coordinated entry provides valuable information about service needs and gaps to support strategic allocation of current resources and identification of the need for additional resources.

Ending Homelessness; Built for Zero

The Continuum of Care Interim Rule[1] requires CoCs to provide coordinated entry, and the Springfield-Hampden County CoC has created this system, in part, as a response to this requirement. Coordinated entry helps our community advance the goals of Opening Doors, the United States comprehensive federal plan to prevent and end homelessness.

Since 2015, the CoC has been a participating community in the Built for Zero campaign, a national effort supported by Community Solutions to help communities to build systems to end veteran and chronic homelessness. The CoC has worked closely with Community Solutions to design and implement a coordinated entry system that will propel the CoC toward its goals of ending veteran and chronic homelessness. The CoC has adapted lessons learned from the Built for Zero campaign to build the portions of the system that are focused on ending youth and family homelessness.

Guiding Principles

Housing First

Housing First is an approach to quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment or service participation requirements. The coordinated access system primarily refers to programs using a Housing First model. The Springfield-Hampden County CoC uses the Housing First model for all its rapid rehousing and permanent supportive housing programs. While the coordinated entry system includes additional programs and housing not funded by the CoC, and these programs may include some requirements which are not consistent with a Housing First model, the CoC encourages all housing providers associated with coordinated entry to limit imposition of barriers to accessing housing.

Low Barrier

The CoC's coordinated entry process does not screen people out of the process due to perceived barriers related to housing or services, including, but not limited to, too little or no income, active or a history of substance use, domestic violence history, resistance to receiving services, the type or extent of disability-related services or supports that are needed, history of evictions or poor credit, lease violations or history of not being a leaseholder, or criminal record–with exceptions for state or local restrictions that prevent projects from serving people with certain convictions.

[1] https://www.hudexchange.info/resources/documents/CoCProgramInterimRule_FormattedVersion.pdf

Coordinated entry refers people to programs that match eligibility requirements. While CoC programs are low-barrier, some programs have funding restrictions which bar certain populations (for example, the public housing bar on Level 3 sex offenders) or limit eligibility to certain criteria (for example, some programs have funds specifically to serve persons who are HIV+, or who are eligible for services funded by the Massachusetts Department of Mental Health). Programs supported by CoC or Emergency Shelter Grant (ESG) funds generally do not deny referrals except for eligibility reasons or funding requirements. Although the CoC discourages it, programs that do not receive CoC- or ESG-funds may deny housing based on tenant screening criteria.

Person-Centered Approach

The CoC is committed to reinforcing a person-centered approach throughout the coordinated entry process. Components of this approach include:

- Use of the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT), a standardized tool developed using trauma-informed principles.
- Use of tools and processes which are clearly explained and easily understood, provision for modifications to processes where needed for accessibility, and availability of screening in Spanish and other languages.
- Provision of training for assessors and navigators regarding trauma-informed communication and minimization of risk and harm.
- Provision of choice to participants regarding decisions such as location and type of housing, level and type of services, and other program characteristics, as well as assessment processes that provide options and recommendations that guide and inform participant choice.
- Clear and understandable referral protocols which ensure that participants will be able to easily understand to which program they are being referred, what the program expects of them, what they can expect of the program, and evidence of the program's rate of success.
- Commitment of staff to successfully completing the referral process once a referral decision has been made through coordinated entry.

Cultural and Linguistic Competency

The CoC is committed to ensuring that coordinated entry incorporates culturally and linguistically competent practices. The CoC provides cultural and linguistic competency training into the required annual training protocols for participating projects and staff members. The CoC strives to reduce cultural and linguistic barriers to housing and services for special populations, including immigrants, refugees, and other first generation populations; youth; individuals with disabilities; and lesbian, gay, bisexual, transgender, queer or questioning (LGBTQ) persons.

Non-Discrimination

Recipients of CoC Program and ESG Program-funded projects must comply with the nondiscrimination and equal opportunity provisions of Federal civil rights laws as specified at 24 C.F.R. 5.105(a), including, but not limited to the following:

- The Fair Housing Act, which prohibits discriminatory housing practices based on race, color, religion, sex, national origin, disability, or familial status;

- Section 504 of the Rehabilitation Act, which prohibits discrimination on the basis of disability under any program or activity receiving Federal financial assistance;
- Title VI of the Civil Rights Act, which prohibits discrimination on the basis of race, color or national origin under any program or activity receiving Federal financial assistance;
- Title II of the Americans with Disabilities Act, which prohibits public entities 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.
- Title III of the Americans with Disabilities Act, which 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.

In addition, HUD's Equal Access Rule at 24 CFR 5.105(a)(2) prohibits discriminatory eligibility determinations in HUD-assisted or HUD-insured housing programs based on actual or perceived sexual orientation, gender identity, or marital status, including any projects funded by the CoC Program, ESG Program, and HOPWA Program. The CoC Program interim rule also contains a fair housing provision at 24 CFR 578.93. For ESG, see 24 CFR 576.407(a) and (b), and for HOPWA, see 24 CFR 574.603.

SECTION 2: COORDINATED SYSTEM

The CoC provides a coordinated system of prevention assistance, outreach, diversion, emergency shelter, rapid rehousing and permanent supportive housing for people who are homeless or at risk of homelessness throughout Hampden County. The core of the CoC are the agencies and programs funded through CoC and ESG funds, and these programs are required to comply with the eligibility and operating standards set forth in these policies and procedures. Agencies funded through other sources are strongly encouraged to participate in this coordinated system and use the same eligibility, assessment and operating standards.

Participating Agencies and Programs

The CoC is made up of the following agencies and programs:

Assistance Type	Program	Target Populations(s)
Homelessness Prevention	Catholic Charities*	Individuals (without children) and families not eligible for state Emergency Assistance (EA)
	Way Finders	Families with children
	Mental Health Association*	Individuals with Behavioral Health Needs
	New North Citizens Council	Person with HIV/AIDS
	Veterans, Inc.	Veterans
Outreach, Engagement, Assessment	Eliot CHS (PATH Provider)	Unsheltered/Sheltered Mentally Ill Individuals
	Health Services for the Homeless	Sheltered/Unsheltered Homeless Individuals and Families
	Behavioral Health Network	Unsheltered/Sheltered Individuals
	Gandara Center Shine Program	Youth age 18-24

	CHD – Safety Zone	Unaccompanied youth up to 21
	Veterans Administration	Unsheltered/Sheltered Veterans
	CSO/Friends of the Homeless – Coordinated Entry*	Adult Individuals and Youth 18-24
Emergency Shelter	CSO/Friends of the Homeless*	Individuals
	MA DHCD	Families with Children
	CHD – Safety Zone	Unaccompanied Youth under 18
	YWCA*	Victims of Domestic Violence
Rapid Rehousing	Catholic Charities*	Individuals (without children) and families not eligible for state Emergency Assistance (EA)
	Way Finders*	Families with children
	Gandara Center*	Youth age 18-24
	New North Citizens Council	Person with HIV/AIDS
	Veterans, Inc.	Veterans
Permanent Supportive Housing	Center for Human Development*	Families
	CSO/Friends of the Homeless*	Individuals
	Domus	Individuals
	Gandara*	Families (sober)
	Mental Health Association (MHA)*	Individuals – Mentally Ill/Dual Diagnosis
	Open Pantry/SMOC*	Individuals
	River Valley Counseling Center (RVCC)*	Individuals and Families – HIV/AIDS
	SHA Chronic Initiative	Individuals and Families
	Soldier On	Individuals – Veterans
	VA-NHA VASH	Individuals and Families – Veterans
	Veterans Valley Opportunity* Council (VOC)	Families
	Viability*	Individuals – Mentally Ill/Dual Diagnosis

*Agencies marked with an asterisk have program(s) which are CoC- or ESG-funded and accessed only through coordinated entry.

SECTION 3: STANDARDS FOR PROVIDING ASSISTANCE

Coordinated entry is for individuals, families, and unaccompanied youth who are literally **homeless** (unsheltered or in shelter), or are **fleeing or attempting to flee domestic violence**. Many programs prioritize those who are **chronically homeless**.

Households at **imminent risk of homelessness** may be eligible for prevention assistance.

The table on the next page shows the categories of persons eligible for the different types of assistance available.

	Prevention	Emergency Shelter	Rapid Rehousing	Permanent Supportive Housing
Eligible Categories	• Imminent risk of homelessness • Homeless under other federal statutes • Fleeing/ Attempting to Flee Domestic Violence	• Literally homeless • Imminent risk of homelessness • Homeless under other federal statutes (see Appendix A) • Fleeing/ Attempting to Flee Domestic Violence	• Literally homeless • Fleeing/ Attempting to Flee Domestic Violence	• Literally homeless
Other eligibility requirements	• Income at or below 30% AMI		• Income at or below 50% AMI	• Disabled • Chronically homeless
Priority	Score of 20 or above on Prevention Assessment Tool; or score of 15-19 with documentation of compelling reason		Short-term: Homeless and VISPDAT score 0-7 Medium-term: Homeless 90+ days and VISPDAT score 4-7	Homeless at least 12 months and VISPDAT score of 8+
Screening Tool	Prevention Assessment	Diversion Screening	VISPDAT TAY-VISPDAT Family-VISPDAT	VISPDAT TAY-VISPDAT Family-VISPDAT

Definitions of Eligibility Categories

Homeless

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

- Has a primary nighttime residence that is a public or private place not meant for human habitation;
- Is living in a publicly- or privately-operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or
- Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

Fleeing/Attempting to Flee Domestic Violence

Any individual or family who:

- Is fleeing, or is attempting to flee, domestic violence;
- Has no other residence; and
- Lacks the resources or support networks to obtain other permanent housing.

Chronically Homeless

1. An **individual** who:
    - Is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
    - Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions in the last 3 years; and
    - Can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability;

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.

Imminent Risk of Homelessness

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

- Residence will be lost within 14 days of the date of application for homeless assistance;
- No subsequent residence has been identified; and
- The individual or family lacks the resources or support networks needed to obtain other permanent housing.

SECTION 4: ACCESS TO COORDINATED ENTRY

Access Points

Assessment is available at the locations indicated below.

Individuals - without children	**Friends of the Homeless**, (413)732-3069, 755 and 503 Worthington Street, Springfield **Rescue Mission Taylor Street Shelter** – via twice-weekly outreach by the FOH Coordinated Entry team
Unaccompanied Youth	Youth may access coordinated entry through the same access points for adult individuals or families. In addition, one site is designated to be accessed only by youth: **Gandara Center SHINE Program**, (413) 654-1554, 364 Main St., Indian Orchard

Families – with children	The Massachusetts Department of Housing and Community Development operates coordinated entry to emergency shelter and rapid rehousing for families. Coordinated entry for permanent supportive housing for chronically homeless families is available at the following agencies: • **Way Finders**, 322 Main St., Springfield, and all family shelter locations • **Center for Human Development**, all family shelter locations • **New England Farm Workers Council**, all family shelter locations • **Valley Opportunity Council**, all family shelter locations
Households fleeing domestic violence	Households fleeing domestic violence may access coordinated access points for adult individuals or families. In addition, one site is designated to be accessed only by this population: **YWCA**, (413)732-3121, One Clough St., Springfield
Persons at risk of homelessness	**Catholic Charities**, (413) 452-0605 **Way Finders** – Housing and Consumer Education Center, (413) 233-1600

No Wrong Door

Households that present at any access point, regardless of whether it is an access point dedicated to the population to which the household belongs, can access an appropriate assessment process that provides the CoC with enough information to make prioritization decisions about that household. Households that are included in more than one of the five populations listed in the table above, e.g., a parenting unaccompanied youth who is fleeing domestic violence, can be served at all access points for which they qualify.

Outreach to the Unsheltered Population

The following agencies outreach to or otherwise interact with unsheltered individuals and are trained to assess and enroll individuals in coordinated entry:

- Eliot Community Human Services
- Mental Health Association
- Mercy Medical Center/Health Care for the Homeless
- Baystate Medical Center
- Behavioral Health Network – Crisis Services. Mission West, and The Living Room

Reasonable Accommodation

Housing Navigators from the Coordinated Entry staff are able to provide variation to the process when needed as a reasonable accommodation for a person with disabilities. For example, a person with a mobility impairment may request as a reasonable accommodation to complete the coordinated entry process at a different location.

Limited English Proficiency

All access points are expected to have Spanish-speaking staff. For other languages, if an agency does not have staff capacity, the agency should use a telephone-based interpreter service to communicate with persons speaking other languages.

Available interpreter services include:

- University of Massachusetts Amherst Translation Center, (413) 545-2203
- Benoit Language Services, Inc., (800) 261-5152
- Language Connections, (877) 731-6332

SECTION 5: PREVENTION AND DIVERSION

The CoC seeks to prevent homelessness and divert households from shelter to stable housing whenever possible. The CoC values provision of assistance prior to shelter entry, recognizing that shelter stays can be destabilizing and traumatic.

Prevention

The CoC offers financial assistance to households in order to prevent eviction or other housing displacement. The CoC's Prevention Assessment Tool is used to determine degree of need and to prioritize assistance. Programs that provide prevention assistance and are funded with City of Springfield ESG funds are required to use the Prevention Assessment Tool; prevention programs funded by other sources are encouraged to use the Tool. The Prevention Assessment Tool is attached as Appendix A.

Diversion

The CoC offers case management services and financial assistance to households seeking shelter, when these resources can prevent entry to shelter. The Diversion Questionnaire helps to frame potential alternatives to shelter. It is attached as Appendix B.

SECTION 6: ASSESSMENT OF HOMELESS HOUSEHOLDS

Many households that enter shelter have short stays and self-resolve within the first days or weeks of shelter stay. The goal of assessment of shelter stayers is to identify and provide targeted assistance to those who will not self-resolve. The goal of assessment is to determine as quickly as possible those households that will not self-resolve. Unsheltered individuals and families face a variety of challenges and housing barriers which warrant assessment as soon as possible.

Timing of Assessment

A homeless household may be assessed for coordinated entry at any time. The CoC's goal is that assessment should take place, at a minimum, according to the following time frames:

- For unsheltered persons: at the first encounter
- For individuals in shelter: within 30 days of entry
- For unaccompanied youth in shelter or a host home: within 15 days of entry
- For families in shelter: once the family has been in shelter 12 months or more

Assessment Tool

The CoC uses the standard assessment tool, the Vulnerability Index-Service Prioritization Tool (VISPDAT). The VISPDAT is customized for three populations, and the CoC uses all three of the customized versions, which are provided as Appendices C, D, and E.

- Individual VISPDAT, for individuals 25 and older
- Family VISPDAT, for families with children
- Transition-Age Youth (TAY) VISPDAT, for unaccompanied youth 24 and younger

Conducting Assessments

The CoC provides training no less than annually on conducting assessments using the VISPDAT tools. In addition, there are videos available online which provide guidance in using the VISPDAT assessment tools.

- Individual VISPDAT: https://vimeo.com/126548635
- Family VISPDAT: https://vimeo.com/126591317

Accuracy of Assessment

VI-SPDAT assessment tools are self-measurement tools—they use an individual's self-report to assess their vulnerability and needs. Where an individual does not self-reveal factors which indicate vulnerability of severity of service needs, the individual's score may not accurately reflect the person's level of need. The CoC takes this circumstance into account through a process that yields an adjusted score. During twice-monthly multi-agency case conferencing meetings, a case manager can indicate the specific factors that result in a lower-than-expected score, and can indicate what makes the case manager believe that specific scoring factors should be higher. The case conferencing group can decide to apply an adjusted score based on the noted factors. An "adjusted score" does not replace the self-assessment VI-SPDAT score. Instead, it is used to provide additional information regarding vulnerability.

Adjustments to score are based only on information that indicates a type of vulnerability or service need that is intended to be captured on the VI-SPDAT and is observable by a caseworker or other person familiar with the individual, but is not captured because of the participant's unwillingness to reveal information. The following list indicates the factors that the CoC uses to indicate high vulnerability/service needs:

- significant challenges or functional impairments, including any physical, mental, developmental or behavioral health disabilities regardless of the type of disability, which require a significant level of support to maintain permanent housing
- high utilization of crisis or emergency services to meet basic needs, including but not limited to emergency rooms, jails, and psychiatric facilities
- the extent to which people are unsheltered
- vulnerability to illness or death
- vulnerability to victimization

Data Platform: Springfield Warehouse and the online Coordinated Access System

Description of the Springfield Warehouse

The Springfield Warehouse is an online data platform created to support coordinated entry for homeless households. The platform is accessible (at different sharing levels) from multiple partners throughout the community, enabling data-sharing where supported by a signed release of information. The Springfield Warehouse's privacy protections are compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Entry of Assessment into the Springfield Warehouse

Individuals conducting assessments of homeless individuals, youth or families should enter the information into the Springfield Warehouse within three days of assessment. If an assessor is not able to access the Springfield Warehouse, the assessor should send the completed VISPDAT to coordinated entry staff at Friends of the Homeless. Mail or deliver to Janice Humason, Coordinated Entry Manager, Friends of the Homeless, 755 Worthington Street, Springfield, MA 01105.

All VISPDATs should provide as much detail as possible about how to contact the household for follow-up. When a housing opportunity is available for an individual, the information entered into the system will be used to make contact.

Consent Form

At the time that the VISPDAT assessment is completed, the assessor should also request that the homeless individual sign a Consent Form, which is provided in Appendix F. The signed Consent Form must be uploaded into the Warehouse. No personal information can be entered into the Warehouse or discussed during a case conferencing meeting unless the individual has signed the Consent Form.

Individuals who refuse to sign the Consent Form and/or refuse to be assessed using the VISPDAT can still be referred for housing assistance. A caseworker can discuss the individual, using initials or other non-identifying information, at the case conferencing meeting. The individual can be referred for a match based on this information, and the case manager can then connect directly with the housing provider to make the match. The homeless individual in this circumstance will still need to provide sufficient information to the housing provider for the provider to meet their grant requirements.

CAS Readiness

At the time of the VISPDAT assessment or at a later date, the assessor should collect information about housing preferences and factors which impact eligibility at certain programs (e.g., criminal history, sex offender status, immigration status). {Note that providers do not regularly bar people with these types of barriers to housing; however, some funding sources categorically exclude persons with certain characteristics. In these cases, the CoC directs individuals to programs that do not have these exclusions.) These items are entered into the person's record in the Warehouse at the tab labeled "CAS Readiness."

SECTION 7: BY-NAME LIST

The CoC supports coordinated entry into PSH and RRH through use of a by-name list. The list includes homeless individuals and families that are chronically homeless or at risk of chronic homelessness, sorted by the orders of priority determined by the CoC.

The by-name list (BNL) is a real-time, up-to-date list of people experiencing homelessness which can be filtered by categories, and shared across agencies. This list is generated with data from the Warehouse, HMIS, outreach, and any other providers working with homeless populations. At this time, the BNL is maintained on a spreadsheet because it incorporates people who have not yet been entered in HMIS, not yet assessed using the VISPDAT, and/or without a Release of Information form. The BNL includes these people using limited information to coordinate engagement, outreach and assessment efforts.

The CoC is building out the Warehouse to automatically generate the BNL from the online system, and this should be activated in 2018. Until the build-out is complete, the BNL is contained on a spreadsheet maintained by the CoC.

The purpose and benefits of a BNL are:

- Ensure individuals experiencing homelessness within our community are identified and their housing needs are known;
- Track the status and progress toward permanent housing of these individuals;
- Coordinate housing and services for each household between all community providers;
- Measure progress toward goals and how close our community is to reaching an end to homelessness among each subpopulation; and
- Identify key barriers to goal attainment and opportunities to resolve them.

Community Solutions has provided guidance and support to assist communities to build *quality* by-name lists for chronic and veteran populations. A quality by-name list~~:~~ includes: all known homeless individuals in the CoC geography; uses standard policies for considering a person active or inactive on the list; tracks changes in status (e.g., sheltered, unsheltered, transitional housing, temporary housing); is used in conjunction with a coordinated outreach strategy; uses unique identifying information to prevent duplication; tracks newly chronically homeless each month; includes people who do not consent to be assessed; tracks when individuals previously assessed become chronic; and tracks returns to active and unhoused status.

The Springfield-Hampden County CoC BNLs meet the standards for Quality Veteran and Quality Chronic BNLs.

Adding to the BNL

The BNLs do not include every household that is experiencing homelessness. Data indicates that most instances of homelessness self-resolve. The BNL includes chronically homeless individuals and families, as well as veterans and youth. Veterans are included because of the additional resources directed toward this population. Youth are included because their age merits added support in accessing stable housing. The following guidelines provide additional information about each population being added to the list.

Chronically Homeless Individuals

Individuals are added to the BNL when they are identified as being likely to meet the definition of chronic. If an individual on the list is determined not to be chronic, the person is removed from the list. The most

common reason for this type of removal is the person indicates that they have not been literally homeless for the minimum required amount of time.

Chronically Homeless Families

Families are added to the BNL when they are identified as being likely to meet the definition of chronic. If a family on the list is determined not to be chronic, the family is removed from the list.

Veterans

Veterans are added to the BNL any time they are identified in an unsheltered setting, and after remaining in shelter or transitional housing for a minimum of 21 days. The CoC has found that most veterans encountered in Hampden County have very brief shelter stays and are never encountered in the CoC again. (One possibility is that veterans come through Springfield en route to Veteran Administration Medical Centers and additional veteran services in Leeds, Worcester and Boston, and therefore have only a transitory stay in Springfield.)

Youth

Youth are added to the BNL when they are identified. Even though many youth have short shelter stays, the CoC's experience is that many go between shelter, outdoors, and couch-surfing. Many avoid shelter because they are not comfortable in adult shelters, and this is a particularly vulnerable population. For these reasons, the CoC elects to engage youth when they are first encountered.

Inactive Status

If there is no contact with an unsheltered person or family on the BNL for 60 days, following attempts to contact the household, the person or family is moved to Inactive Status. If there is later contact with a person or family who is Inactive due to no contact, the status is immediately moved back to Active. The purpose for this Inactive/Active policy is to keep the list as up-to-date as possible and make sure that housing referrals are likely to be filled quickly.

Households are placed on Inactive Status when they enter transitional housing. If the household leaves the transitional housing placement, they are returned to Active Status only if they meet the definition of chronically homeless. The stay in transitional housing will be a break in continuous homelessness, so at the time of release the household will only meet the definition of chronically homeless if they have experienced four episodes in the last three years that add up to a total of twelve months.

Individuals retain Active Status when they initially enter an institutional care setting (incarcerated, hospitalized, detained pursuant to a Section 12 or Section 35, etc.). After 90 days, if they are still in institutional care, they are moved to Inactive Status. For those who become inactive because of a stay of more than 90 days in institutional care, they will be added back to Active Status at the next point that they meet the definition of chronically homeless.

Inflow/Outflow

The CoC uses information from active management of its BNL to document and understand inflow (people newly identified for the list, aging into chronic status, or returning to homelessness after being housed) and outflow (people housed, moved to inactive status). This data informs our effort to end veteran and chronic homelessness and build a system that prevents and quickly ends homelessness for these populations.

SECTION 8: HOUSING NAVIGATION

Role of Housing Navigator

The Housing Navigator serves as the main point of contact for each targeted individual. The Navigator helps collect all documents needed for the targeted individual/household to be placed in housing and coordinate the entry of information about the person's status into the Warehouse. After the housing match is made, the Housing Navigator may provide additional support necessary to finalize the housing placement. When accessing rapid rehousing, the Housing Navigator will assist the person in their housing search to locate a unit in which they can use the assistance. The Housing Navigator may provide referrals, offer coordination, or provide in-person support to clients for their mental health, physical health, entitlement enrollment, and other service needs. The level of support provided is based on a client's independence and an agency's capacity to provide supportive services; at a minimum, the Housing Navigator will serve as the main point of contact for the individual and help identify available supports in the community.

Assignment of Housing Navigator

Housing Navigators are assigned at case conferencing meeting. If a case manager is already working with an individual/household, the case worker will be assigned as the Housing Navigator. FOH Coordinated Entry staff will be assigned as Housing Navigators to individuals not working with any case managers in the community. Not all persons on the by-name list will have a Housing Navigator. The CoC aims to provide Navigators for those individuals who are otherwise prioritized for housing to assist those individuals with gathering the documentation needed to access a housing unit.

Change during navigation process

There are times when circumstances call for a change of Housing Navigator assigned to a homeless individual—for example, when a person leaves shelter and a shelter-based case manager no longer has contact with the individual. Changes of Housing Navigator will be made as needed, and addressed during case conferencing meetings.

After person is housed

There is no expectation that a Housing Navigator will continue to work with a homeless individual once the individual is housed. The expectation is that the homeless individual will begin receiving service support from the housing provider. To ensure the continuity of supportive services as the client is housed, one ogf the final roles of the Housing Navigator will be to facilitate as seamlessly as possible for the client a hand off to the provider that will provide ongoing services, as the client may need additional support during the transition to becoming housed.

Assembling Documents for Housing Placement; Uploading to the Warehouse

A key task of the Housing Navigator is to work with the targeted individual/household to locate and assemble the documents needed for a housing placement. Documents should be uploaded to the Warehouse for safekeeping and ease of sharing in the referral from Housing Navigator to Housing Provider.

Required Documents

The following documents are required:

- Birth Certificate
- Identification
- Social Security Card
- Documentation of Chronic Homelessness, if applicable
- DD-214, if applicable

Documentation of Chronic Homelessness

Documentation of Chronic Homelessness includes three components: 1) current homelessness; 2) presence of a disability; and 3) length of homelessness and number of times homeless. It is important that this information be accurate and documented correctly, because most permanent supportive housing providers are required to document chronic status as a condition of eligibility. The Housing Navigator should use the forms in Appendix H to document chronic status.

Housing providers may be able to house some chronically homeless individuals before chronic homelessness documentation is complete, or without full documentation. Housing Navigators should diligently work to get all required documentation, but should not assume that a person cannot be housed because they do not yet have full documentation.

Use of Notes in the Warehouse

The Notes function in the Warehouse enables Housing Navigators to provide information relevant to the individual's progress toward housing. This may include updates regarding location (for example, "left shelter and location unknown"), notes regarding documentation ("birth certificate being mailed from out of state") or notes about housing matches ("move-in date delayed because unit not ready").

SECTION 9: PRIORITIZATION

The CoC uses the electronic Coordinated Access System (CAS) associated with the Warehouse to make automatic referrals to housing vacancies. The CoC's prioritization rules are built into the system, and vacancies are filled according to the rules, except in unusual circumstances, where a decision may be made in a case conferencing meeting to override the rules in a particular case. Examples are when there is an uncommon type of unit that becomes available (such as wheelchair accessible) and the only person on the list in a wheelchair is not next on the list. Another example is when the case conferencing group agrees that a person's VISPDAT score does not accurately reflect the person's need for services.

Housing Type 1: Permanent Supportive Housing

The CoC's prioritization for PSH units is consistent with HUD Notice CPD-16-11 (July 25,2016). All CoC-funded units are dedicated or prioritized for chronically homeless, so the order of priority list in 1 below applies, unless there are no persons in this category to refer, in which case, the order moves to the next priority list.

PRIORITY 1: Chronically Homeless

Chronically homeless persons with the longest periods of homelessness and highest severity of service needs. Within this priority, the following orders of priority apply:

1. Individuals (including youth age 18-24) and families who have been cumulatively homeless for more than 2 years (24 months) and have a VI-SPDAT score of 8 or higher. Within this category, prioritization is by highest VI-SPDAT score first.
2. All others who are chronically homeless, prioritized by highest VI-SPDAT score first.

PRIORITY 2: Other High Need Homeless

Persons who do not meet the definition of chronically homeless but who are included in the following list. The order of this list is each numbered item, ranked in order by VISPDAT score.

1. Episodically homeless with a cumulative stay of at least 12 months and has severe service needs (does not need to verify 4+ occasions of homelessness in 3 years). Must have been homeless at least 12 months in the last 3 years and have a VI-SPDAT score 8 or higher or case conferencing establishes level of service needs that should justify score of 8+.
2. Disabled and has severe service needs, as demonstrated by a VI-SPDAT score 8 or higher or case conferencing establishes level of service needs that should justify score of 8+. There is not a minimum length of homelessness required.
3. Disabled.
4. Persons coming from transitional housing.

Housing Type 2: Medium-Term Rapid Rehousing

This housing type provides up to 24 months of rapid rehousing rental assistance and supportive services. The CoC uses the following order of prioritization for this assistance:

PRIORITY 1: Non-EA Families

Families with children that are literally homeless, and are not eligible for Massachusetts Emergency Assistance or Residential Assistance for Families in Transition (RAFT).[2]

PRIORITY 2: Chronically Homeless Individuals without High Service Needs

Individuals (including youth 18-24, and couples or other households without children) who meet the definition of chronically homeless but do not have high service needs as indicated by a VISPDAT score of 7 or lower, or case conferencing establishes level of service needs that should justify score of 7 or lower.

PRIORITY 3: Disabled Individuals, Homeless for at least 3 Months

Individuals (including youth 18-24, and couples or other households without children) who are disabled and have been literally homeless for 90 days or more.

PRIORITY 4: Individuals Homeless for at Least 3 Months

Individuals (including youth 18-24, and couples or other households without children) who have been literally homeless for 90 days or more but do not have a disability.

Housing Type 3: Short-Term Rapid Rehousing

This housing type provides rental assistance for 3 months or less, and may also provide security deposit.

[2] These are the only families with children eligible for this housing type because all other families can access Massachusetts HomeBase assistance, which can provide medium-term rental assistance.

PRIORITY 1: Non-EA Families

Families with children that are literally homeless, and are not eligible for Massachusetts Emergency Assistance or Residential Assistance for Families in Transition (RAFT).

PRIORITY 2: Individuals Homeless for 30+ Days

Individuals (including youth 18-24, and couples or other households without children) who have been homeless 30 days or more.

Prioritization of Veterans

Within each housing type and level of prioritization above, any time there is a veteran household with the same level of priority as another household, the veteran household will receive the higher priority.

Transfer from one PSH unit to another

There are some limited instances in which a chronically homeless household housed in a PSH unit needs to leave that unit—for example, due to permanent changes in household size. In these instances, the household retains chronic homelessness status for purpose of a move from one PSH unit to another. A transfer may be prioritized above a person on the BNL.

SECTION 10: HOUSING MATCH & REFERRAL

Process for Prioritization & Referral

When a vacancy occurs, it must be reported in the CAS. Providers should report vacancies as soon as they are aware of them (even if the unit is not yet ready.)

The online CAS is programmed with business rules that match vacancies with people in need of housing according to the CoC's prioritization rules. When a vacancy is entered, the CAS system will search among persons in CAS for the household with the highest priority who meets the eligibility rules for the project. The CAS system will send an email to the CoC Administrator seeking confirmation that the match is correct (that is, the match does meet all rules for the available unit). Following confirmation, CAS will send emails to the Housing Navigator and then to the Housing Provider notifying of the match and seeking confirmation.

The Housing Provider will have two weeks to locate the client and determine if the client is interested in the housing opportunity. The Housing Navigator should respond to CAS as soon as the client is located and provides an answer.

If the Housing Navigator indicates the client is interested in the housing opportunity, CAS will generate an email to the Housing Provider. The Housing Provider can accept the referral, or, if the Provider regularly reviews Criminal Record Offender Information (CORI), can contact the Housing Navigator directly to arrange for the client to give permission to obtain CORI. If the Housing Provider reviews CORI and proposes to deny the client based on this information, the Housing Provider must set a CORI review hearing in CAS.

CoC-funded housing providers are expected to accept clients referred to them, unless there is a reason to deny based on CORI. If a provider rejects a client for any other reason, the reason must be detailed in CAS as part of the rejection. Rejections by CoC-funded providers will be reviewed by the CoC for compliance with all

laws and program requirements. The rejection of referred clients may be taken into consideration during program monitoring and evaluation for continued funding.

Once the Housing Navigator and the Housing Provider approve the match, they coordinate to assist the client to access the unit. The Housing Provider updates CAS with the date of client move-in, at which point the CoC is notified and the match is closed.

Eligibility Determination

In the context of the coordinated entry process, determining eligibility is a project-level process governed by written standards as established in 24 CFR 576.400(e) and 24 CFR 578.7(a)(9). CAS only refers persons to projects for which they are eligible. Projects or units may be legally permitted to limit eligibility, *e.g*., to persons with disabilities, through a Federal statute which requires that assistance be utilized for a specific population, *e.g*.., the HOPWA program, or through State or local preferences in instances where Federal funding is not used and Federal civil rights laws are not violated. Programs are prohibited from restricting access to persons with a specific diagnosis unless it is a requirement of another funding source for the project.

The process of collecting required information and documentation regarding eligibility may occur at any point in the coordinated entry process, *i.e*., after or concurrently with the assessment, scoring, and prioritization processes.

Participant Refusal of Unit Offer

Coordinated entry respects participant choice. If an individual refuses a unit to which they are referred, the individual remains on the by-name list with the same priority status the person previously had. The goal is to house people, so there is no limit to the number of referrals that will be made for an individual.

Housing Provider Decline of a Referral

There may be rare instances where programs do not to accept a referral from CAS. Refusals are permitted in limited circumstances, including:

- The person does not meet the program's eligibility criteria;
- The person would be a danger to others or themselves if allowed to stay at this program; and
- The person has previously caused serious conflicts within the program (*e.g.* was violent with another consumer or program stuff).

If the program determines a consumer is not eligible for their program after they have received the referral from the coordinated access system, the homeless individual will be referred back to their Housing Navigator, who will reactivate the individual on the by-name list. The individual maintains the priority status they had prior to the referral.

CoC-funded programs that consistently refuse referrals will be reviewed for compliance with contract requirements and may risk suspension or loss of funding. Programs that are not CoC-

funded and consistently refuse referral will be evaluated to determine if the program is appropriate to participate in CAS.

SECTION 11: GRIEVANCE PROCEDURE

Any person participating in the coordinated entry process has the right to file a grievance. Grievances related to a particular service provider (for example, a grievance related to how an assessment was conducted at a particular provider) should be resolved through that provider's grievance procedure. Grievances specific to the coordinated entry system (for example, a grievance related to the match making process), should be forwarded to the Continuum of Care.

SECTION 12: PRIVACY AND DATA PROTECTION

CAS operations and staff must abide by all state and federal privacy protections. Client consent protocols, data use agreements, data disclosure policies, and any other privacy protections offered to program participants as a result of each client's participation in HMIS will be the same as CES.

Appendix: Forms

Appendix A: Other Federal Definitions of Homelessness

Appendix B: Prevention Assessment

Appendix C: Diversion Questionnaire

Appendix D: Individual VISPDAT

Appendix E: Family VISPDAT

Appendix F: TAY-SPDAT

Appendix G: Consent Form

Appendix H: Verification of Chronic Homelessness