NC-507 - Raleigh/Wake, North Carolina Coordinated Entry System Policies and Procedures Manual

Adopted 1/19/18

Revised 11/16/18

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Revised May 2020

Coordinated Entry Overview

In 2017, the City of Raleigh-Wake County, North Carolina initiated a process to improve the delivery of housing, crisis response services and assistance to 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 process, the ***Coordinated Entry System (CES)***, institutes consistent and uniform access; assessment; prioritization; and referral processes to determine the most appropriate response to each person's immediate housing needs. Coordinated Entry is mandated by HUD and many other funders. It is recognized nationally as a best practice to improve efficiency within systems, provide clarity for people experiencing homelessness, and can help serve more people more quickly and efficiently with assistance targeted to address their housing needs.

This CES Policies and Procedures document is an operational manual, providing guidance and direction for the day to day operation, management, oversight, and evaluation of Raleigh-Wake's coordinated entry approach. This manual will be updated and revised on a bi-annual basis as the actual application and practical experience of CES design principles are refined and improved. The review process will include a two-week public comment period where all suggested edits to the policies and procedures will be sent electronically to the HOUSE WAKE! Access Hub. The CoC Quality Improvement Committee will review the comments and makes necessary edits within two weeks of closing the public comment period. The revised version of the policies and procedures will be posted on the CoC Lead Agency website, www.partnerhsipwake.org

Table of Contents

Introduction and Purpose

In July 2012, HUD published the new Continuum of Care (CoC) Program interim rule (24 CFR 578). The CoC Program interim rule requires that the CoC establish and consistently follow Policies and Procedures for providing CoC assistance, in consultation with recipients of the Emergency Solutions Grant (ESG) program.

At a minimum, these Policies and Procedures must include:

- Standards for evaluating eligibility for assistance in the CoC Program
- Standards for determining and prioritizing who will receive assistance for permanent supportive housing assistance, transitional housing assistance, rapid re-housing assistance, and homelessness prevention

The goals of the Policies and Procedures are to:

- Establish community-wide expectations on the operations of projects within the community
- Ensure that the system is transparent to users and operators
- Establish a minimum set of standards and expectations in terms of the quality expected of projects
- Make the local priorities transparent to recipients and sub-recipients of funds
- Create consistency and coordination between recipients' and sub-recipients' projects within the CoC
- CoC Program standards must remain in compliance with Violence Against Women Act (VAWA) regulations

The CES is Raleigh-Wake, North Carolina's approach to organizing and providing services and assistance to people experiencing a housing crisis throughout the Continuum of Care. Individuals or families experiencing a housing crisis are directed to defined Access Sites, assessed in a uniform and consistent manner, prioritized for housing and services, and then linked to available interventions in accordance with the intentional service strategy defined by CoC leadership. Each participant's acuity level and housing needs are aligned with a set of service and program strategies that represent the appropriate intensity and scope of services needed to resolve the housing crisis.

Guiding Principles

The following Access Sites have been identified to ensure equal access for all persons seeking support for a housing crisis to help both centralize and standardize connection to the most critical resources in our community, expediting permanent housing for people experiencing homelessness.

Website: http://wake.nc.networkofcare.org

Haven House Services
600 W. Cabarrus St.
Raleigh, NC 27603
(919)-833-3312

InterAct
1012 Oberlin Road
Raleigh, NC 27605
(919) 828-7501 (office)
(919) 828-7740 (24 Hour Crisis Line)

Durham Veteran Affairs Medical Center
508 Fulton Street
Durham, NC 27705
(877) 424-3838

Wake County Southern Regional Center
130 N. Judd Parkway NE
Fuquay-Varina, NC 27526
(919) 557-2501

Wake County Eastern Regional Center
1002 Dogwood Drive
Zebulon, NC 27597
(919) 404-3900

Wake County Northern Regional Center
350 E. Holding Ave.
Wake Forest, NC 27587
(919) 562-6300

Dorcas Ministries
187 High House Road
Cary, NC 27511
(919) 469-9861 Ext. 203

Oak City Cares
1430 S. Wilmington St.
Raleigh, NC 27603
(984) 344-9599 Option 4

Process for Determining Access Sites:
Each Access Site was selected based on the following criteria:

- **Geographic Location:** Each of the Access Sites are centrally located in separate regions of the county with public transportation access. This ensures full geographic coverage of the county and equal access for all Wake County residents.
- **Organizational Capacity:** Each Access Site has the staff and organizational capacity to accommodate potential increases in client interaction, services, assessments and referrals
- **Access for Priority Subpopulations: In order to increase access to Coordinated Entry for priority subpopulations, the following agencies were selected as Access Sites:**
  - Haven House Services: Serving youth and young adults under the age of 24 experiencing or at risk of experiencing homelessness.
  - Durham VA Medical Center: Serving Veterans experiencing homelessness.
  - InterAct: Serving survivors of Domestic Violence and Sexual Assault.

  All other access sites are available to all individuals and families experiencing or at risk of experiencing homelessness.

The guiding principles for these Access Sites include:

- Housing First: When an individual or family is experiencing 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. Other services may need to commence concurrently but should not take precedence over housing.
- Client-centered: Based on the identified needs of the household we will focus on connecting them with community resources designed to achieve housing stability.
- System-wide prioritization of limited supportive housing resources: Our community has a limited number of moderate to intensive housing supports including Rapid Re-housing slots, public housing units and vouchers, specialized housing vouchers for individuals and families experiencing homelessness and case management services.

Fair Housing, Tenant Selection and Other Statutory and Regulatory Requirements

All CoC projects in The NC-507 – Raleigh/Wake CES must include a strategy to ensure CoC resources and CES options (referral options) are eligible to all people regardless of race, color, national origin, religion, sex, age, familial status, disability, actual or perceived sexual orientation, gender identify, or marital status. Special outreach to people who might identify with one or more of these attributes ensures the CES is accessible to all people.

All CoC projects in the NC-507 – Raleigh/Wake CES must ensure that all people in different populations and subpopulations throughout the geographic area, including people experiencing chronic homelessness, veterans, families with children, youth, and survivors of domestic violence, have fair and equal access to the coordinated entry process, regardless of the location or method by which they access the crisis response system.

All CoC projects in the NC-507 – Raleigh/Wake CES must document steps taken to ensure effective communication with people with disabilities. Access Sites must be accessible to people with disabilities, including physical locations for people who use wheelchairs, as well as people in Raleigh-Wake who are least likely to access homeless assistance.

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 include 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.
F. "Equal Access in Accordance with an Individual's Gender Identity in Community Planning and Development Programs." Through this final rule, HUD ensures equal access to individuals in accordance with their gender identity in programs and shelter funded under programs administered by HUD's Office of Community Planning and Development (CPD).

When the Access Sites identify gaps in services to any subpopulation of people, they will notify the CoC Quality Improvement Committee of these gaps in the system of care within the community. The Committee and CoC will be responsible for working with the local agencies and departments to address the gap in services and ensure that all residents of Wake County have access to appropriate services to address their housing crisis.

Right to Appeal

Consumer Appeals

Individuals or families experiencing homelessness seeking to appeal decisions of the CES and/or if a consumer is filing a non-discrimination complaint must contact the Raleigh-Wake Partnership to End and Prevent Homelessness Coordinated Entry Manager at cemanager@endhomelessnesswake.org or 919-824-7898 and submit an official appeal, either verbally or in writing. The Coordinated Entry Manager will communicate directly with the head of household or designee regarding the appeal. Appeals will be initially directed to the Coordinated Entry Manager and will have five (5) business days to consult with the head of household or designee, review all applicable evidence, consult with professional parties involved (if applicable), and issue a formal decision in writing to the household. If the head of household or designee feels the issue remains unresolved, they may further appeal to the next level of oversight beginning with the Raleigh-Wake Partnership to End and Prevent Homelessness Executive Director, and ending with an independent review committee of the CoC. Each level of appeal will comply with the timelines listed above and will issue a formal response in writing to the head of household or designee.

If appealed to the Coordinated Entry Manager, that decision will be considered final and binding (pending any extra legal and/or Federal appeal proper). A consumer not presently affiliated with a local project sponsor/agency but still appealing a Coordinated Entry decision (such as consumers served via street outreach) may file an appeal directly with Raleigh-Wake Partnership to End and Prevent Homelessness staff. The Raleigh-Wake Partnership to End and Prevent Homelessness will maintain and review records of all CES appeals for at least five (5) years, in compliance with HUD recordkeeping requirements. In its role as federal funding entity, HUD shall assume and maintain regulatory oversight regarding Coordinated Entry in matters of compliance.

Project-Level Appeals

All projects participating in the CES, whether as part of funding requirements or through voluntary participation, are required to have a project-level appeals policy and procedures in place, inclusive of the procedures for appeals and in accordance with HUD requirements of due process. All households being screened for project admission must be provided information on their right to file an appeal and/or a non-discrimination complaint and the process in which to do so. Households contacting The Raleigh-Wake Partnership to End and Prevent Homelessness regarding project-level decisions will be directed to the specific program to address concerns and pursue appeals. Projects must fully comply with their project-level appeals process and notify The Raleigh-Wake Partnership to End and Prevent Homelessness, as CES lead, of any appeals related to the processing and acceptance of CES referrals. The Raleigh-Wake Partnership to End and Prevent Homelessness notification requirement only applies to the timeframe from referral receipt through processing and acceptance/denial of referrals, up to and including formal project entrance or referral closure. Projects must provide all appeal responses in writing to the head of household or designee and copy The Raleigh-Wake Partnership to End and Prevent Homelessness via email.

Coordinated Entry System Terms

Chronically Homeless (HUD Definition)

HUD defines a chronically homeless person as follows:

An individual or family 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).

For qualifying 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)

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

a. Has a primary nighttime residence that is a public or private place not meant for human habitation;
b. 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 programs); or
c. 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)

Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who:

a. Are defined as homeless under the other listed federal statutes;
b. Have not had a lease, ownership interest, or occupancy agreement in permanent housing during the 60 days prior to the homeless assistance application;
c. Have experienced persistent instability as measured by two moves or more during in the preceding 60 days; and
d. Can be expected to continue in such status for an extended period of time due to special needs or barriers

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

Any individual or family who:

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

At Risk of Homelessness

Category 1: Individual and Families

a. Has an annual income below 30% of median family 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
c. 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 low-income individuals; 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 Con Plan

Category 2: Unaccompanied Children and Youth

a. A child or youth who does not qualify as homeless under the homeless definition, but qualifies as homeless under another Federal statute

Category 3: Families with Children and Youth

a. 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 CoC jurisdiction. Usage of the HMIS is mandated by the U.S. Department of Housing and Urban Development (HUD) for any person experiencing homelessness.

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

The Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT) developed and owned by OrgCode and Community Solutions is a triage tool that assists in informing an appropriate 'match' to a 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, released May 2015 and is the current version being used. The NC-507 – Raleigh/Wake CES has agreed to use the VI-SPDAT as the universal triage tool across the CoC for screening and matching people experiencing homelessness in Raleigh/Wake. Staff administering any of the VI-SPDAT tools will be trained by an authorized trainer.

Planning, Staffing Roles, and Participation Responsibilities

Coordinated Entry System Continuum of Care Leadership

Leadership from the CoC Governance Board of Directors along with the CoC Quality Improvement Work Group (CoC QI) will conduct oversight and monitoring of Coordinated Entry functions to ensure consistent application of CES Policies and Procedures and high-quality service delivery for those experiencing a housing crisis.

Continuum of Care Providers Serving People Experiencing Homelessness will:

1. **Adopt and follow Coordinated Entry System policies and procedures.** Participating providers shall maintain and adhere to these policies and procedures for CES operations. As established by the CoC Leadership for Access Sites, assessment procedures, prioritization, and referral to available services and housing must also remain consistent with CES Policies and Procedures.

2. **Maintain low barrier to enrollment.** Providers serving individuals or families experiencing homelessness shall limit barriers to enrollment in services and housing. Persons may not 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. Providers maintaining restrictive enrollment practices must maintain documentation from project funders, providing justification for the enrollment policy.

   CoC providers offering Prevention and/or Short-Term Rapid Re-housing assistance (i.e. 0 – 24 months of financial assistance) may choose to apply some income standards for their enrollment determinations.

3. **Maintain Fair and Equal Access**. CES participating providers shall ensure fair and equal access to CES 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.

   If a program participant's self-identified gender creates safety or health issues within a facility, accommodations based on concern for the health and safety of the individual seeking accommodations should be based on the individual's own request to be otherwise accommodated.

   CES participating providers shall offer universal program access to all subpopulations as appropriate, including chronically homeless people, veterans, youth, transgender people and people fleeing domestic violence.

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 will continue to operate and receive prioritized referrals. Any new project wishing to institute exclusionary eligibility criteria will be considered on a case-by-case basis and receive authorization to operate as such on a limited basis from the CoC Leadership and their funders.

4. **Provide appropriate safety planning**. CES participating providers shall provide necessary safety and security protections for people fleeing or attempting to flee family violence, stalking, dating violence, or other domestic violence situations. Minimum safety planning must include a threshold assessment for presence of participant safety needs and referral to appropriate trauma-informed services if safety needs are identified.

5. **Create and share written eligibility standards**. CES participating providers shall provide detailed written guidance for eligibility and enrollment determinations. Eligibility criteria should be limited to that required by the funder; any requirements beyond those required by the funder will be reviewed and a plan to reduce or eliminate them will be discussed. Eligibility and enrollment standards shall 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 CES Continuum of Care Leadership as well as funders.

6. **Communicate vacancies**. Homeless providers must communicate project vacancies, either bed, unit, or voucher, to the Coordinated Entry Manager in a manner determined by and outlined in these policies and procedures.

7. **Limit enrollment to participants referred through the defined Coordinated Entry System Access Sites.** Each bed, unit, or voucher that is required to serve someone who is homeless must receive their referrals through the prioritization criteria outlined below. Any agency filling homeless mandated units from alternative sources will be reviewed with funders for compliance. CES Access Sites will need to be informed of every opening and how and when they were filled.

8. **Participate in Coordinated Entry System planning**. CoC projects shall participate in CES planning and management activities as defined and established by CES Continuum of Care Leadership.

9. **Contribute data to HMIS if mandated per federal, state, county, or other funder requirements.** Each provider with homeless dedicated units will be required to participate in HMIS. Providers should work with the Raleigh-Wake HMIS Lead Agency and Local System Administrator with funding sources to determine specific forms and assessments required for HUD compliance within HMIS. Agencies must enter client data

into HMIS within 24 hours of collection.

10. **Ensure staff who interact with the Coordinated Entry System process receive regular training and supervision.** Each provider must notify CoC Leadership to changes in staffing, to ensure employees have access to ongoing training and information related to the CES. The CoC provides training opportunities at least once annually to organizations and or staff persons at organizations that serve as Access Sites or administer the VI-SPDAT in addition to updating and distributing training protocols at least annually to provide all staff administering assessments with access to materials that clearly describe the methods by which assessments are to be conducted with fidelity to the NC-507 – Raleigh/Wake Coordinated Entry Policies and Procedures. (see appendix)

11. **Ensure individual and families' rights are protected and that they are informed of their rights and responsibilities.** People shall have 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 CES 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/reject housing and/or services
    - The right to confidentiality and receive information about when confidential information will be disclosed, to whom, and for what purposes, as well as the right to deny disclosure.

12. **Support transparency through marketing.** The Raleigh-Wake Partnership to End and Prevent Homelessness will be responsible for advertising and marketing Coordinated Entry policies, procedures and services. This includes the development and distribution of marketing materials. Providers shall post on their premises in a location clearly visible to program participants a notice stating participation in the CoC's CES in both English and Spanish. In lieu of resources for street outreach, Coordinated Entry flyers will be posted in GoRaleigh and GoTriangle bus terminals, at least one public libraries per Wake County municipality, community centers, and meal distribution centers. 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.

13. **Ensure universal program access.** All programs serving people who are experiencing homelessness within the geographic bounds of the 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.

Coordinated Entry System Workflow and Policies

I. Coordinated Entry Workflow Overview

Street outreach, shelter, transitional housing staff will ensure client are triaged appropriately with the VI-SPDAT, as well as day centers, Rapid Re-housing, and Permanent Supportive Housing staff will work to ensure as many of the people they engage with will be assessed with VI-SPDAT, clients are connected to the right resource to administer the VI-SPDAT and are readily able to be located, motivated to pursue housing, in possession of the documentation required for potential housing options, and successfully engaged by CoC providers seeking to resolve their crisis of homelessness.

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

Raleigh-Wake, North Carolina utilizes a de-centralized access model with previously noted Access Sites for adults without children, adults accompanied by children, unaccompanied youth 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 Sites for which they qualify as a target population. Regardless of initial access point(s), people experiencing homelessness or at risk of homelessness are given the same assessment approach, including standardized decision-making and assessment tool specific to each population (adults without children, adults accompanied by children, unaccompanied youth, and persons at risk of homelessness).

III. Safety Planning and Domestic Violence

Upon a household entering the CES, 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 that 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 24-Hour Crisis Line at (919) 828-7740 or email at info@interactofwake.org

b. Victims of domestic violence who need an order of protection can file electronically at the InterAct office or they go to the Office of the Clerk of Court Monday – Friday 9-5. More information can be obtained by calling the InterAct 24-Hour Crisis Line.

c. 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 to assist in determining the appropriate course of action to ensure the safety of the clients and those around the client.

Wake County's domestic violence shelter uses a separate database that will run a By-Name List that mirrors data fields in the HMIS By-Name List, but does not include primary identifying information such as first name, last name, date of birth, or social security number. Instead, the By-Name List generates a unique client ID. This list is then sent to the Raleigh-Wake Partnership to End and Prevent Homelessness Coordinated Entry Manager and is integrated into the HMIS By-Name List.

IV. Non-Discrimination

All CoC providers must operate with as few barriers to entry as possible. People may access emergency services, such as emergency shelter, independent of the operating hours of the system's intake and assessment processes, or http://wake.nc.networkofcare.org/

Physical locations must be accessible to people with disabilities, including accessible locations for people who use wheelchairs, with a particular focus on people experiencing homelessness who are least likely to access homeless assistance.

CoC providers 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 must also take reasonable steps to offer Coordinated Entry process materials and instruction in multiple languages to meet the needs of minority, ethnic, and groups with Limited English Proficiency (LEP).

V. Initial System Access

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

When an emergency shelter or street outreach staff engages a person experiencing homelessness, they should update an existing HMIS record or create a new HMIS record according to complete the fields accompanying intake forms

Prior to HMIS data input, the person performing initial intake of the household must obtain a signed written consent to having the household's personally identifiable information entered into HMIS. For families 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. Survey – Explaining What You're Doing and Why

The Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT) developed and owned by OrgCode and Community Solutions is a triage tool that assists in informing an appropriate 'match' to a 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, released May 2015 and is the current version being used. The NC-507 – Raleigh/Wake CES has agreed to use the VI-SPDAT as the universal triage tool across the CoC for screening and matching people experiencing homelessness in Raleigh/Wake. Staff administering any of the VI-SPDAT tools will be trained by an authorized trainer.

People engaged by providers representing the CES should receive the same information regarding what that process involves. Assessors should communicate the survey process and its results clearly and consistently across the community. This ensures both that the benefits to participating in a survey are described clearly to encourage people to participate but is equally important to make sure that people understand that participating does not guarantee (and may not result in) housing. It is also important that 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
- That it usually takes less than 10 minutes to complete
- That only "Yes," "No," or one-word answers are being sought
- That any question can be skipped or refused
- That the information is going to be stored in the Homeless Management Information System
- That other providers conducting assessments and the housing providers connected to the CES will have access to the information so that the person does not need to complete the assessment multiple times
- That housing providers can identify people to target for housing resources as they come available, and for planning purposes.
- That if the participant does not understand a question, clarification can be provided
- The importance of relaying accurate information to the assessor and not feeling that there is a correct or preferred answer that they need to provide, nor information they need to conceal

VII. Additional 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 coordinated entry process on the basis that the person is or has been a victim of domestic violence, dating violence, sexual assault, or stalking. While people currently experiencing homelessness have often previously survived domestic violence, the Violence Against Women Act (VAWA) prevents providers dedicated to serving this subpopulation from inputting their personally identifiable information within HMIS because of the additional safety precautions specific for this population. While the VI-SPDAT is not primarily a domestic violence-specific triage tool, providers dedicated to serving survivors of domestic violence can assess people that desire access to the broader range of housing options dedicated to people experiencing homelessness. Those results will need to be stored within a VAWA-compliant electronic system or in paper files secured according the full requirements of the law.

VIII. Survey Refusals

For limited instances when people refuse specific questions throughout the assessment process, the assessor may request permission to ask additional questions to utilize their conversation with the person, surveyor observation, documentation, and information from other professionals in order to provide responses. When staff encounter individuals or families who do not provide a response to any of the first questions, they should stop and acknowledge that the assessment will not provide useful information to support their housing crisis 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. Survey – Concluding the Engagement

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

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

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

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 quantify which essential documents the person currently possesses and begin working with them to begin collecting missing documents, as staff time and resources allow.

Assessors should emphasize that specific documentation is required for many programs, including but not limited to government issued photo identification, social security card, birth certificate, proof of income or zero income, verification of homelessness, and DD-214 for people who have served in the United States Armed Forces (regardless of discharge status or length of service).

XI. Functions of Case Conferencing and Consultation:
Providers participating in HMIS and Coordinated Entry will convene twice per month to conduct Coordinated Entry case consultation and review successful, pending, and unsuccessful referrals, as well as successful, pending, and unsuccessful matches. Additionally, providers will set priorities in engaging higher need clients and be prepared to update the Case Conferencing team at each meeting.

Data Management
HMIS is used by the CoC's coordinated entry process for collecting, using, storing, sharing, and reporting participant data associated with the coordinated entry process. For the complete description of CoC Written Standards pertaining to HMIS, data management, and privacy protections, see the HMIS Written Standards and NC HMIS Policies and Procedures. Participants must be informed that they are freely allowed to decide what information they provide at every step of the assessment process, including refusing to answer questions entirely. Participants may also refuse specific services, housing options, and personal information sharing options without any retribution or limiting their access to any form of

assistance that does not explicitly require that specific information to establish or document program eligibility. This right to refusal fully covers any specific medical diagnosis or disability information.

By-Name List Case Staffing
The CoC utilizes closed, individualized case staffing sessions to coordinate housing and support services across multiple potential community service providers. In accordance with the Privacy Rights and HMIS Written Standards, CES participants may opt out of participation in the Coordinated Entry case conferencing process through the CoC Release of Information (ROI).

Staff from programs covered by the CoC ROI are allowed to attend these meetings for the sole purpose of identifying and coordinating housing and support services. Staff must sign in and identify their agency and service role before these meetings begin, and any agency or role not covered by the ROI is asked to leave before the closed staffing session starts. Any client who has not provided consent through the CoC ROI to have personal or service information shared at these meetings cannot be discussed during the meeting.

Referrals
For the program components, rapid-rehousing, permanent supportive housing, and homelessness prevention, referrals are only accepted through the CoC's CES. The other sources of referrals outside the CES would be to emergency services only (street outreach and emergency shelter). These other sources of referrals outside the CES include, but are not limited to, a variety of community agencies and partners, such as police officers, NCCARE360, Wake Network of Care, United Way's 211, Wake County Public School System, and hospitals. Programs must comply with all applicable Federal civil rights laws, including equal access, nondiscrimination, and fair housing. Federal, State, and local Fair Housing laws and regulations require that participants not be "steered" toward any particular housing facility or neighborhood because of race, color, national origin, religion, sex, disability, or familial status. The CoC maintains an active, updated list of all programs currently receiving referrals through the CES, as well as their stated program-specific eligibility criteria.

If a CES participating program wishes to reject, decline, inactivate, exit, or otherwise cease services to a program participant for any other reason, that case should be staffed at the Coordinated Entry Case Conferencing Team. Rejection criteria should be clearly documented in HMIS. If client is denied based on eligibility requirements, the client must receive a written notice and be given the opportunity to appeal the denial. Projects should have this process clearly stated in Agency Written Standards.

Prioritization of Referrals

The CoC must use the coordinated entry process to prioritize homeless persons within the CoC's geographic area for referral to housing and services. The prioritization policies must be documented in Coordinated Entry policies and procedures and must be consistent with CoC and

ESG written standards established under 24 CFR 576.400(e) and 24 CFR 578(a)(9). These policies and procedures must be made publicly available and must be applied consistently throughout the CoC areas for all populations.[1]

All referrals for Prevention, Street Outreach, Transitional Housing, Rapid Re-Housing and Permanent Supportive Housing will be made through the CES.

Notice of upcoming vacancy within a program is made electronically. The NC-507 – Raleigh/Wake CoC has established a community-wide list within HMIS of all known homeless persons who are seeking or may need CoC housing and services to resolve their housing crisis. The community-wide list generated during the prioritization process, variously referred to as a "By-Name List," uses the prioritization outlined below for generating referrals and provides an effective way to manage an accountable and transparent prioritization process. Referrals are made based on eligibility[2] and other community priorities.

Upon referral to a program, a collaborative effort will be made to locate the matched household to support with document readiness, and verifying eligibility. All efforts must be exhausted (i.e. Outreach, Case Consultation, utilizing HMIS, etc.) before a household is considered inactive or unavailable for a housing match.

The Housing Provider will document any unsuccessful matches and provide both the (A) reason(s) why they were not housed, (B) date of unsuccessful match/"unenrollment" and (C) name of the project being unassigned within HMIS so that the person can be reassigned to additional providers (further outlined below). The housing provider will also document when each match does lead to successful program entry and providing the date the person moves into housing within HMIS.

A. Homelessness Prevention Prioritization:

People at imminent risk of homelessness will be referred to ***Homelessness Prevention*** according to the following prioritization criteria (each of the criteria for each category must be met before proceeding to people who do not meet the priority category 1):

Priority Category 1:
Imminent risk of eviction with documentation

[1] https://www.hudexchange.info/resources/documents/Notice-CPD-17-01-Establishing-Additional-Requirements-or-a-Continuum-of-Care-Centralized-or-Coordinated-Assessment-System.pdf
[2] http://ctagroup.org/wp-content/uploads/2015/10/Homeless-Definition-and-documentation.pdf

B. Transitional Housing Prioritization
People experiencing homelessness will be referred to ***Transitional Housing*** per the following prioritization criteria (only proceeding to the next category when no one remains in the initial/previous category):

Priority Category 1:
Chronic Homelessness

Priority Category 2:
Literally Homeless; not experiencing chronic homelessness

Priority Category 3:
Highest VI-SPDAT score

C. 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 Category 1:
- Chronic Homelessness
- 1+ HUD Disabling Condition(s)
- Length of Time Homeless
  VI-SPDAT Score Range 4 – 11

Priority Category 2:
- Not Chronically Homeless
- 1+ HUD Disabling Condition(s)
- Length of Time Homeless
  VI-SPDAT Score Range 4-11

Priority Category 3:
- Not Chronically Homeless
- Length of Time Homeless
  VI-SPDAT Score Range 4-11

D. 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 Category 1:

- Chronic Homelessness[3]
- 1+ HUD Disabling Condition(s)
- Length of Time Homeless
  VI-SPDAT Score Range 8-Max

Priority Category 2:

- Chronic Homelessness
- 1+ HUD Disabling Condition(s)
- Length of Time Homeless
  VI-SPDAT Score Range 8-Max

Priority Category 3:

- Not Chronically Homeless
- 1+ HUD Disabling Condition(s)
- Length of Time Homeless
  VI-SPDAT Score Range 8-Max

Connection to Mainstream Resources:
People who may benefit from a connection to a mainstream service provider, such as the Department of Social Services, Legal Aid, income based housing or other services may be provided a referral to connect to these mainstream providers. All mainstream service referrals shall be documented in the 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. CoC staff shall engage key mainstream service providers to enhance and streamline the connection between their resources and CoC providers.

Unsuccessful Matches Process

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 on behalf of staff, programs, and/or agencies may require case conferencing and additional discussion with CoC leadership. A client's rejection of housing/services will not affect their location on the By-Name List and may require additional case conferencing to identify the barriers to accepting housing/services and potential solutions.

[3] https://www.hudexchange.info/resources/documents/Flowchart-of-HUDs-Definition-of-Chronic-Homelessness.pdf

By Housing Provider
NC-507 – Raleigh/Wake CoC providers and program participants may deny or reject referrals from the CES, although service denials should be infrequent and must be documented in HMIS. The specific allowable criteria for denying a referral shall be published by each project and be reviewed and updated annually or as they change, whichever happens first. All participating projects shall provide the reason for service denial and may be subject to a limit on the number of service denials.

Agencies 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 choose to appeal this decision, a new referral will not be provided to the housing program until the appeal process has reached its conclusion.

The Housing Provider will document any unsuccessful matches and provide both the (A) reason(s) why they were not housed and the (B) date of unsuccessful match/"unenrollment" within HMIS so that the person can be reassigned to additional providers. The housing provider will also document when each match does lead to successful program entry and providing the date the person moves into housing within HMIS.

Re-Screening

While people generally do not need to be surveyed multiple times with the VI-SPDAT, there are circumstance 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 Severe and Persistent Mental Illness (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 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.

Coordinated Entry System Monitoring and Evaluation

Monitoring, Evaluation and Reporting of the CES

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.

HMIS users must understand and follow the privacy rules associated with collection, management, and reporting of client data according to the State and CoC HMIS Policies and Procedures. The State-defined monitoring process will report on performance objectives related to CES utilization, efficiency, and effectiveness.

HUD has developed the following seven system-level performance measures to help communities gauge their progress in preventing and ending homelessness:

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

- Successful housing placement;

Beyond HUD's required System-wide Performance Measures, NC-507 – Raleigh/Wake CoC will include additional metrics to measure effectiveness of the CES over time:

- Percent of referrals that are accepted by receiving programs (RRH, TH and PSH) and lead to program enrollments
- Qualitative analysis of understanding why/when referrals are rejected by providers
- Returns to homelessness following project exits (assessing returns following all project exits)
- Average wait time for an assessment
- Length of time that passes from initial assessment to a client's first referral for those of highest priority
- Average time between referral and agency response (acceptance or denial)
- HMIS timeliness and data quality
- Adherence to Housing First principles
    - Reduced barriers to project entry
    - Enrollment of highest-need households
    - Minimal termination of households

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

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

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

Ongoing Training and Amendment of CES Policies and Procedures

The NC-507 – Raleigh/Wake CoC will consult with each participating project and project participants at least annually to evaluate the intake, assessment, and referral processes associated with the CES. Feedback requests must address the quality and effectiveness of the entire Coordinated Entry experience for both participating projects and households.

Participants will be identified through their Continuum-wide feedback requests made directly to participating agencies, through case managers, and through self-identification. Requests for modification, update, additions, or removals from current Coordinated Entry processes will be provided to the CoC Governance Board for approval.

CoC ensures adequate privacy protections of all participant information collected in the course of the annual coordinated entry evaluation, and no personally identifiable information will be included.

Appendices

Appendix A

Coordinated Entry System Program Component Definitions

Component definitions provide detailed descriptions of each CoC program type available through the CES.

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.	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. In addition, outreach staff should provide or link single 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.	Individuals and families experiencing unsheltered homelessness, frequently targeting those living with mental illness(es), severe addiction(s), or dual-diagnoses As providers funded to end homelessness match single 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

Prevention

Component Type	Essential Elements	Target Population
Prevention from homelessness includes financial assistance and services to prevent people and families from becoming homeless and help those who are experiencing homelessness. The funds under this program are intended to target people and families who would be homeless but for this assistance.	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.	Individuals and families who are "at risk of homelessness."

Emergency Shelter

Component Type	Essential Elements	Target Population
Emergency Shelter programs providing stabilization and assessment 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, rapid housing placement and linkage to other services.	Entry point shelter with: • 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 that 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,	Individuals and families experiencing homelessness Priority is given to individuals and families experiencing literal homelessness based on an acuity score that indicates the type of housing intervention best suited to their ongoing needs. For example, someone who is unsheltered or fleeing domestic violence would be prioritized over someone in a motel or doubled up.

	mental illness, and co-occurring disorders). On-site supportive service staff should conduct the ***VI-SPDAT*** of repeat people 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	

Rapid Re-Housing

Component Type	Essential Elements	Target Population
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	**Housing Identification** • 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. **Rent and Move-In Assistance (Financial)** • Provide assistance to cover move-in costs, deposits, and the rental	The Rapid Re-Housing model targets homeless individuals and families who could quickly and successfully transition out of homelessness with the provision of immediate and limited assistance

that a single entity provide all three services nor that someone will utilize them all.	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. **Rapid Re-Housing Case Management and Services** • 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 that the person has access to resources related to benefits, employment and community-based services (if needed/appropriate) so that they can sustain rent payments independently when rental assistance ends. • Ensure that 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.	

Transitional Housing

Component Type	Essential Elements	Target Population
Safe, temporary apartments located in project-based or scattered-site housing that focuses on housing planning, addictions treatment, stabilization, and recovery for people and families with temporary barriers to self-sufficiency.	Safe units located in site-based or scattered site housing that focuses on housing planning, addictions treatment, stabilization, and recovery for people and families with temporary barriers to self-sufficiency. Recognizing that 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 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. Housing plan within two weeks. Average stay is six months. Could stay up to two years. All programs provide follow up	• People experiencing homelessness contemplating recovery or newly in recovery, • youth, • ex-offenders, • veterans (choosing GPD) • People who are actively fleeing domestic violence • Individuals and families requiring additional support to transition from homelessness into stable, independent housing. The US Interagency Council on Homelessness and National Alliance to End Homlessness recommend reserving TH programs for special need populations like domestic violence survivors, those in recovery from substance abuse and unaccompanied youth.

	case management post exit. Expectation of six months of post placement tracking to assess success	

Permanent Supportive Housing

Component Type	Essential Elements	Target Population
Project-based, clustered and scattered site permanent housing linked with supportive services that help residents maintain housing.	Permanent housing with supports that help people maintain housing and address 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 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	Individuals and families experiencing chronic homelessness, living with disabilities, and significant barriers to self-sufficiency.

	needs from their case manager and/or the ACT multidisciplinary team.	

Permanent

Housing – Market

Component Type	Essential Elements	Target Population
Housing where people may stay indefinitely with temporary or long-term rental assistance and/or supportive services.	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 maintain the same primary case manager for as long as	People who were formerly homeless

	they are in the homeless system, but members of the multi-disciplinary team may change as the person's needs change.	

Appendix B

Example Messaging When Conducting VI-SPDATs

"My name is [ ] and I am with [ ]. Our community completes a questionnaire that helps us understand how we can support your search for housing. It should take about 10 minutes, and most questions only require a “yes” or “no” answer. Some of the questions are personal and you can always choose to skip a question. If you need me to explain a question better, please feel free to ask. All that I need from you is to be honest in responding. 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 will be saved goes in a secure database called the Homeless Management Information System, and will only be share with those housing agencies that you give us permission to share it with. 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.

There are no “right or wrong” answers, and our goal is to make sure you are able to access the services that are most appropriate, so the more honest you are, the better we can be at finding you resources that meet your needs.

Is it ok for us to begin the questionnaire?

Appendix C

SPDAT Process

While the VI-SPDAT is a pre-screen or triage tool that looks to confirm or deny the presence of more acute issues or vulnerabilities, the SPDAT (or "full SPDAT" or "full SPDAT for single people") 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 too low on the VI-SPDAT to qualify for permanent supportive housing (i.e., 7 or below), those people may be recommended for full SPDAT assessment. The primary reason for recommending a SPDAT are when the person being assessed 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.

Appendix D

2018/2019 Coordinated Entry Training Curriculum
Dates and Time to be determined

HMIS Referral Process

- Provided by CoC Lead Agency LSA

HMIS Entry/Exit Training:

- Provided by CoC Lead Agency LSA

Prevention and Diversion

- Provided by OrgCode

Trauma Informed Care

- Provided by The Salvation Army

Harm Reduction

- Provided by CSH

Critical Time Intervention

- Provided by TBD

Working with Survivors of Domestic Violence

- Provided by InterAct

Fair Housing

- Provided by the City of Raleigh