OVERVIEW

Overview of Coordinated Assessment

The CoC Interim Rule defines several responsibilities of the Continuum of Care (*578.7 (a) (8)*). One of these responsibilities is to establish and operate either a centralized or coordinated assessment system, in consultation with recipients of Emergency Solutions Grants program funds within the geographic area. This centralized or coordinated assessment system provides an initial, comprehensive assessment of the needs of individuals and families for housing and services. The Continuum must develop a specific policy to guide the operation of the centralized or coordinated assessment system on how its system will address the needs of individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking, but who are seeking shelter or services from non-victim service providers. This system must comply with any requirements established by HUD by Notice.

Another responsibility of the Continuum of Care, is to establish and consistently follow written standards for providing Continuum of Care assistance. At a minimum, these written standards must include:

(i) Policies and procedures for evaluating individuals' and families' eligibility for assistance under this part;

(ii) Policies and procedures for determining and prioritizing which eligible individuals and families will receive transitional housing assistance;

(iii) Policies and procedures for determining and prioritizing which eligible individuals and families will receive rapid re-housing assistance;

(iv) Standards for determining what percentage or amount of rent each program participant must pay while receiving rapid re-housing assistance;

(v) Policies and procedures for determining and prioritizing which eligible individuals and families will receive permanent supportive housing assistance;

A coordinated assessment system is defined as a coordinated process designed to coordinate program participant intake, assessment, and provision of referrals. A coordinated assessment system covers the geographic area, is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool. This definition establishes basic minimum requirements for the Continuum's coordinated assessment system *(CoC Interim Rule).*

Coordinated assessment systems are important in ensuring the success of homeless assistance and homeless prevention programs in communities. In particular, such assessment systems help communities systematically assess the needs of program participants and effectively match each individual or family with the most appropriate resources available to address that individual or family's particular needs.

Goals of Coordinated Assessment

Most communities lack the resources needed to meet all of the needs of people experiencing homelessness. This, combined with the lack of well-developed coordinated entry processes, has resulted in severe hardships for people experiencing homelessness. They often face long waiting times to receive assistance or are screened out of needed assistance. A Coordinated Assessment System helps communities prioritize assistance based on vulnerability and severity of service needs to ensure that people who need assistance the most can receive it in a timely manner. The Coordinated Assessment System also provides information about service needs and gaps to help communities plan their assistance and identify needed resources.

The Coordinated Assessment System is intended to increase and streamline access to housing and services for households experiencing homelessness, match appropriate levels of housing and services based on their needs, and prioritize persons with severe service needs for the most intensive interventions.

HUD's primary goals for coordinated entry processes are:

1. Assistance will be allocated as effectively as possible.
2. Assistance is easily accessible no matter where or how people present.

The Central Tennessee CoC identified the following common goals for the Coordinated Assessment System:

1. The process will be easy for the client, and provide quick and seamless entry into homelessness services.
2. Individuals and families will be referred to the most appropriate resource(s) for their individual situation.
3. The process will prevent duplication of services.
4. The process will reduce length of homelessness.
5. The process will improve communication among agencies.

Target Population

This process is intended to serve individuals and households experiencing homelessness and those who are at imminent risk of homelessness. Homelessness and imminent risk of homelessness will be defined in accordance with the HUD definition of homelessness.[1]

This Document

These policies and procedures will govern the implementation, governance, and evaluation of the Central Tennessee CoC Coordinated Assessment System. This is a living document and will be reviewed annually in accordance with the Central Tennessee CoC Governance Charter. Changes can be made based on the information gathered through the evaluation process.

[1] The definition is available here: https://www.hudexchange.info/resources/documents/HEARTH_HomelessDefinition_FinalRule.pdf

Basic Definitions

Terms used throughout this document are defined below

- **Chronically Homeless –**
    - An individual who: (i) Is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and (ii) Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions in the last 3 years where those occasions also cumulatively total at least 12 months; and (iii) Can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000 (42 U.S.C. 15002)), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability;
    - An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition [as described in Section I.D.2.(a) of this Notice], before entering that facility;
    - A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) of this definition [as described in Section I.D.2.(a) of this Notice, including a family whose composition has fluctuated while the head of household has been homeless. *(24 CFR 578.3)*
- **Client –** Individual or family who accesses the Coordinated Assessment System
- **Literally Homeless (HUD Homeless Definition Category 1) -** An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; (ii) An individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low income individuals); or (iii) 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 *(24 CFR 578.3)*
- **Imminently at Risk of Homelessness (HUD Homeless Definition Category 2) -** An individual or family who will imminently lose their primary nighttime residence,

provided that: (i) The primary nighttime residence will be lost within 14 days of the date of application for homeless assistance; (ii) No subsequent residence has been identified; and (iii) The individual or family lacks the resources or support networks, e.g., family, friends, faith-based or other social networks needed to obtain other permanent housing *(24 CFR 578.3)*

- **Fleeing domestic abuse or violence (HUD Homeless Definition Category 4) -** Any individual or family who: (i) 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 individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence; (ii) Has no other residence; and (iii) Lacks the resources or support networks, e.g., family, friends, faith-based or other social networks, to obtain other permanent housing *(24 CFR 578.3)*
- **Homeless Management Information System (HMIS) -** The information system designated by the Continuum of Care to comply with the HMIS requirements prescribed by HUD. The HMIS used in Central Tennessee is Service Point.
- **HMIS Lead –** The entity designated by the Continuum of Care to operate the Continuum's HMIS on its behalf. Buffalo Valley, Inc. (BVI) is the HMIS Lead for the Central Tennessee Continuum of Care.
- **Housing Interventions -** Housing programs and subsidies; these include transitional housing, rapid re-housing, and permanent supportive housing programs, as well as permanent housing subsidy programs (e.g. Housing Choice Vouchers).
- **Prioritization List Manager – (PLM)** Agency chosen to manage the Prioritization List, and serve as a central point of contact for the agencies within the Coordinated Assessment system.
- **Program –** A specific set of services or a housing intervention offered by a provider.
    - Ex: Emergency Shelter, Transitional Housing
- **Provider –** Organization that provides services or housing to people experiencing or at-risk of homelessness.
    - *Ex: Buffalo Valley, Inc (Provider) has Patriot Place (Program) and ESG Rapid Re- Housing (Program)*
- **VI-SPDAT and VI-F-SPDAT –** *Vulnerability Index-Service Prioritization Decision Assistance Tool* and *Vulnerability Index-Service Prioritization Decision Assistance Tool for Families* are the standardized assessment tools used in the Coordinated Assessment System. The VI-SPDAT and VI-F-SPDAT are pre-screening, or triage tools that are designed to be used by all providers within the Coordinated Assessment System to quickly assess the health and social needs of people experiencing homelessness and match them with the most appropriate support and housing interventions that are available.
- **Victim Service Provider (VSP) –** An agency with a specific mission to provide direct services to victims of domestic violence. This term includes permanent housing providers—including rapid re-housing, domestic violence programs (shelters and non-residential), domestic violence transitional housing programs, dual domestic violence and sexual assault programs, and related advocacy and supportive services programs.

GOVERNING DOCUMENTS

CoC Interim Rule
(https://www.hudexchange.info/resources/documents/CoCProgramInterimRule.pdf)
578.7 (a) (8) In consultation with recipients of Emergency Solutions Grants program funds within the geographic area, establish and operate either a centralized or coordinated assessment system that provides an initial, comprehensive assessment of the needs of individuals and families for housing and services. The Continuum must develop a specific policy to guide the operation of the centralized or coordinated assessment system on how its system will address the needs of individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking, but who are seeking shelter or services from non-victim service providers. This system must comply with any requirements established by HUD by Notice.

ESG Interim Rule
(https://www.hudexchange.info/resources/documents/HEARTH_ESGInterimRule&ConPlanConformingAmendments.pdf)
576.400 (d) Centralized or coordinated assessment. Once the Continuum of Care has developed a centralized assessment system or a coordinated assessment system in accordance with requirements to be established by HUD, each ESG-funded program or project within the Continuum of Care's area must use that assessment system. The recipient and subrecipient must work with the Continuum of Care to ensure the screening, assessment and referral of program participants are consistent with the written standards required by paragraph (e) of this section. A victim service provider may choose not to use the Continuum of Care's centralized or coordinated assessment system.

HUD Coordinated Entry Policy Brief
Appendix A and at: https://www.hudexchange.info/resources/documents/Coordinated-Entry-Policy-Brief.pdf

Each local continuum of care is required to develop and/or operate a centralized or coordinated intake or assessment system if any agencies in the continuum of care receive THDA funding. Recipients and subrecipients must participate in the centralized intake for their continuum of care. If there is not yet a centralized intake, a recipient or sub-recipient must participate in its implementation and eventually its use.

Recipients and subrecipients must use the CoC's centralized or coordinated assessment system to evaluate client eligibility. THDA recipients must ensure the CoC's system is consistent with the written standards for determining THDA assistance. Note that victim service providers that receive THDA funds may opt to not use the CoC's system.

Coordinated Assessment System Procedures

This section outlines and defines the key components of the Coordinated Assessment System and how the coordinated assessment process will work.

Accessing the Coordinated Assessment System

Because of the diversity and size of the COC, access to the Coordinated Assessment System follows a “No Wrong Door” approach. The principles of this approach are:

- A client can seek housing assistance through any of the participating housing providers and will receive integrated services.
- Clients should have equal access to information and advice about the housing assistance for which they are eligible in order to assist them in making informed choices about available services that best meet their needs.
- Participating providers have a responsibility to respond to the range of client needs pertaining to homelessness and housing, and act as the primary contact for clients who apply for assistance through their service unless or until another provider assumes that role.
- Participating providers will guide the client in applying for assistance or accessing services from another provider regardless of whether the original provider delivers the specific housing services required by a presenting client.
- Participating housing providers will work collaboratively to achieve responsive and streamlined access services and cooperate to use available resources to achieve the best possible housing outcomes for clients, particularly for those with high, complex or urgent needs.

Initial Screening

The Coordinated Assessment System utilizes a standardized assessment tool, The Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT and VI-F-SPDAT). This tool assists the provider in consistently evaluating the level of need of individuals and families accessing services.

- When an individual or family contacts a service provider for housing assistance, a Pre- Screen Form is completed as an initial screen to determine basic eligibility (e.g. screening out those who are over income or non-DV from a DV provider). This form can be completed in person or over the phone. *(attach appropriate form as an example)*
- If the individual or family meets eligibility (homeless and below income guidelines), the VI-SPDAT or VI-F-SPDAT is completed either in person or over the phone. *(attach appropriate form as an example)*
- If the acuity score of their assessment indicates the individual or family meets the criteria for a housing referral, the Universal Data Element (UDE) Form is completed, the Coordinated Assessment System Release of Information is signed, and the information is entered into the Prioritization List. (attach appropriate forms as examples)

Initial Screen of Domestic Violence Survivors

Victim service providers (VSP) in the CoC may elect to administer the VI-SPDAT to their clients who are seeking services from other housing service providers in the CoC to ensure their emotional and safety concerns are addressed. If a provider, elects to do so, they will follow this procedure:

- When an individual or family contacts a VSP for housing assistance, a Pre-Screen Form is completed as an initial screen to determine basic eligibility (e.g. screening out those who are over income or non-DV from a VSP). This form can be completed in person or over the phone.
- If the individual or family meet eligibility (homeless and below income guidelines), the VI-SPDAT is completed either in person or over the phone.
- If the acuity score of their assessment indicates the individual or family meets the criteria for a housing referral, the VSP provides the VI- SPDAT score and a unique anonymous identifier, such as “Safe Place Client-12345,” for the prioritization list. The VSP destroys the paper copy of the VI-SPDAT.
- The VSP enters the client’s score and identifier into the prioritization list.

- If and when the requested service becomes available for the client, the appropriate housing agency contacts the VSP and references the client using the anonymous identifier.
- The VSP contacts the client and tells him or her that the service is available and asks the client if he or she would like to receive the service. The VSP then communicates the client's intentions to the housing provider. The VSP will need a signed release of information and waiver of non-disclosure in order to share the client's name with the housing provider for cases in which the client intends to use the housing provider's service.
- If the VSP decides not to administer the VI-SPDAT to their clients, the DVSP will refer these clients to another agency within the local region that does administer the VI-SPDAT.

Whether the VI-SPDAT is first conducted on paper or directly inputted within HMIS, all VI- SPDAT assessments must be recorded in either the HMIS Prioritization List within 48 business hours of when the information was first collected.

If the individual/family is not prioritized for any interventions, the provider administering the VI-SPDAT should explain why and what other services will be available to them (e.g., shelter case management, connection to mainstream resources, help connecting with family or friends). The client should be referred to the appropriate emergency shelter or other housing crisis resource, where they will receive case management and other services to help them access housing. The assessment process ends for the client at this point.

Prioritization List

The HMIS Lead will work with participating agencies to create the Prioritization Lists. Agencies that use ServicePoint will be able to make referrals to ServicePoint Prioritization Lists using the "Referrals" feature of the software. Anyone with a ServicePoint user license can make a referral to the ServicePoint Prioritization Lists.

Individuals and families being referred to the Prioritization Lists do not need to be enrolled in a program at the agency making the referral.

> For additional guidance on using the Prioritization Lists in ServicePoint, you can access training at www.pathwaysmisi.org

Agencies making referrals to the Prioritization Lists will be responsible for following up with the individuals and families they refer in order to determine whether the individual or family is still in need of permanent or transitional housing. Follow-up contact must occur every 90 days at a minimum. If the individual or family is still in need of housing, the agency should update contact information if necessary. If the individual or family is no longer in need of housing, the agency can delete the referral to remove the individual or family from the Prioritization List. Providers that contact a referral to offer services and find out the household is no longer in need, can also close a referral in Service Point, even if that provider did not make the referral.

Referral Process

It is prohibited for any HUD-funded homelessness assistance programs to serve individuals and/or families experiencing homelessness or who are at imminent risk of homelessness, without the household first going through the Coordinated Assessment System. A referral to the Prioritization List is the only way for a household to enter a housing program.

When a program has an opening, the responsible staff person must consult the Prioritization Lists in ServicePoint. Using the Order of Priority established for the program (attachment to be included) program-specific requirements (e.g. single, youth, specific disability, etc.), and the VI-SPDAT score, the program will offer services to the highest prioritized individual/family.

If a program does not take the highest prioritized individual or family from the Prioritization Lists to fill an available spot, that agency must document the reason for not accepting that referral in the ServicePoint client file. If the highest prioritized client does not have a ServicePoint client file (because the client was referred from a VSP), the agency must provide a written explanation. It is the responsibility of the agency not taking the highest prioritized individual or family to ensure that the individual or family has a new referral to the Prioritization List, if needed. The individual or family remains on the Prioritization List in order to access the next available program spot, as long as the individual or family is in need of permanent or transitional housing.

Declined Referrals

One of the guiding principles of the CoC Coordinated Assessment System is client choice. Individuals and families will be given information about the programs available to them and have some degree of choice about which programs they want to participate in. If an individual or family declines a referral to a housing program, their name remains on the Prioritization List until the next housing opportunity is available.

Coordinated Assessment System Policies

This section outlines and defines the policies governing the Coordinated Assessment System.

Joining the Coordinated Assessment System

All programs that receive Continuum of Care funding or Emergency Solutions Grant funding are required by their funders to participate in the Coordinated Assessment System. Other programs are encouraged and welcome to join the Coordinated Assessment System. Those programs that are not required by their funder to participate in the Coordinated Assessment System, but want to participate, will sign a Memorandum of Understanding agreeing to participate in the system for a minimum of six months.

System Advertisement and Outreach

Outreach

The CoC Lead will contact private and public agencies including those in the Continuum of Care, 2-1-1, VA, social service agencies and state and/or local government agencies to educate and provide information on available programs. Outreach activities will be done a minimum of once per year. These activities can be done in conjunction with the Point in Time Count or at another time as determined by the CoC. The CoC Lead will coordinate with existing street outreach programs as well as private and public agencies, social service organizations, etc. for referrals, so that people sleeping on the streets are prioritized for assistance in the same manner as any other person assessed through the Coordinated Assessment System.

Single page flyers publicizing the Coordinated Assessment System Providers will be provided by the CoC Lead for distribution. Providers are encouraged to distribute the material about the Coordinated Assessment System to 24 hour establishments, restaurants, hospitals, hot meal programs, churches, schools, check cashing locations, and other places known to be frequented by the target population. In

addition, each Provider is **encouraged** to explore various outreach activities such as hosting a booth at local community events, resource fairs, festivals and county fairs to provide information and resources.

Advertisement

Advertisement is to include a **minimum of flyers** posted at those places stated above (as allowed). Other forms of advertisement can include newspaper ads, radio, websites, etc. to generate referrals and applications. Advertising is to focus on people experiencing literal homelessness and will clearly state eligibility requirements in an effort to reach the target population as opposed to those who do not meet the criteria. Information about the Coordinated Assessment System will also be available.

Data Collection

Data will be collected on everyone that is assessed through the Coordinated Assessment System. This section, in addition to instructions embedded within the assessment tool, will detail when and how data about clients going through the Coordinated Assessment System will be collected.

Once the Pre-Screen Form has been completed and the client is deemed eligible to be assessed, the staff member will review the ServicePoint Release of Information form with the client. The staff member will explain what data will be requested, how and with whom it will be shared, and what the client's rights are regarding the use of their data. The staff member will be responsible for ensuring clients understand the Release of Information and their rights regarding data confidentiality. If they sign the form, the staff member will begin the assessment process either in ServicePoint or on paper, with relevant data entered into the data fields in ServicePoint within 48 business hours.

Some clients should never be entered into ServicePoint. These include:

- Clients who want domestic violence-specific services should never have

information entered into ServicePoint. The VI-SPDAT should be done on a paper form, the score recorded, and the form shredded. If the client is being served by a DVSP, that agency may enter their information into a ServicePoint-comparable database.

- Clients who do not consent to data sharing should also never have their data entered into ServicePoint.

Access to parts of each client record or assessment form may be restricted for safety reasons or by client request.

Grievance Policy

Client Grievances

This policy refers to client grievances regarding the Coordinated Assessment System only. If a client has a grievance regarding a particular agency, they should follow that agency's grievance procedure.

The agency completing the screening should address any complaints by clients as best as they can in the moment. Complaints that should be addressed directly by the agency staff member or agency staff supervisor include complaints about how they were treated by agency staff, agency conditions, or violation of confidentiality agreements. Any other complaints should be referred to the CoC Coordinator to be dealt with in a similar process to the one described below for providers. Any complaints filed by a client should note their name and contact information so the CoC Coordinator can contact him/her to discuss the issues.

Provider Grievances

It is the responsibility of all boards, staff, and volunteers of CoC-funded programs and ESG- funded programs to comply with the rules and regulations of the Coordinated Assessment System. Anyone filing a complaint concerning a violation or suspected violation of the policies and procedures must be acting in good faith and have reasonable grounds for believing an agency is violating the Coordinated Assessment System policies and procedures.

To file a grievance regarding the actions of an agency, contact the CoC Lead Agency with a written statement describing the alleged violation of the Coordinated Assessment System policies and procedures, and the steps taken to resolve the issue locally. The CoC Coordinator will contact the agency in question to request a response to the grievance. Once the CoC Coordinator has received the documentation he/she will decide if the grievance is valid and determine if further action needs to be taken.