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Coordinated Entry Process

A Coordinated Entry (CE) process represents a new approach to coordination and management of a Continuum of Care’s (CoC) housing crisis response system. CE enables Region providers and homeless assistance staff to make consistent decisions from available information to efficiently and effectively connect people in crisis to interventions that will rapidly end their homelessness. The CE approach also aligns with Indiana Balance of State (BOS) goals to transform crisis response systems to improve outcomes for people experiencing a housing crisis.

In 2009, the McKinney-Vento Homeless Assistance Act was amended by the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act. Among other actions, the HEARTH Act consolidated several of HUD’s separate homeless assistance programs into a single grant program, the Continuum of Care Program, and it codified into law the CoC planning process.

The CoC Regions program interim rule (24 CFR 578) released by HUD in 2012 requires that Regions establish and operate a “centralized or coordinated assessment system,” hereafter referred to as a Coordinated Entry system. The rule defines Coordinated Entry as:

*A centralized or coordinated process designed to coordinate program participant intake assessment and provision of referrals. [Such a] system covers the [Region’s] geographic area, is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool. (24 CFR part 578.3)*

Both the Region Program interim rule and the Emergency Solutions Grants (ESG) program interim rule *(24 CFR part 576)* released in 2011 require that projects operated by recipients and sub-recipients of Region or ESG grant funds must participate in the established Coordinated Entry process.

Coordinated Entry Vision

For households experiencing a housing crisis or homelessness, Clients are quickly assessed and offered appropriate interventions that align with their needs and will resolve the crisis. Our access system aligns available resources effectively to end homelessness in Indiana.

Mission Statement

The mission of the Indiana Balance of State Continuum of Care’s Coordinated Entry process is to rapidly connect the most appropriate need-based interventions to households that are facing or are at-risk of facing homelessness.
Why Coordinated Entry?

Coordinated Entry refers to the process used to assess and assist in meeting the housing needs of people at risk of homelessness and people experiencing homelessness. Key elements and benefits of Coordinated Entry include:

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<th>Element of a CE System</th>
<th>Benefits</th>
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<td><strong>Designated intake locations &amp; staff</strong></td>
<td>Clear points of access for households; prevents Clients from seeking services at agencies that cannot help them; can reduce new entries into homeless system through diversion and prevention efforts.</td>
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<td><strong>Standardized assessment tools</strong></td>
<td>Each household assessed utilizing the Standardized Assessment Tool (VI-SPDAT), prioritizes most vulnerable in entire community population.</td>
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<td><strong>Centralized Prioritization List per Region &amp; database</strong></td>
<td>Centralized Prioritization List in each Region; households no longer manage their status on multiple wait lists; collaboration among service agencies.</td>
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<td><strong>Matching needs to interventions</strong></td>
<td>Needs-first approach in lieu of “First Come First Served” interventions. Households no longer determine their eligibility for each agency individually; greater housing match accuracy</td>
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<td><strong>Targeted &amp; coordinated referrals</strong></td>
<td>Tailored to household match; agency knows to expect Client; Client knows what to prepare ahead of time; coordinated across Region</td>
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The implementation of Coordinated Entry is now a requirement of receiving certain funding (namely Emergency Solutions Grant and Continuum of Care funds) from the Department of Housing and Urban Development (HUD) and is also considered national best practice. When implemented effectively, Coordinated Entry can also improve a community’s ability to perform well on Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act outcomes and accelerate the Region’s progress on ending homelessness.

Why Now?

Reforming the current system of care for households experiencing homelessness has been a primary goal for the state of Indiana. The Indiana Balance of State Continuum of Care will develop and implement a Coordinated Entry system that prioritizes those who are chronically homeless using a Housing First approach with particular emphasis on the sub-populations of Veterans, Families with children and Youth.

Coordinated Entry Design Principles

The goal of the Coordinated Entry process is to provide each household with adequate services and supports to meet their housing needs, with an initial focus on connecting chronically homeless households to Permanent Supportive Housing (PSH). Below are the guiding principles that will help Indiana BOS meet these goals.

- **Client Choice:** Households will be given information about the programs available to them and be given the right to choose which programs in which they want to participate. Households will also be engaged as key and valued partners in the implementation and evaluation of Coordinated Entry through focus groups, surveys, and other methods designed to obtain their input on the effectiveness of the Coordinated Entry process.
• **Collaboration**: Because Coordinated Entry is being implemented system wide, it requires a great deal of collaboration between the Region, providers, mainstream assistance agencies (e.g., Department of Social Services, hospitals, and jails), funders, and other key partners. This spirit of collaboration will be fostered through open communication, transparent work by a strong governing council (the Coordinated Entry Steering Committee), consistently scheduled meetings between partners, and consistent reporting on the performance of the Coordinated Entry process.

• **Accurate Data**: Data collection on people experiencing homelessness is a key component of the Coordinated Entry process. Data from the assessment process that reveals what resources households need the most will be used to assist with reallocation of funds and other funding decisions. To capture this data accurately, all assessment staff and providers must enter data into the Homeless Management Information System (HMIS) in a timely fashion (with the exception of some special populations and special cases outlined later in this document). Client rights with regard to access to and release of privileged information will always be made available to them, and no household will be denied services for refusing to share personal data.

• **Performance-Driven Decision Making**: Decisions about and modifications to the Coordinated Entry process will be driven primarily by the need to improve the performance of the homelessness assistance system on key outcomes. These outcomes include reducing new entries into homelessness, reducing lengths of episodes of homelessness, and reducing repeat entries into homelessness. Changes may also be driven by a desire to improve process-oriented outcomes, including reducing the amount of wait time for an assessment.

• **Housing First**: Coordinated Entry will support a housing first approach, and will thus work to connect households with the appropriate permanent housing opportunity, as well as any necessary supportive services, as quickly as possible.

• **Prioritizing the Hardest-to-House**: Coordinated Entry referrals will prioritize those households that appear to be the hardest to house or serve for program beds and services. This approach is most likely to reduce the average length of episodes of homelessness and result in better housing outcomes for all.

**Definitions**

**Balance of State (BOS)**: The Indiana Balance of State (BOS) consists of 91 counties which are grouped into 16 Regions. Each Region is made up of 1 to 10 counties.

**CA/CAS/CE/CES**: Coordinated Access/Coordinated Access System/Coordinated Entry/Coordinated Entry System all pertain to the Coordinated Entry system.

**Centralized Point of Access**: A central location within a geographic area where individuals and families present to receive homeless housing and services

**Chronically homeless**: the target population for the first phase of Indiana BOS’s CE system. Chronically homeless is defined by HUD as “an individual or family with a disabling condition who has been continuously homeless for a year or more or has had at least four episodes of homelessness in the past three years.” (24 CFR Parts 91 & 578) SEE EXHIBIT H.

**Coordinated Entry Steering Committee**: The Role and Responsibility of the CE Steering Committee is to provide guidance for the Indiana BOS CoC in creating, implementing, and updating Policies and Procedures for the CE process statewide. The committee consists of Regional Chairs, Lead Agencies, and IHCDA staff.
**De-Centralized Point of Access:** Two or more locations within a geographic area where individuals and families present to receive homeless housing and services.

**Homeless Management Information System (HMIS):** is a “local information technology system used to collect Client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness. Each Continuum of Care is responsible for selecting a Homeless Management Information System (HMIS) software solution that complies with HUD's data collection, management, and reporting standards.” *(24 CFR part 578.7 and 580.3)*

**Household:** The Clients, consumers, participants, etc., served through the CE system. The Household may consist of one person or multiple family members that live together in the same housing unit.

**Lead Agency:** Lead agencies from each of the 16 Regions will serve as the Managing Entity of their respective Region’s Prioritization List. They will lead the implementation of the Coordinated Entry and will commit resources and staffing to administer assessments, analyze assessment results and support referrals to housing interventions. They will also serve on the Indiana BOS’s Coordinated Entry Steering Committee, as the systems are launched, managed and evaluated.

**Lead Agency Prioritization List Manager:** Main contact person at Lead Agency responsible for updating, monitoring, and managing the Prioritization List for their Region.

**Project/Program/Provider:** Refers to any homeless services provider in the CoC. Currently only those providers currently receiving CoC funding are required to participate. Any provider in Indiana may participate voluntarily in their Region’s CE.

**Region:** The Indiana BOS CoC is made up of 16 Regions. Each Region contains from 1 to as many as 10 counties. *SEE EXHIBIT A.*

**VI-SPDAT** (Vulnerability Index-Service Prioritization Decision Assistance Tool as created and owned by Community Solutions and OrgCode Consulting, Inc.): Standardized Assessment Tool(s) used by all CE Access Points to determine a household’s current housing situation, housing and service needs, risk of harm, risk of future or continued homelessness, and other adverse outcomes. Staff administering the VI-SPDAT Standardized Assessment Tool(s) must complete required training through OrgCode, creator of the tool(s).

**Coordinated Entry Framework of Core Elements**

**Management Roles**
The Coordinated Entry system is being established in all Regions with overall program management support from the Indiana BOS Continuum of Care. The communities will focus on quickly connecting households experiencing chronic homelessness to permanent housing interventions. Each Region will develop centralized or de-centralized entry points of access for Client households, managed by lead agencies. These designated Regional access centers will be the sole locations where homeless or those at-risk of homelessness will be directed for assessment prior to being admitted to any homeless assistance program.

**Lead and Participating Agencies**
Lead agencies from each of the 16 Regions will serve as the Managing Entity of their respective Region’s Prioritization List. They will lead the implementation of the Coordinated Entry and will commit resources...
and staffing to administer assessments, analyze assessment results and support referrals to housing interventions. They will also serve on the Indiana BOS’s Coordinated Entry Steering Committee, as the systems are launched, managed, and evaluated. Participating agencies will support the implementation of Coordinated Entry and may commit resources and staffing, serve as entry points, and support data collection, analysis, and referrals.

**Standardized Access and Assessment**

All defined access point providers must administer the Indiana CE Standardized Assessment Tool (VI-SPDAT) according to HUD standards. The assessment process must be standardized across each participating Region, with uniform decision-making across all assessment locations and staff. CE will operate using a Client-centered approach, allowing Clients to freely refuse to answer assessment questions and/or refuse referrals. Reasonable accommodations will be made to ensure those with disabilities, language barriers or literacy barriers are able to fully participate in the intake process. Staff may utilize interpretation services available via telephone or in-person to assist those whose primary language is something other than English. Staff will take the necessary steps to accommodate those clients with disabilities as well as literacy barriers in the intake process by making the necessary adjustments.

To ensure transparency in Client care coordination and decision making, all CE participants receiving a comprehensive assessment and referral to a Permanent Supportive Housing Project (PSH) or Rapid Rehousing (RRH) must be offered written documentation of the assessment results and referral. This “receipt” of the CE assessment and referral process includes a description of the CE screening and assessment results and indicates the CE participant’s prioritization for the referral intervention being offered. Referrals for PSH or RRH are valid for five days. If client fails to accept the referral within the five day period, the housing opening will be offered to the next eligible client on the Prioritization List. **SEE EXHIBIT B.**

Regions will employ a progressive assessment approach. Progressive assessment stages the asking and sequencing of assessment questions such that prospective program participants are asked only those questions directly related to service enrollment and prioritization decisions necessary to progress the participant to the next stage of assessment or determine a referral to a service strategy.

**Assessment**

It is prohibited for any ESG or CoC funded permanent housing assistance organization (unless the designated Coordinated Entry Access Sites are closed or immediate shelter is necessary in order to ensure the safety of the Client/Household) to admit or serve Clients without the Client going through the Coordinated Entry process and getting a referral to that agency. A Client that needs shelter after hours when a physical intake site is closed will be referred via telephone to the nearest provider offering emergency shelter or domestic violence shelter. The provider will perform their standard intake to ensure client meets eligibility requirements.

Coordinated Entry staff in Indiana will administer the VI-SPDAT assessment tools in its Coordinated Entry system. The process is as follows:

1. CE staff explains the assessment process to the Client and answers any questions presented by household/Client.
2. The staff member conducting the assessment will present the household/Client the Consent Form either in paper form or electronically. Assessment staff will go over the form with the
Client and explain what data will be requested, how it will be shared, whom it will be shared with, and what the Client’s rights are regarding the use of the data. Assessment staff will be responsible for ensuring Clients understand their rights as far as release of information and data confidentiality. If the household/Client signs the Consent Form, the assessment staff member will also sign the Consent Form. **SEE EXHIBIT C.**

3. CE staff administers the VI-SPDAT per instructions and scores each assessment per scoring instructions.

4. If a Client is assessed and no further contact with the Client takes place for 90 days or longer, the Client will be reassessed during the next contact with staff. This is to explore the possibility of changes in the Client’s status since the previous assessment.

A note on data collection: **Consumers who do not agree to share their data through the Homeless Management Information System (HMIS) on the Client release of information (ROI) form should never have their data entered into HMIS.**

**Prioritization**

The State of Indiana has determined that an effective Coordinated Entry process ensures that people with the greatest needs receive priority for any type of housing and homeless assistance available in the Region, including PSH, Rapid Re-housing (RRH), and other interventions.

Each Region must define a minimum VI-SPDAT score or score range associated with referrals to Region resources such as RRH, Transitional Housing (TH), or PSH.

**Individuals and families will be referred to Rapid Re-housing according to the following prioritization criteria:**

75% of available RRH resources must be filled with individuals or families that score for RRH based on the VI-SPDAT as determined by each Region. Regions may enact more rigorous standards.

**Individuals and families will be referred to Transitional Housing according to the following prioritization criteria:**

At least 75% of available TH units within a Region must be filled with households that score for TH based on the VI-SPDAT AND meet the criteria of at least one of the priority groups identified below:

- **Youth:** All individuals up to the age of 24 who present as a household. This can include unaccompanied youth (household size of one), and multiple youth who are seeking assistance together.
- **Youth Parents:** Women and men up to the age of 24 who are the parent of at least one child and are seeking assistance with that child(ren).
- **Domestic Violence survivors:** Individuals and families with at least one person who identifies a domestic violence experience as the primary reason causing their housing crisis.
- **Persons being released from correctional facilities and that were homeless before entering prison/jail.**
- **Pregnant women:** Women who are pregnant, regardless of their age or whether they have any additional children.
- **Persons in the early stages of AOD (alcohol or drug) addiction recovery:** Individuals and families with at least one person who recently began receiving services to assist in their recovery from alcohol or other drug addiction. This can include (but is not limited to) people who were recently released from a treatment center or other institution.
Veterans (choosing Grant and Per Diem - GPD).

**Individuals and families will be referred to Permanent Supportive Housing according to specific prioritization protocols as defined by each Region which must include the following attributes:**

- Chronic homelessness as defined by HUD (SEE EXHIBIT F,G (forms pertaining to proof/history of homelessness/chronic homelessness).)  
- Longest history of homelessness  
- Most severe service needs as determined by the VI-SPDAT score

If a client is eligible for PSH and no units are readily available, the client may be housed with Rapid Re-housing Assistance and will maintain their chronically homeless status for the purpose of eligibility for other permanent housing programs dedicated to serving the chronically homeless, such as HUD-VASH and CoC funded PSH (so long as they meet any other additional eligibility criteria for these programs). Clients maintain their chronically homeless status during the time period that they are receiving the RRH assistance. RRH is a model for helping homeless individuals and families obtain and maintain permanent housing, and it can be appropriate to use as a bridge to other permanent housing programs. It is important to note that although the clients in RRH are considered chronically homeless for purposes of eligibility for other programs, the housing itself is still considered permanent housing; therefore, these clients are not considered chronically homeless (or homeless) for counting purposes, and must not be included in the CoC’s sheltered Point-in-Time (PIT) count. *(HUD FAQ ID 530)* SEE EXHIBIT D, H.

**Referral Standards**

Regions must establish written protocols in accordance with HUD guidelines for referrals that explicitly identify the VI-SPDAT score or score range associated with referrals to each Region component type including PSH, TH, RRH, and self-resolve strategies. Regions shall adopt locally specific prioritization criteria and referral protocols based on local Region capacity, inventory and availability of Region housing and services. The referral process shall be standardized and consistently administered; however, the prioritization of housing and services will vary over time due to fluctuating participant demand, changes in availability of Region housing and services, and dynamic client needs and preferences.

Clients must be provided the ability to enroll in Region component types that are less intensive than the CES referral choice offered. The applicability and accuracy of VI-SPDAT score ranges may vary among Regions based on local Region design, resource availability, and funder requirements. Prioritization processes and tools will be assessed and updated annually by each Region based on analysis of actual score prevalence rates and available Region inventory.

**When offering referral options to Clients, the following information shall be provided:**

- Information about the referred housing providers and housing types using resources such as web pages and Region inventory information;  
- Referral rejection recommended guidance;  
- Right to choose options less intensive than the CES referral offered;  
- Guidance about possible impact associated with accepting, rejecting, or changing the project type recommended for the household by the CES assessment and prioritization process.
Referral Criteria for All Region Projects

All Regions must define referral criteria for all projects within the Region’s geographic area. Referral criteria must identify all the eligibility and exclusionary criteria used by program staff to make enrollment determinations for referred persons or households. Established guidelines must describe acceptable time frames for reviewing and communicating referral decisions (i.e., whether the potential program participant is either accepted or denied enrollment). If a potential Client is not offered enrollment, the reason for rejection must be clearly communicated and documented in HMIS. The referral criteria must be published at least annually and support the identification of and connection to appropriate housing and services for all assessed Clients.

Referral Process

- Referrals will only be made to programs with open housing units.
- CE staff will notify the household if multiple permanent housing interventions are matches. If there are multiple matches, the household will choose which housing agency they will pursue.
- The application for the permanent housing opening will be completed by the agency receiving the Client referral.
- The Household is referred by CE staff at intake site to PSH agency if there is availability. CE staff prepares referral packet:
  - Copy of Client assessment(s) or Homeless Management Information System (HMIS) data,
  - Copy of ROI,
  - The referral packet is submitted to the PSH agency by secure fax or secure email and includes a referral checklist/cover page (cover page should include the name or number of household, proof that CE contacted PSH agency regarding Client’s arrival or to set up appointment for Client, contact info of referring CE staff, proof that CE staff updated Homeless Management Information System (HMIS) for this household),
  - CE staff should keep some form of confirmation that information was sent.
  - The household is given appropriate directions, contact information, any needed referral forms and transportation assistance (if eligible) to the referred agency.
  - Household meets with PSH agency intake staff for case management services and housing intake. It is critical at this point for staff to secure a reliable mode of contact with the Client.
- If a household is referred HMIS will be updated so that the household is no longer on the Prioritization List.
- If CE staff cannot reach intake staff at the PSH agency, another PSH agency that meets the household’s composition will be chosen for the referral.
- If no PSH agency has immediate availability, household will remain on the Prioritization List until a unit opens or staff has no contact with the Client for 90 days.
- If household does not follow up with PSH agency within three days of scheduled appointment, PSH agency will notify CE assessment worker who will try to follow up with the household. If no contact within two additional business days, that household will lose this particular opportunity and the next eligible client on the Prioritization List will be offered the housing. Households will remain on the Prioritization List if CE staff is unable to make contact with them within three days or if Client rejects a housing referral opportunity. Clients that reject three opportunities presented to them for permanent housing will be removed from the Prioritization List. Clients that are unable to be located will be removed from the list after ninety days.
Prioritization Standards
The matching process and eventual referral linkage process will take into account a set of prioritization criteria for each project type. The order of Client priority on the Prioritization List will, under no circumstances, be based on disability type or diagnosis. Regions will establish priority for each project type based on the severity of the needs, length of time homeless, or sub-population characteristics, depending on the specific Region component type. Regions that do not adopt and comply with these priority standards must provide documentation that demonstrates different local needs that warrant an alternative approach to service strategy prioritization.

Referrals will also be based on each program’s admissions eligibility criteria, including populations served. For example, programs that serve only single adult men will only receive single adult male referrals.

Agencies participating in Coordinated Entry must submit all of their eligibility criteria to the Coordinated Entry Region’s Lead Agency before they can participate in the Coordinated Entry process. Any changes to a program’s eligibility criteria or target population must be sent immediately to the Coordinated Entry Region’s Lead Agency and Regional Chair to make sure referral protocol is updated accordingly. Criteria that agencies may have that are not bound to local law or strict funders’ requirements will be reviewed by the Coordinated Entry Lead Agency and Regional Chair along with data about people who have remained in emergency shelter for more than 45 days or are living on the street. If the Lead Agency or Regional Chair has a concern that a program’s requirements may be contributing to “screening out” or excluding households from needed services, the Lead Agency and/or Regional Chair may request to meet with the provider to discuss their criteria. If the Lead Agency and/or Regional Chair can clearly show a link between underserved populations and a provider’s eligibility criteria, and the provider is unwilling to modify the criteria, the Lead Agency and/or Regional Chair may recommend to the Regional Planning Council and Coordinated Entry Steering Committee that the provider be de-prioritized for CoC or other sources of funding.

Prioritization List Management and Notification of Referral
Prioritization List management and notification of referrals will be the responsibility of Lead Agency staff members. Lead Agency staff members may be assigned or may periodically trade-off responsibility among Lead Agency staff members for alerting the Client’s case manager when an opening has become available for them in a specific program. When it is a Lead Agency staff member’s given time (day, week or month) to take on this responsibility, they will need to check program availability at least weekly to see if new openings are becoming available and contact the Client’s case manager to notify them of an opening in a program.

Special Populations
There are many sub-populations of people coming through the Coordinated Entry process that may have special needs or need to be directed to specific resources to have their needs met. While this document includes specific instructions for some of those populations, assessment staff members who believe that a Client is eligible for another specific resource should contact the Lead Agency or Regional Chair for assistance.
Post-Referral Procedure
Once a Client has entered a shelter or other crisis housing, the program should make sure the Client is connected to a case manager. Both the case manager and Client will receive updates on where their Client stands on the Prioritization List if they are waiting for a longer-term intervention.

Referral Rejection (Declined Referral) Recommended Guidance
Both Region providers and program participants may deny or reject referrals from the defined CES access point. Service denials should be infrequent and must be documented in HMIS or the approved system with specific justification as prescribed by the Region. The specific allowable criteria for denying a referral must be established by the Region, must be shared with each program and the Client, and must be reviewed and updated annually. All participating programs must provide the reason for service denial, and may be subject to a limit on the number of service denials allowed. Aggregate counts of service denials, categorized by reason for denial, must be reported by the Region annually. If a program is consistently refusing referrals (more than 25%) they will need to meet with the Regional Planning Council to discuss the issue that is causing the denials.

At minimum a program's referral rejection/denial reasons must include the following:
- Client/household does not meet required criteria for program eligibility
- Client/household unresponsive to three communication attempts
- Client resolved crisis without assistance
- Client/household safety concerns (The Client’s/household’s health or well-being or the safety of current program participants would be negatively impacted due to staffing, location, or other programmatic issues).
- Client/household needs cannot be addressed by the program (The program does not offer the services and/or housing supports necessary to successfully serve the household).
- Program at bed/unit/service capacity at time of referral
- Property management denial (include specific reason cited by property manager)
- Conflict of interest

In the event of a service denial or participant rejection the following steps must be followed:
1. Any referral rejection must be communicated back to the Prioritization List Manager, assessment and referral provider, and/or Client advocate within three business days.
2. All referral requests that result in a denial must be reviewed by the Prioritization List Manager, assessment and referral provider, and/or Client advocate designated by the Region.
3. If a referral is returned to the housing referral provider or designee, the HMIS record must be updated to reflect the reason for denial.
4. The Region program denying the referral must notify the Prioritization List Manager, assessment and referral provider, and/or Client advocate within a specified amount of time determined by the Region. Further communication must include a detailed written justification of the referral denial provided within three business days. The written justification of service denial must also be shared with the Client and documented in HMIS.
5. A program that denies three sequential referrals will be required to participate in a case conferencing meeting with the Lead Agency Prioritization List Manager, assessment and referral provider, and/or Client advocate designated by the Region.
6. A Client who denies three sequential referrals will be encouraged to participate in a case conferencing meeting with the Lead Agency Prioritization List Manager, assessment and referral provider, and/or Client advocate, and will be removed from the Prioritization List.
7. If a provider receives a referral for a client removed previously from the provider’s program for any reason, (including but not limited to: violence, illegal activity, threats, or damage to property) the client may be re-assessed by the provider for re-admittance into the program following a ninety day period and on a case-by-case basis.

Grievance Procedures
Grievance procedures can be found in EXHIBIT E.

Coordinated Entry Statewide Policy on Transfers Around the State
When a household has been assessed in one statewide Region and requests that their assessment be transferred to another Region the following processes will be used (Note: per a Client’s choice they may be on two Prioritization Lists at once or they may choose to switch from one Region’s list to another. It is not recommended that a Client be on more than two lists at one time.):

HMIS (shared) Client process:
1. The person who was made aware of the household’s request will notify their Region’s Prioritization List (PL) Manager.
2. The PL Manager will determine if an ROI is needed to share information with the new Region’s Prioritization List Manager or if the HMIS ROI is adequate.
3. New Region’s PL Manager will check the CES eligibility requirements for the Region’s housing stock where the household would like to go.
4. If the household appears eligible, the original PL Manager will send the referral to the receiving Prioritization List Manager through HMIS for review (using the HMIS referral function).
5. PL Manager of the receiving Region will review the Client record in HMIS and either contact the household for further information or assign the appropriate access point with the task of connecting with the household.
6. Once all information is obtained the Client is accepted or declined in HMIS.
7. If accepted, the Client is added to the receiving Region’s Prioritization List.
8. If the Client wishes to be on only the new Region’s list, then their original referral is closed by the original Region’s Prioritization List Manager.
9. If the Client chooses to be on both Region’s Prioritization Lists the PL Managers for both Regions must coordinate how they will communicate with the other Region regarding that Client.
10. The original Region’s PL Manager will notify the Client of the outcome of the referral.

Non-HMIS (not shared) Client process:
1. The person who was made aware of the household’s request will notify their Region’s Prioritization List (PL) Manager.
2. The PL Manager will obtain an ROI to speak to the other Region regarding the Client transfer and will ensure any agency that will need Client information to execute the transfer is covered by the ROI.
3. New Region’s PL Manager will check the CES eligibility requirements for the Region’s housing stock where the household would like to go.
4. If the household appears eligible, the original PL manager will e-mail or fax the CES Assessment to the receiving Region via secure e-mail or secure fax for review.
5. The PL Manager of the receiving Region will review the Client’s CES Assessment and either contact the household for further information or assign the appropriate access point with the task of connecting with the household.
6. Once all information is obtained the Client is accepted or declined and the new Region will inform referring PL Manager of the outcome.
7. If accepted, Client is added to the receiving Region’s Prioritization List.
8. If the Client wishes to be on only the new Region’s list, then their original referral is closed by the original Region’s Prioritization List Manager.
9. It is the receiving PL Manager’s responsibility to document that the household is on multiple lists using a method appropriate for their non-shared list structure so that if the Client is referred to a housing program they can notify the other Region(s).
10. The original Region’s PL Manager will notify the Client of the outcome of the referral.

**Additional Guidelines:**
Households may be on up to two IN Region’s Prioritization Lists at one time. A Client may be on more than two Prioritization Lists at PL Manager discretion and preferably only in situations where appropriate housing is limited due to family size, health, or safety.

The Client should want to live in the Region they are requesting to be transferred or added to. Filling housing vacancies takes time and effort and this process hopes to prevent households from being placed on all lists because they are willing to live “anywhere” in the state.

Staff should have conversations with Clients regarding Client choice, accessibility and resources in the community they wish to go to. Clients should be notified that county residency may be required for some referrals. If the Region where the Client would like to go has eligibility criteria that does not allow the Client to access their CES then the Client must be informed that they are not eligible for CES in that Region.

**Participation Requirements**
HUD and VA have recently established guidance that instructs all Region projects to participate in their CoC’s Coordinated Entry system. A Region project includes any homeless prevention or homeless assistance program regardless of funding source. However, projects that receive HUD funding (CoC Program, ESG) or VA funding (SSVF, GPD, VASH) must further comply with the specific participation requirements as established by the corresponding CoC jurisdiction.

The State of Indiana has established minimum statewide requirements for CE participation for all state funded homeless projects, including those funded by Emergency Solutions Grant (ESG), and Transitional Housing Program.

**At a minimum CE participation includes the following for all Regions in Indiana:**
- CoC projects must publish written standards for Client eligibility and enrollment determination
- CoC projects must communicate project vacancies (bed and/or unit) to the Coordinated Assessment administrative entity (Region’s Prioritization List Manager) established by Region leadership.
- Persons experiencing a housing crisis must access CoC services and housing using Region defined access points.
- CoC projects must enroll only those Clients referred according to the Region’s designated referral strategy.
- CoC projects must participate in the Region’s Coordinated Assessment planning and management activities as established by CoC leadership.
Governance and Oversight

Indiana Balance of State Continuum of Care Board of Directors
The Indiana Balance of State Coordinated Entry process will have three levels of governance, roles, and responsibilities. The CE is governed by the Indiana Balance of State Continuum of Care Board of Directors. The Board will be responsible for:
- Evaluating the efficiency and effectiveness of the Coordinated Entry process;
- Providing general oversight of Coordinated Entry;
- Recommending and approving changes or improvements to the process, based on performance data.

Balance of State Coordinated Entry Steering Committee
The second level of governance for the system is the Balance of State Coordinated Entry Steering Committee. The Coordinated Entry Steering Committee is responsible for:
- Providing general oversight and management of Coordinated Entry;
- Investigating and resolving consumer and provider complaints or concerns about the process, which are not resolved at the local level. Providing information and feedback to the Indiana Balance of State Continuum of Care Board of Directors;
- Evaluating the efficiency and effectiveness of the Coordinated Entry process;
- Reviewing performance data from the Coordinated Entry process; and
- Recommending changes or improvements to the process, based on performance data, to the Indiana Balance of State Continuum of Care Board of Directors.

Local Coordinated Entry Steering Committee (Regional Planning Council)
The third level of governance for the Coordinated Entry process is the local community Regional Planning Council. The Steering Committee is responsible for:
- Providing local oversight and management of Coordinated Entry;
- Investigating and resolving consumer and provider complaints or concerns about the process.
- Providing information and feedback to the Indiana Balance of State Coordinated Entry Steering Committee
- Evaluating the efficiency and effectiveness of the Coordinated Entry process;
- Reviewing performance data from the Coordinated Entry process; and
- Recommending changes or improvements to the process, based on performance data, to the Indiana Balance of State Coordinated Entry Steering Committee.

Low Barrier Policy
The term “low barrier” refers to minimal eligibility and enrollment obstacles resulting in homeless persons being engaged and enrolled in homeless assistance projects regardless of perceived barriers such as lack of income, lack of sobriety, presence of criminal records, or historical non-compliance with program requirements. No Client may be turned away from crisis response services or homeless designated housing due to lack of income, lack of employment, disability status, domestic violence status, or substance use unless the project’s primary funder or local government jurisdiction requires the exclusion or a previously existing and documented neighborhood covenant/good neighbor agreement has explicitly limited enrollment to Clients with a specific set of attributes or characteristics.
Funders restricting access to projects based on specific Client attributes or characteristics will need to provide documentation to the Region providing a justification for their enrollment policy. Region projects offering Prevention and/or Short-Term Rapid Re-housing assistance (i.e. 0 – 6 months of financial assistance) may choose to apply some income standards for their enrollment determinations.

Fair and Equal Access
All Regions will ensure fair and equal access to CES system programs and services for all Clients regardless of actual or perceived race, color, religion, national origin, age, gender identity, pregnancy, citizenship, familial status, household composition, disability, Veteran status, sexual orientation, or domestic violence status. To ensure fair access by individuals with disabilities, physical and communication accessibility barriers must be addressed by appropriate accommodation within each Coordinated Entry Region. Each Region’s written policies and procedures must establish protocols for fair and equal access to Region housing and services.

If an individual’s self-identified gender or household composition creates challenging dynamics among residents within a facility, the host program should make every effort to accommodate the individual or assist in locating alternative accommodation that is appropriate and responsive to the individual’s needs.

Emergency Services
Defined access points must provide directly or make arrangements through other means to ensure universal access to crisis response services for Clients seeking emergency assistance at all hours of the day and all days of the year. Each Region must document their planned after-hours emergency services approach. After-hours crisis response access may include telephone crisis hotline access, coordination with law enforcement, and/or emergency medical care.

Safety Planning
Each Region must provide necessary safety and security protections for persons fleeing or attempting to flee family violence, stalking, dating violence, or other domestic violence situations. Safety planning guidelines and examples of trauma-informed approaches to care coordination will be fully developed via a partnership with the Indiana Coalition Against Domestic Violence.

Inclusivity of Sub-populations
All sub-populations including chronically homeless individuals and families, Veterans, youth, persons and households fleeing domestic violence, transgendered persons, and refugees and new immigrants must be provided equal access to Region crisis response services regardless of the characteristics and attributes of their specific sub-populations.

Outreach
All Region outreach activities, projects, or initiatives must be integrated with the Region’s CES design, serving as an engagement resource or designated access point for Region resources, services, and housing.

Stakeholder Inclusion
Regions will support the implementation, expansion, and ongoing operation and evaluation of Coordinated Entry Systems by regularly gathering stakeholder input and creating feedback
opportunities. Each Region must develop a plan to collect stakeholder feedback at least annually and will engage participants from all Region component types: referral sources, residents and participants of homeless services and programs, funders of homeless response systems, and mainstream system providers.

**Full Coverage**
The full geography of the IN BOS CoC must be covered by CES services including access to crisis response services, assessment of Clients, and referral options.

**Privacy Protections**
Coordinated Entry System operations and staff must abide by all State of Indiana defined privacy protections as defined by the Indiana Balance of State Continuum of Care Board of Directors and its sub-committees. Client consent protocols, data use agreements, data disclosure policies, and any other privacy protections offered to program participants as a result of each Client’s participation in Homeless Management Information System (HMIS) will be the same as CES.

**List of Resources**
Each CES Lead Agency will maintain a list of all available Region resources, including each project’s eligibility criteria. The list of resources must be updated annually and be made publicly available.

**Coordinated Entry Training**
Regions must develop and implement an annual CE training plan to ensure all participating CE partners are knowledgeable of Region-specific CE participation and performance expectations, are following statewide guidelines and protocols for CE operations, and are striving to achieve national best practices and promising approaches for the most effective Coordinated Entry System. Needs or gaps in training effectiveness will be assessed annually as part of each Region’s evaluation of CE processes.

Elements of locally-specific training shall include the following:
- CE access points and access protocols;
- CE assessment tools, processes, and uses of assessment information to coordinate Client care;
- General eligibility requirements for all Region projects;
- Prioritization standards and protocols for how Client’s placement on Prioritization Lists will be managed;
- Referral processes and protocols (rather than specific referral policies which will likely be more standardized across the state);
- Data collection, data management, data sharing and reporting requirements and responsibilities.

Elements of standardized approaches across all Regions in Indiana will be reinforced by state-level training and capacity building opportunities and shall include but are not limited to the following:
- Effective strategies for VI-SPADT assessment, score analysis, and referral determinations;
- Effective Client engagement techniques for challenging or difficult to engage Clients (e.g. motivational interviewing, Housing First approaches);
- Trauma-informed care throughout the CE process;
- Assessment practices and approaches that honor the lived experience of the specific culture or sub-population accessing emergency services;
• Co-occurring issues of substance use disorders, mental illness, physical disability, chronic health conditions, and sexual assault and family violence;
• Domestic and sexual violence 101, exploring dynamics of violence and how violence impacts a person’s executive decision making and functioning;
• Information specific to working with immigrant/refugee and undocumented people and families as it relates to domestic and sexual violence;
• Strategies for culturally competent CE practices and mitigating historical inequities among racial, ethnic, and cultural minorities;
• Maintaining high quality data collection and reporting practices;
• Strategies for maintaining Client confidentiality and privacy while coordinating care among multiple Region partners;
• Linkage of CE practices to achieving HUD’s Region system performance measures.

Training on topics related to culturally appropriate engagement, assessment practices and programming should be designed and conducted by members of communities representing the specific culture or sub-population impacted.

Trainings should be made available remotely via webinar or posted online along with in-person training events.

Data Sharing
All Regions shall comply with the data sharing policies developed by the Indiana Balance of State Continuum of Care Board of Directors and its sub-committees.

HMIS and Data Collection
Each Region will use a data collection system as designated by the Region to manage data related to CE operations. It is recommended that Regions collect data in the HMIS system designated by the CoC. At a minimum, data collected from CE participants must include all data necessary to generate an accurate and complete Coordinated Entry Annual Performance Report (APR). Use of the designated HMIS will allow for providers to gather data accurately and ensure they are collecting the data points required for the APR.

The Coordinated Entry APR data will be derived from the HUD-defined Universal Data Elements (UDEs) and select Project-Specific Data Elements (PSDEs).

Regions may independently explore and utilize other HMIS functions and services in support of CE operations.

Mainstream Services
Each Region must implement a screening protocol to assess each Client’s potential eligibility for the following mainstream resources or services:
• Housing
• Medical benefits
• Nutrition assistance
• Income supports
Monitoring and Reporting of Coordinated Entry

All Regions must adhere to the State-defined CE Monitoring and Reporting Plan. The State-defined CE Monitoring and Reporting Plan will include requirements for reports on performance objectives related to CE utilization, efficiency, and effectiveness. The specific CE Monitoring and Reporting Plan will be published by the CE Steering Committee and updated on an annual basis.

The Indiana CE Monitoring and Reporting Plan will include the following narrative and management report sections to be submitted annually by each Region:

1. Narrative. A narrative description of the status of CE implementation during the reporting period. The narrative must be no longer than one page in length and identify the Region’s experience of barriers and challenges related to implementation and management of Coordinated Entry, and identify plans for expansion and improvements in the upcoming reporting period.

2. Coordinated Entry Annual Performance Report. A HMIS or data-generated CE APR covering the twelve month period coinciding with the State’s fiscal year (currently July 1 to June 30). The CE APR will include the following performance indicators:
   A. The number of individuals receiving CE services:
      i. Number of families and individuals completing initial triage/diversion screen
      ii. Number of families and individuals completing Client intake/assessment
      iii. Number of families and individuals completing comprehensive/housing assessment
   B. Demographics and attributes of persons/households receiving CE assistance
   C. Number of persons and individuals by VI-SPDAT score
   D. Number of persons and individuals receiving CE referrals to the following
      i. Self-Resolve
      ii. Rapid Re-housing
      iii. Transitional Housing
      iv. Permanent Supportive Housing (PSH)
      v. All other
   E. Destination of persons and individuals to each service strategy as a result of CES referral
      i. Rapid Re-housing
      ii. Transitional Housing
      iii. Permanent Supportive Housing (PSH)
      iv. All other
   F. Length of time from completion of CE comprehensive/housing assessment to program entry
      i. Average length of time from assessment to referral for each component type
      ii. Average length of time waiting on prioritization list for each component type
   G. Number of persons who waited for each Region component type for greater than 30 days
The following schedule identifies specific Region reporting requirements, including required data, report structure, and submission deadlines:

<table>
<thead>
<tr>
<th>Region CE Evaluation Component</th>
<th>Format</th>
<th>Reporting Period</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region Annual Report</td>
<td>Narrative &amp; CE APR</td>
<td>July 1 – June 30</td>
<td>August 30</td>
</tr>
<tr>
<td>Region Stakeholder feedback (Region partners)</td>
<td>Narrative report incorporating data from surveys, questionnaires, or focus group meetings</td>
<td>July 1 – June 30</td>
<td>August 30</td>
</tr>
<tr>
<td>Region Stakeholder feedback (participants in CE)</td>
<td>Narrative report incorporating feedback from Client focus groups, participant advisory groups, surveys, or questionnaires</td>
<td>July 1 – June 30</td>
<td>August 30</td>
</tr>
</tbody>
</table>

Coordinated Entry Statewide Evaluation

The Coordinated Entry process will be evaluated on a regular basis to ensure that it is operating at maximum efficiency. Evaluation will be carried out primarily through the Regional Planning Councils, the Indiana Balance of State Coordinated Entry Steering Committee and any consultants or third parties they engage to help them.

Evaluation mechanisms will include the following (see table on previous page):

- A monthly review of metrics from the Coordinated Entry process. The data to be reviewed, and the thresholds that should be met will be developed.
- Each Region will conduct a semi-annual focus group with people experiencing homelessness that have been through the Coordinated Entry process. Focus Group results will be submitted in writing to the Coordinated Entry Analyst annually by January 30th and July 30th.
- Each Region’s Lead Agency will submit an Annual Report on Coordinated Entry and homelessness assistance system outcomes to the Coordinated Entry Analyst by August 30th. This report will include trends from the month-to-month analysis of Coordinated Entry data, the total number of assessments and referrals made, successes to be shared, and a note from the Regional Planning Council’s Chair on the process’s progress. A member of the Regional Planning Council will present major findings from this report at the Region meeting the month it is released. Regional Planning Council members may ask for City or County staff assistance in writing and producing this report.

A comprehensive system evaluation of CE will be performed annually to ensure that both qualitative and quantitative information is collected and used to identify opportunities for continuous system improvement. Results of the statewide evaluation of CE operations may be shared with funders and policy makers.
Areas of inquiry may include the following:

1. **CE Coverage**
   - A. Which Region projects are participating? What does participation mean (listing vacancies, accepting referrals)?
   - B. Are all geographic areas of the Region covered by CE processes? (non-HMIS)

2. **System Gaps**
   - A. What is the actual demand for Region crisis response services?
   - B. Is demand effectively managed by the available resources and Region assets?
   - C. What is the distribution of referrals by project type?
   - D. What are rates and reasons for referral rejections?

3. **Assessment Process**
   - A. Is participant assessment data complete, accurate, and timely for referral process?
   - B. Is the assessment process respectful of participant preferences, culturally appropriate, and/or trauma informed? (non-HMIS)
   - C. When referred, do participants get accepted/enrolled?
   - D. When referred, do participants accept referral options?
   - E. What is the length of time from referral to placement in housing?
   - F. Are prioritized populations being successfully referred and enrolled in available housing and services?
   - G. Is there assessment information collected that is not readily used to inform case planning or care coordination? (non-HMIS)

4. **Access Consistency**
   - A. Does the relationship between referrals and eligibility vary in terms of presenting program participants’ race, household size, age or gender of children, or geography (such as rural vs. urban)?
   - B. If the Region has established different access points for singles, families, survivors of domestic violence, and youth are those sub-populations experiencing variance in rates of referral and enrollment when compared to other groups?
   - C. Do rates of return to homelessness vary by program participant characteristics or site?

**Domestic Violence and Coordinated Entry**

**Coordinated Entry for Domestic Violence Survivors**

The Coordinated Entry Process for Domestic Violence Survivors (includes those fleeing or attempting to flee domestic violence, dating violence, sexual assault, trafficking, or stalking) utilizes trauma-informed practices, is safety focused, and provides confidential data collection consistent with federal, state, and local laws.

Trauma Informed Practices are sensitive to the lived experience of all people presenting for services. Domestic Violence and sexual assault are often very traumatic for individuals and households, including children. The violence and harassment can continue and often escalates when a survivor is leaving their relationship and reaching out for housing resources.

Client safety will be immediately assessed upon the Client’s disclosure stating they are a survivor of domestic violence, dating violence, sexual assault, trafficking, or stalking. The Indiana Coalition Against Domestic Violence (ICADV) and the IN BOS CoC Board of Directors recognize and understand the highly sensitive nature of information gathered from individuals experiencing domestic violence. These two
groups have worked together to include a non-scoring pre-screen assessment consisting of four questions.

**Domestic Violence Pre-screen Assessment for All Clients**

The pre-screen assessment should be used to determine Client safety and to determine an appropriate housing and/or crisis intervention as needed.

**Pre-Screen Assessment questions for all Clients for domestic violence:**

1. Are you fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, trafficking, stalking, or other dangerous or life-threatening conditions that relate to violence against you or a family member?
   
   *If Client answers yes, continue by exploring the immediate level of danger by asking the Client:*

2. Has your partner ever used a weapon against you or your children or threatened you or your children with a weapon?

3. Do you believe your partner is capable of killing you or your children?

4. Has your partner threatened to kill you or your children?
   
   *If Client answers yes to any of these questions, inform the Client they are currently at a Homeless Provider Agency Coordinated Entry Access Site and their information will not be kept confidential when entered into HMIS. Ask the Client if they would like to be directed to an access point that is designated for serving victims of domestic violence (DV).*

At this point if the Client chooses to be referred to a Victim Services provider, the CE Assessment staff member will explain to the Client the need for a signed Release of Information in order for staff to contact and share the Client’s basic information with the nearest victim service provider. If the Client agrees to sign the ROI, the CE Assessment staff will contact the DV service provider and refer the Client for assistance. If the Client is in need of transportation, the CE Assessment staff will contact 211 for transportation assistance.

If the Client chooses to enter emergency shelter with a Domestic Violence provider, once the Client enters emergency shelter, the Client’s DV provider case manager will begin working on a housing plan with the Client. The Client will be given the opportunity to participate in the CE process through a CE Access Site within the Region once the Client is ready to do so. If the Client chooses not to participate in the CE process while in the DV shelter, the DV case manager will work with the Client to resolve homelessness utilizing other mainstream resources, DV RRH, or diversion. The DV provider will document the Client’s refusal or acceptance to participate in the Coordinated Entry process by documenting the Client’s reason(s) via case note in DV ClientTrack (part of HMIS specific to DV providers).

The Client may also, instead of being referred, choose to participate in the CE Intake Process with the current Homeless Services Provider. CE Assessment staff will present the Client with the Client Consent or HMIS Client Consent form. CE Assessment staff will review the form with the Client ensuring the Client understands their rights and, if necessary, how their information will be used and shared in HMIS:

- If the Client agrees to Option 1 on the Consent Form (stating that their information may go into HMIS), CE Assessment staff will proceed with normal CE Intake procedures and enter the Client’s information into HMIS. The Client will then be prioritized for housing and placed on the Prioritization List.
• If the Client agrees to Option 2 (stating that they will share information but do not want it entered into HMIS) on the Consent Form, CE Assessment staff will proceed by completing a paper CE Intake and VI-SPDAT or Family VI-SPDAT with the Client’s information. The Client’s information will NOT be entered into HMIS and the CE Assessment staff will work with the Client to find a solution to the Client’s current need utilizing paper documents only.

• If the Client agrees to Option 3 (stating they do not want to provide any information at all) and will provide no information to the CE Assessment staff, the Client is notified that they may be unable to receive certain services from the agency if the Client’s eligibility to receive the services cannot be verified.

For clarification on the above listed options SEE EXHIBIT C.
EXHIBIT A: Coordinated Entry Region Map
EXHIBIT B: Coordinated Entry Receipt

COORDINATED ENTRY RECEIPT

This receipt is proof that you have completed a VI-SPDAT and supplemental assessment in our region.

**ASSESSING AGENCY**
Assessor:  
Phone:  
Agency:  

**SIGNATURE**
Date:  

**RECIPIENT NAME**  
**DATE OF ASSESSMENT**  
**YOU ARE ELIGIBLE FOR THE FOLLOWING TYPE OF HOUSING:**

- [ ] Transitional Housing  
- [ ] Rapid Re-Housing  
- [ ] Permanent Supportive Housing

Indiana HMIS Release of Information (Consent Form) was signed?  
[ ] Yes  
[ ] No

What you need to know:

1. This receipt places your household on a housing list for ALL homeless programs in the region. You do not need to contact each program separately.

2. Persons are selected for open units based on need and eligibility versus first-come first-serve criteria.

3. It is your responsibility to let me or my agency know if your contact information or housing status changes (i.e. if you no longer need housing or are evicted from housing). We will try and contact you if selected, but there will be a short response time to accept or decline the offer. If we cannot reach you, another household will be selected.

4. If your household is selected, you will still be required to verify your eligibility AND find a landlord (For Rapid Re-Housing willing to rent to you. Agencies can help with limited housing search (i.e. search suggestions, rental lists). If you are selected for a fixed site program the property managers will still do a background check. Fixed site projects have less strict entry requirements, but still require background checks to help assure the safety of other tenants.

5. You have the right to turn down an offer of housing. Your household will remain on the Region’s Priority list, but there is no guarantee when your name will be selected the next time. Valid reasons to turn down housing are: location, type (wanting fixed vs. scattered site), or conflict with the agency.

6. Finally, due to the high demand for housing and limited program openings, wait times vary from 1 week to months or even a year. You are encouraged to continue to seek out other non-homeless options (job training, emergency assistance, public housing, food baskets, social services, etc.).

**TYPE OF HOUSING**  
**DESCRIPTION**

- **Transitional Housing**  
  - Housing with support services for up to 24 months.  
  - For persons in transition who will be successful with short-term assistance.  
  - A Housing Stability Plan is required.

- **Rapid Re-Housing**  
  - Housing with support services for short term (0-3 months), medium term (4-8) months or long-term (9-24 months)  
  - For persons who will be successful with short-term assistance, with ability to maintain stability after assistance ends.

- **Permanent Supportive Housing**  
  - Housing with support services without a timeline (if eligibility criteria and needs exist).  
  - For persons with a disability coming from homelessness.  
  - Some programs may also require chronic homelessness status.

THANK YOU AND PLEASE REMEMBER TO UPDATE YOUR CONTACT INFORMATION IF IT CHANGES!
EXHIBIT C: Client Consent Form

Client Consent

HMIS Client Consent

Purpose of this form: This Agency uses the Homeless Information Management System ("HMIS"), a database and case management system that collects and maintains information on the characteristics and service needs of clients. The system collects and stores client-level data that can be utilized to generate unduplicated and aggregate reports for the U.S Department of Housing and Urban Development ("HUD") that can be analyzed to determine the use and effectiveness of the services being provided by Agency. When you request or receive services, we may collect and share your Protected Personal Information ("PPI") including data on your household such as:

* First name and last names, dates of birth, Social Security Numbers, gender, ethnicity, race, veteran status, prior residence, contact information and program status.
* Your service needs, income, government benefits, education, employment, destination, disability, general health, as well as pregnancy, HIV/AIDS, behavioral health, mental health, legal and history of domestic violence, dating violence, sexual assault, and stalking.

How will my PPI be used?

Your data will be entered into the HMIS to generate reports that can be analyzed to determine the use and effectiveness of the services being provided by the Agency. The ways in which this Agency may use or disclose your information are discussed in our Notice of Privacy Practices, which is posted in this Agency near the intake stations (or comparable location) for review by clients.

How will my PPI be protected?

* We are required to protect the privacy of your PPI by complying with the privacy practices described in our Privacy Policy.
* Your information is protected by passwords and encryption technology. Each Agency and user must sign an agreement to maintain the security and confidentiality of your information. Any person or Agency that uses the HMIS and violates the terms of the agreement may lose its access rights and may be subject to other negative consequences.

How will my PPI be shared and disclosed?

The PPI we collect can be shared and disclosed under the following circumstances:
* Shared with other HMIS service providers.
* To provide or coordinate services to you and your household.
* For HMIS administrative purposes.
* When required by law or for law enforcement purposes or to prevent a serious threat to health or safety.
* Reports to HUD, audits and management functions.

I UNDERSTAND THAT:

* The Agency may not refuse or decline certain services to me if I refuse or am unable to provide information; however, some information may be required by the applicable program to determine eligibility for housing or services, to assess needed services, or to fulfill reporting requirements. Therefore, I am not required to sign this consent. I may request a copy of this consent.
* This consent permits any HMIS service provider to add or update my information in the HMIS database, without asking me to sign another consent form.
* This consent expires in three (3) years. I have the right to revoke this consent at any time in writing. PPI that I previously authorized to be shared cannot be entirely removed from the HMIS database and will remain accessible to the limited number of organization(s) that provided me with direct service.
* This Agency has posted a Notice of Privacy Practices, and I may request a paper copy of the Notice from this Agency. I acknowledge that I have been given an opportunity to read and/or request a copy of the Notice and that I have read the Notice. The Notice describes ways in which my personal information may be used and disclosed. Every effort will be made to ensure the proper use and security of my information.
EXHIBIT C: Client Consent Form

Client Informed Consent

By Signing this form:

☐ I agree that this Agency and its employees and agents can enter all of my information into the HMIS and share my PPI with other HMIS Service Providers.

☐ I will provide my information to the Agency but I do not agree to allow the agency to enter any of my information into the HMIS or share my PPI with other HMIS service providers.

☐ I do not agree to provide any information to this Agency and I understand that I may not be able to receive certain services from this Agency if my eligibility to receive these services cannot be verified.

Client Signature: ______________________________

Client Name: _______________________________

Date: ______________________________

Case Manager Signature: ______________________________

Case Manager Name: ______________________________

Date: ______________________________

Restriction Options

Restriction:  ☐ Restrict to Organization
            ☐ Restrict to MOU/InfoRelease
### EXHIBIT D: Coordinated Entry Prioritization Policy

**Indiana BOS 502**

**Coordinated Entry Prioritization Policy**

The Indiana Balance of State Continuum of Care Board of Directors adopts the following policy and guidance around Coordinated Entry and prioritizing the most vulnerable persons experiencing homelessness.

<table>
<thead>
<tr>
<th>HOUSING INTERVENTION</th>
<th>TARGET POPULATION</th>
<th>PRIORITIZATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diversion</td>
<td>All Persons seeking assistance via Coordinated Entry</td>
<td></td>
</tr>
</tbody>
</table>
| Permanent Supportive Housing ** | Persons experiencing chronic homelessness | 1. Highest VI-SPDAT Score (8+)  
2. HUD Guidelines/Prioritization  
3. Longest history of homelessness |
| Rapid Re-Housing      | Persons literally homeless  
Veterans experiencing homelessness | 1. VI-SPDAT Score (4+)  
2. Length of homelessness  
3. Regional Prioritization:  
   - Veterans*  
   - Youth*  
   - Families*  
   - Single Adults*  
4. Date of Assessment (Only in tie breaker situation) |
| Emergency Shelter     | Persons literally homeless and not diverted | 1. First come, first served  
2. When person is literally homeless and no permanent housing/rapid rehousing is available |
| Referrals to Mainstream Resources | | 1. VI-SPDAT (0 – 3) |

As the Coordinated Entry System continues to evolve, regional decision making and prioritization needs should be taken into consideration. Procedures will be developed for regions as the CE implementation progresses to help guide decision making at the regional level.

**If a person is prioritized for PSH and no PSH is available, that person should be prioritized for other types of assistance such as RRH. In this situation the person does not lose their Chronically Homeless status and can be moved into PSH when a unit becomes available.**

September 2017
EXHIBIT E: Grievance Procedures

Grievance Procedures

Provider Grievances
Providers should bring any concerns about Coordinated Entry to the Regional Planning Council, unless they believe a consumer is being put in immediate or life-threatening danger, in which case they should deal with the situation immediately. A summary of concerns should be provided via email to the chair of the Regional Planning Council. The chair should then schedule for that provider’s representative to come to the next available Regional Planning Council meeting so the issue can be resolved. If the issues need more immediate resolution, the chair will be in charge of determining the best course of action to resolve the issue.

Consumer Grievances
The assessment staff member or the assessment staff supervisor should address any complaints by consumers as best as they can in the moment. Complaints that should be addressed directly by the assessment staff member or assessment staff supervisor include complaints about how they were treated by assessment staff, assessment center conditions, or violation of data agreements. Any other complaints should be referred to the chair of the Regional Planning Council for resolution as above. Any complaints filed by a consumer should note their name and contact information so the chair can contact them and offer them the chance to appear before the committee to discuss them.

1. If the Regional Planning Council is unable to reach a decision and plan for resolution, the Regional Chair will forward the grievance information to the Coordinated Entry Analyst, Lori Wood via secure email or fax. The Coordinated Entry Analyst will then present the grievance for review by the Coordinated Entry Steering Committee during the next monthly phone call/meeting.

2. If the Coordinated Entry Steering Committee is unable to reach a decision and plan for resolution, the Coordinated Entry Analyst will then forward the grievance to the IN BOS CoC Board of Directors for review during the board’s next monthly meeting.

3. The IN BOS CoC Board of Directors decision is final and will be communicated back to the Regional Chair of the grievance’s originator. The Regional Chair will then communicate the final decision to the agency/program and client involved.
### Participant Eligibility Worksheet (HUD Homeless Documentation form)

- **Project Name:**
- **Tenant Name:**
- **Date of Intake:**

**Type of Homelessness Documentation (Check the appropriate type of documentation used to verify):**

<table>
<thead>
<tr>
<th>Homeless Status</th>
<th>Type of Documentation</th>
<th>Documentation attached</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons sleeping in a place not designed for or used as a regular sleeping</td>
<td>A signed and dated general certification from an outreach worker verifying that the services are going to</td>
<td></td>
</tr>
<tr>
<td>accommodation, including a car, park, abandoned building, bus or train station,</td>
<td>homeless persons, and indicates where the persons served reside.</td>
<td></td>
</tr>
<tr>
<td>airport, camping round, etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Person living in a shelter designed to provide temporary living arrangements</td>
<td>Staff should provide written information obtained from third party regarding the participant’s whereabouts, and, then sign and date the</td>
<td></td>
</tr>
<tr>
<td>(including emergency shelter, congregate shelters, hotels, motels paid for by</td>
<td>statement.</td>
<td></td>
</tr>
<tr>
<td>charitable organizations or by government programs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persons exiting where they resided 90 days or less AND were residing in an</td>
<td>Written verification from the institution's staff that the participant has been residing in the institution for less than 90 days; and information</td>
<td></td>
</tr>
<tr>
<td>Emergency shelter or place not meant for human habitation immediately prior to</td>
<td>on the previous living situation as being homeless in shelter or streets.</td>
<td></td>
</tr>
<tr>
<td>entering the institution</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Persons coming from transitional housing for homeless persons who originally</td>
<td>Written verifications to include program residency and homeless status prior to program entry. (Chronic</td>
<td></td>
</tr>
<tr>
<td>came from the streets or ES.*</td>
<td>Homeless persons cannot come from TH for eligibility. Utilize chronic homeless forms to help document the length &amp; times)</td>
<td></td>
</tr>
<tr>
<td>Fleeing or is attempting to flee domestic violence AND no subsequent residence</td>
<td>Written verification if available. Self-report is okay.</td>
<td></td>
</tr>
<tr>
<td>has been identified AND No Resources or support networks to obtain permanent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>housing.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Self-Declaration of homelessness (use only if third party is unavailable):**
**EXHIBIT F: Examples of Eligibility Worksheets/Documentation Forms**

**Participant Eligibility Worksheet (Homeless Documentation form)**

<table>
<thead>
<tr>
<th>Homeless Status</th>
<th>Type of Documentation</th>
<th>Documentation attached</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Sleeping in a place not designed for or used as a regular sleeping accommodation, including a car, park, abandoned building, bus or train station, airport, camping round, etc.</td>
<td>A signed and dated general certification from an outreach worker verifying that the services are going to homeless persons, and indicates where the persons served reside.</td>
<td></td>
</tr>
<tr>
<td>1 Person living in a shelter designed to provide temporary living arrangements (including emergency shelter, congregate shelters, transitional housing, hotels, motels paid for by charitable organizations or by government programs).</td>
<td>Staff should provide written information obtained from third party regarding the participant’s whereabouts, and, then sign and date the statement. Written referral from the agency.</td>
<td></td>
</tr>
<tr>
<td>1 Persons exiting where they resided 90 days or less AND were residing in an Emergency shelter or place not meant for human habitation immediately prior to entering the institutions.</td>
<td>Written verification from the institution’s staff that the participant has been residing in the institution for less than 90 days; and information on the previous living situation as being homeless in shelter or streets.</td>
<td></td>
</tr>
<tr>
<td>4 Fleeing or is attempting to flee domestic violence AND No Subsequent residence has been identified AND No Resources or support networks to obtain permanent housing.</td>
<td>Written verification if available. Self report is okay.</td>
<td></td>
</tr>
</tbody>
</table>

**Self Declaration of homelessness (use only if 3rd party is unavailable):**

*Use reverse if more space needed.*

Homelessness and attach it to this worksheet. Maintain all in the participant file.

<table>
<thead>
<tr>
<th>Client Signature</th>
<th>Date</th>
</tr>
</thead>
</table>
EXHIBIT F: Examples of Eligibility Worksheets/Documentation Forms

Participant Eligibility Worksheet (Imminent Risk Homeless Documentation form)

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Participant Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date of Intake

Homeless or At Risk: Circle the appropriate type of criteria & documentation to verify. Maintain all in the participant file

<table>
<thead>
<tr>
<th>At Risk Homeless Status</th>
<th>Type of Documentation</th>
<th>Documentation Attached</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. An individual or family who will imminently lose their primary nighttime residence provided that:</td>
<td>1. At least one of the following stating that the household must leave within 14 days:</td>
<td></td>
</tr>
<tr>
<td>(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;</td>
<td>A court order resulting from an eviction notice or equivalent notice, or a formal eviction notice;</td>
<td></td>
</tr>
<tr>
<td>These may include: At Risk of Homelessness: a) Has moved because of economic reasons 2 or more times during the 60 days immediately preceding the application for assistance; OR b) Is living in the home of another because of economic hardship; OR c) 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 d) 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 e) 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 f) Is exiting a publicly funded institution or system of care; OR g) 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</td>
<td>For individuals in hotels or motels that they are paying for, evidence that the individual or family lacks the necessary financial resources to stay for more than 14 days; or An oral statement by the individual or head of household stating that the owner or renter of the residence will not allow them to stay for more than 14 days.</td>
<td></td>
</tr>
<tr>
<td>The intake worker must verify the statement either through contact with the owner or renter, or documentation of due diligence in attempting to obtain such a statement.</td>
<td>2. Certification by the individual or head of household that no subsequent residence has been identified.</td>
<td></td>
</tr>
<tr>
<td>3. Self-certification or other written documentation that the individual or head of household lacks the financial resources and support networks to obtain other housing.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Self Declaration of imminent risk of homelessness (use only if 3rd party is unavailable) or DV person.

Staff Signature

Client Signature  Date
EXHIBIT F: Examples of Eligibility Worksheets/Documentation Forms

**Instructions:** This suggested template may be sent to homeless service providers requesting their verification of the chronically homeless status of an individual known to them. This template letter may be copied onto letterhead or recreated with the same context and printed on letterhead.

Date: ____________________

To:

____________________________________

____________________________________

Dear ____________________,

This letter is to confirm that (Tenant name) is currently staying at the (shelter/program name) as of (entry date) and can stay until (anticipated exit date).

(Tenant name) has also stayed at this shelter on the following occasion(s):

Please enter any past entry and exits dates (e.g.: 01/01/2013 – 03/01/2015) on each line

____________________________________

____________________________________

____________________________________

Please do not hesitate to contact me if you have any questions.

Sincerely,

____________________________________

Staff signature

Name
Staff title
Agency name
Agency/shelter address
Agency/shelter phone number
Agency/shelter fax number
EXHIBIT G: PSH Forms

Certification of (Chronic) Homeless Status

Tenant Name: ______________________

Instructions: This form provides a suggested timeline to analyze whether or not the chronology of a person’s history meets the time frame for the definition of chronic homelessness. This should capture both experiences of homelessness and breaks of seven (7) days or more. A household can self-certify up to three (3) months of episodes of homeless and still be considered as documented with third party verification.

Third party documentation is required from at least one of the following sources:

___Certification letter(s) from an emergency shelter for the homeless. Attach to this form
___Certification letter(s) from a homeless service provider or outreach worker. Attach to this form
___Certification letter(s) from any other health or human service provider. Attach to this form

Definition: a household experiencing chronic homelessness as: a homeless person/family with a disability AND has been continuously homeless for twelve (12) months or more. (HUD defines ‘homeless’ as ‘a person sleeping in a place not meant for human habitation [e.g. living on the streets] OR living in an emergency shelter.) OR has had four (4) episodes of homelessness in the last three (3) years, where the total of these episodes equals at least twelve (12) months. (An episode of homelessness is defined by a break of seven [7] days or more.)

<table>
<thead>
<tr>
<th>Time Period (Entry/Exit dates)</th>
<th>Location (shelter name or housing)</th>
<th>3rd Party/Self-Certify</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: 01/01/05 – 02/27/05</td>
<td>ABC Shelter, Indianapolis</td>
<td>3rd party</td>
</tr>
<tr>
<td>Example: 02/28/05 – 3/10/05</td>
<td>Staying with a friend, Indianapolis</td>
<td>Self-Certify</td>
</tr>
</tbody>
</table>

By signing below, I am self-certifying that the above information regarding my housing and stays in shelter programs is true and accurate to the best of my knowledge. I have been informed that this assistance is funded by the United States Department of Housing and Urban Development (HUD). I have been informed that I am subject to the laws and statutes of HUD in regard to making untrue statements.

Tenant Signature ______________________ Date ______________________

Staff Signature ______________________ Date ______________________
EXHIBIT G: PSH Forms

Permanent Supportive Housing Verification of Disability Form

SECTION A:
This section must be completed in order to be considered for PSH rental assistance.

Name of Tenant: _____________________________________________________________

Disability: May only accept persons experiencing homelessness with a qualifying disability.

For the purpose of qualifying for occupancy in the program, the tenant must have a mental, emotional, and/or physical impairment that meets the following criteria:

1. As a result of his/her disability, the need for treatment is expected to be of a long, continued, and indefinite duration; AND
2. The disability substantially impedes his/her ability to live independently; AND
3. Is of such nature that the disability could be improved by more suitable housing conditions.

If the tenant is disabled by chronic problems with alcohol and/or drugs, the person’s disability must meet the following criteria: Problematic use/abuse of alcohol and or/drugs that 1) has occurred for at least 12 months and 2) has caused serious difficulties in interpersonal relationships as evidenced by disruptions in employment, loss of housing, and/or loss of role in family structures or other important relationships.

SECTION B:

Documentation: Verification is required to come from a professional who is licensed by the state to diagnose and treat the condition. It must be a credentialed psychiatric title or medical doctor (MD), Licensed Physician’s Assistant (PA), and/or Licensed Nurse Practitioner (NP), or medical professional trained to make such a determination (example: Ph.D.). Persons with a LCSW, MSW, ACSW, BSW titles do not qualify. The possession of a title such as case manager or substance abuse counselor does not by itself qualify a person to make a determination. “Self-certification” is also unacceptable.

In my opinion, the above reference tenant is disabled as defined in Section A above

Signature: _______________________________________________________________

Name: _________________________________________________________________

Title: _________________________________________________________________

Date: __________________________

Qualifications / Degree(s) of individual verifying disability: _____________________________

Agency ________________________________________________________________

Address ________________________________________________________________

____________________________________________________________

Telephone: ________________________________
SECTION B Continued

OR Other ways to document disability:

- Social Security Administration (SSA) can verify persons receiving disability benefits OR
- VA Disability Check OR
- Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) checks

Circle Appropriate Verification of Disability. Attach appropriate documentation

1. SSA verification: Letter of statement
2. VA Disability Check: Attach copy of check
3. SSI/SSDI Check: Attach copy of check

Intake staff-recorded observation of disability may be used to document disability status as long as the disability is confirmed by the aforementioned evidence within 45 days of the application for assistance.

Intake Staff Name & Title: ________________________________________________________________

Agency: ____________________________________________________________________________

Date: ______________________________________________________________________________

Within 45 days of this signature, the professional licensed certification or the disability check
documentation must be attached.
Permanent Supportive Housing Program Agreement
Recommendations, Requirements, and Examples

This document includes recommendations and that can be used in your agreement with Tenants. However, it also includes requirements that must be used in your program agreements.

Recommendations:
- Do not set rules that cannot be enforced.
- Use a Housing First model: at its foundation, the “housing first” strategy operates under the philosophy that safe, affordable housing is a basic human right and a prerequisite for effective psychiatric and substance abuse treatment. Key components of the housing first model include (1) a simple application process that does not require numerous site visits and excessive documentation; (2) a harm reduction approach in which tenants are not required to be clean and sober in order to obtain or keep their housing; and (3) no conditions of tenancy that exceed the normal conditions under which any lesseholder would be subject, including participation in treatment or other services.

Requirements:
- Both the case manager and tenant must sign and date the agreement; a copy of the agreement should be maintained in the tenant’s file and a signed copy should be given to the tenant.
- Provide information to Tenants regarding the termination and appeals process at the beginning of the enrollment process.
- Due process. In terminating assistance to a Tenant, there will be a formal process that recognizes the rights of individuals receiving assistance under the due process of law. This process, at a minimum, will consist of:
  - Providing the Tenant with a written copy of the program rules and the termination process before the Tenant begins to receive assistance;
  - Providing a written notice to the Tenant containing a clear statement of the reasons for termination;
  - A review of the decision to terminate, in which the Tenant is given the opportunity to present written or oral objections before a person other than the person (or a subordinate of that person) who made or approved the termination decision; and
  - Providing written notice of the final decision to the Tenant within 10 days of the final decision.

Example of Grounds for Termination of Assistance:
- Termination of Assistance. A Tenant’s assistance may be terminated if it violates program requirements or conditions of occupancy.
- The Tenant's rental assistance will be terminated under the following circumstances:
  - The Tenant is evicted from the residence due to a violation of the landlord/tenant agreement by the Tenant or those family members living with the Tenant.
  - The Tenant engages in illegal activity that endangers the premises.
  - If the Tenant moves to another HUD-assisted project, or another subsidized permanent housing unit, or moves out of the unit without providing notice.
  - If the Tenant is hospitalized for either medical or psychiatric reasons or incarcerated in prison/jail for more than 90 days.
  - If the Tenant terminates the agreement.
  - If the Tenant submits inaccurate information.
  - If the Tenant does not pay its portion of the rental assistance.
  - If the Tenant sublets the premises to another person.

Example of a Signature Block:

Tenant: ________________________________ Date: ________________________________

Case Manager: _________________________ Date: ________________________________

Case Manager Phone: __________________ E-mail: ____________________________
EXHIBIT G: PSH Forms

Permission to Share Confidential Information to Secure Necessary Services

I authorize the personnel of (Sub-recipient) to share my identity, that I have a confirmed eligible criteria for the Permanent Supportive Housing Program, and that I seek their services for support. I authorize only those agencies or individuals who are listed below.

Unless I have initiated and signed additional release forms for specific purposes; no information that might identify me may be shared by representatives of the sub recipient, with any other person or organization. I understand that the sub-recipient will take all necessary precautions to protect my identity.

By my signature below, I hereby agree that I shall not hold the sub recipient liable for the performance or quality or degrees of performance of services agreed to by affiliates.

I authorize the sub recipient to release my identity, my diagnosis, when necessary, and my need for services and support to the individuals, groups, or agencies listed below. This release is subject to revocation at any time except to the extent that the program has acted upon it. I voluntarily waive the Indiana Law provision that the consent expire in sixty (60) days after signing and specify that this consent remain in effect for thirty (30) days after my discharge from the program.

My signature authorizes the sub recipient to release necessary information to the agencies and individuals initialed by me, below.

Applicant's Initials

HUD

IHCOA

Landlord

Sub-recipient

Other (specify)

Applicant

Signature: ____________________________ Date: ______________

Witness: ______________________________ Date: ______________
### EXHIBIT G: PSH Forms

<table>
<thead>
<tr>
<th>Goal #1:</th>
<th>Action Steps:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1)</td>
</tr>
<tr>
<td></td>
<td>2)</td>
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<td></td>
<td>3)</td>
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<td></td>
<td>4)</td>
</tr>
</tbody>
</table>

Person(s) responsible:

<table>
<thead>
<tr>
<th>Goal #2:</th>
<th>Action Steps:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1)</td>
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<tr>
<td></td>
<td>2)</td>
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<td></td>
<td>3)</td>
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<td></td>
<td>4)</td>
</tr>
</tbody>
</table>

Person(s) responsible:

<table>
<thead>
<tr>
<th>Goal #3:</th>
<th>Action Steps:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1)</td>
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<tr>
<td></td>
<td>2)</td>
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<td>3)</td>
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<td>4)</td>
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</tbody>
</table>

Person(s) responsible:

<table>
<thead>
<tr>
<th>Goal #4:</th>
<th>Action Steps:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1)</td>
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<td>2)</td>
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<td></td>
<td>3)</td>
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<tr>
<td></td>
<td>4)</td>
</tr>
</tbody>
</table>

Person(s) responsible:

<table>
<thead>
<tr>
<th>Goal #5:</th>
<th>Action Steps:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1)</td>
</tr>
<tr>
<td></td>
<td>2)</td>
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<tr>
<td></td>
<td>3)</td>
</tr>
<tr>
<td></td>
<td>4)</td>
</tr>
</tbody>
</table>

Person(s) responsible:

Tenant: ___________________________ Date: ___________________________

PSH Staff: ________________________ Date: ___________________________
EXHIBIT G: PSH Forms

Income Information

Annual gross income must be reassessed at least annually. However, if there is a substantial decrease in the participant’s income during the year, the participant may request that the income be recalculated to reflect the change and potentially the amount of assistance received.

Documentation and Verification of Income: As a condition of participation in the program, we are required to have third party documentation for each household member and they agree to supply such certification, release, information, or documentation to verify the member’s income.

The income of each household member over the age of 18 must be included. In addition, if children under the age of 18 are receiving social security assistance, that income must be counted.

Attached to this application provide third party documentation of the following applicable income documentation:

- Wage verification – Copies of at least 3 paystubs or written verification from employer
- Pension Verification – Copy of check or bank statement showing deposit
- Social Security Verification – Copy of check, SSA award letter, or bank statement showing deposit
- TANF Verification – Print out showing monthly benefit amount
- Child Support Verification – Print out showing monthly benefit amount
- Banking Verification – Copy of last statement

Deductions from income can be considered from the following two sources:

- Medical Expenses/Spend-Down Verification – Documentation of out of pocket non reimbursable medical expenses paid by the applicant
- Child Care Expenses – Letter from center of how much child care has been paid, if the child care is provided by a family member or a home provider, the letter must be notarized.

I certify that all of the information and the amount of my income and financial resources on this application are correct and true. I have been informed that this assistance is funded by the United States Department of Housing and Urban Development (HUD). I understand that I am legally responsible for the statements I made to receive assistance to pay my rent. I have been informed that I am subject to the laws and statutes of HUD in regard to making untrue statements.

_______________________________      _________________      _______________________________      _________________
Tenant’s Signature                           Date                           Sub-recipient Representative                     Date
EXHIBIT G: PSH Forms

Zero Income Affidavit

I, ____________________________, have applied for rental assistance through the HUD Permanent Supportive Housing program. Program regulations require verification of all income from participating households of each household member over the age of 18 without any income.

Income includes but is not limited to:
- Gross wages, salaries, overtime pay, commissions, fees, tips and bonuses
- Net income from operation of a business or from rental or real personal property
- Interest, dividends and other net income of any kind for real personal property
- Periodic payments received from Social Security, annuities, insurance policies, retirement funds, pensions, disability or death benefits and other similar types of period receipts
- Lump sum payment(s) for the delayed start of a periodic payment (except as provided in 24 CFR 5.609(b)(5))
- Payments in lieu of earnings, such as unemployment and disability compensation, worker’s compensation, and severance pay
- Public assistance
- Alimony and child support payments (whether through the court system or not)
- Regular pay, special pay and allowances of a head of household or spouse who is a member of the Armed Forces (whether or not living in the dwelling)
- Regular monetary gifts from family and/or friends

- I have stated during this verification process that I have no income at this time. I have not received income since ______________ (date). I do not expect to receive any income until ______________ (date).

I understand that any misrepresentation of information or failure to disclose information requested on this form may disqualify me from participation in the PSH program, and may be grounds for termination of assistance. WARNING: It is unlawful to provide false information to the government when applying for federal public benefit programs per the Program Fraud Civil Remedies Act of 1986, 31 U.S.C. §§3801-3812.

I certify that the above information is true and correct. I also understand that it is my responsibility to report all changes to my household composition or income in writing to within ten (10) business days of such change.

Signature: ____________________________ Date: ________________

Witness: ____________________________ Date: ________________

Case Manager Notes:
EXHIBIT H: Chronic Homeless Verification Information

Aligning the PSH and CE processes for documenting chronic homelessness and how/when to house households that do not meet that definition

PSH projects that dedicate or prioritize beds for chronically homeless individuals or families must maintain and follow written intake procedures:

*Establish the following order of priority for obtaining evidence:*

- Third-party
- Intake worker observation
- Certification from the person seeking assistance (Self-Certification)

Self-Certification: Each PSH program can have no more than 25% of households served in an operating year self-certify their chronic homeless status. Households can self-certify up to, but not over, three months of homelessness and not count towards this 25% maximum.

*If a third-party cannot be obtained:*

**Document**
- Written record of intake workers due diligence to obtain AND
- The intake worker’s documentation of the living situation AND
- The individual’s self-certification of the living situation

*Documenting breaks:*

Breaks are defined as at least seven nights not residing in an emergency shelter, safe haven, or as residing in a place meant for human habitation (e.g., staying with a friend, in a hotel/motel paid for by program participant).

Stays in institution of fewer than 90 days do not constitute a break and **do** count toward total time homeless

*Evidence of a break can be documented by:*

- Third-party evidence
- The self-report of the individual seeking assistance (100% of breaks can be documented by self-report).

*Documenting institutional stays:*

Obtain discharge paperwork or a written or oral referral from a social worker, case manager, or other appropriate official stating the beginning and end dates of the time residing in the institutional care facility.

If that information is not attainable, create a written record of intake workers due diligence to obtain **AND** the individual’s signed self-certification that they are exiting an institutional care facility where they resided for less than 90 days.